

Chapter 1

Introduction

Prologue

'But you're the professional....'

These four words *still* resonate deeply within me, despite the fact that they were uttered over ten years ago while I was attending a graveside service for the brother of a work colleague. As the coffin was being lowered into the ground, a fellow mourner and close personal friend suggested that I step forward and put my arms around my work colleague and her father as they were becoming distressed by the sight of their loved one being laid to rest. When I responded by saying that I didn't feel the need to do so but that *she* could if she wanted to, she seemed somewhat taken aback by my reply. With an expression of utter disbelief on her face, she looked me squarely in the eyes and said, "But *you're* the professional."

I remember the internal jolt I experienced upon hearing those words, for here I was, at a painful and intimate time, being seen through the lens of my profession as a psychologist, rather than as a fellow mourner and friend who was struggling with her own responses to the loss. In that moment, not only did it feel as if I had been depersonalised by being assigned to my professional role, but that in occupying this role, with its accompanying expectation of caring for others, I had been located outside the loss and grief circle - a professional amongst lay mourners rather than a lay mourner myself.

Upon reflection, I wondered what might have happened if, during the graveside service, I had begun to cry, or had fainted, or had asked someone to put their arms

around *me*? How would others have responded? Would they too have experienced an internal jolt as they were forced to refocus their lens from my professional role to my personal being? And what if the death had been that of *my* brother rather than that of my colleague's? Could I have expected the same responses and reactions as she had been receiving, or again, would my professional role somehow mitigate the ways in which my grief might be understood and attended to by others? Where then would that leave my personal stories and experiences in instances of loss?

As I traced back through the years since I have become a psychologist, I connected with several other loss-related occasions when I had felt that my professional role had been the primary one through which I had been viewed. Within my family of origin, I have vivid memories of sitting on the edge of my mother's hospital bed after she'd had a stroke, holding her hand and asking her how she was feeling. "Darling, don't talk to me like a psychologist" she had replied, to which I had found myself protesting, "But I'm not! I'm talking to you like a daughter!" On another occasion I remember my feelings of dismay as I listened to a friend inform a group of mutual acquaintances that she had rung me first after her mother's death because she knew that I was "tough". I often wondered whether this toughness was because I'm a psychologist who specialises in loss and grief and therefore am somehow inoculated against having a personal response, or was I "tough" because that's how she (and others) needed me to be in order to cope?

Whilst acknowledging the difficulty in finding the space and permission to express my responses to loss within my personal life, I have also come to recognise that this difficulty pales in comparison to that experienced in relation to losses experienced within my professional realm. I often reflect on the struggle I experienced in relation

to the death of a terminally ill client whom I had counselled since his initial diagnosis of cancer nine months earlier. His death evoked little recognition from others who had known of my involvement that I might be as affected by his death as they were. Instead, the expectation was that my professional role continue, post-death, through the provision of grief counselling to his family members.

Encounters with others within the field would suggest that I am not alone in this experience. Within my roles as a psychologist in private practice, and as an educator in a university-based counsellor training programme, I have become increasingly aware of the *lack* of loss-related stories told by trainee counsellors, or by the therapists I supervise, or by my peers in the profession. Whilst this may simply be due to the fact that they have chosen to share these stories elsewhere, I have often wondered if it might be because they too have experienced the personal-professional split that I have come to regard as being one of the hazards of the job.

I can vividly recall a conversation I had with another psychologist several years ago who had come to me for counselling in relation to the death of her close friend. Having assumed the 'responsible' role during the process of her friend's dying, she stated that she had ended up becoming locked into it – an observer who commentated about the experience rather than a participant in it. During the course of our work together, not only did she come to recognise that she had very few arenas in which to express her personal voice but that even in these arenas she tended to limit her voice in order to protect others from her pain. For her, then, the goal was to engage in a process of what she described as softening, in which her personal story of, and responses to, the loss could be heard, validated and supported.

It was this personal–professional split that I had observed within my colleagues and myself, and the acute sense of disenfranchisement that accompanied it, which therefore became the catalyst for the present study.

Rationale for and Aim of the Current Research

From a purely academic standpoint, the fact that my previous post-graduate study has been in the area of loss and grief, meant that it felt academically, professionally, and personally prudent that any subsequent study be located within this field. Furthermore, since what had struck me most about the literature I had read with regard to disenfranchised grief (see Doka 1989, 1995, 2001; Martin & Doka 2000; Thompson 2002) was that whilst, not surprisingly perhaps, it had been strongly associated with suicidal deaths; the term “survivors of suicide” had been used repeatedly to refer to the deceased’s family members, but rarely to anyone else. Where, then, did that leave non-family members who had also been impacted by the individual’s suicide? And what if the non-family member, due to a professional role, fell outside the more visible, though still rarely acknowledged, public network of the deceased’s friends or work colleagues?

In light of the above, it seemed that perhaps one of the most likely scenarios for the occurrence of disenfranchised grief would be in instances of client suicide, since not only is the act of suicide still socially-unsanctioned (and therefore difficult to speak about) but, in the context of a relationship *already* bound by the silence that therapeutic confidentiality affords, may also leave therapists struggling to find arenas in which their stories could be told.

The broad aim of this research has been to contribute to the emerging literature available with regard to therapists' experiences of client suicide. The central foci have been to:

- a) Explore how therapists' personal and professional stories about client suicide become disenfranchised.
- b) Identify the factors which exacerbate or ameliorate this occurrence.
- c) Explore the impact that disenfranchisement has on therapists and, in light of these findings;
- d) Provide recommendations for the future training, support and supervision of therapists in relation to this experience.

The research therefore set out to examine the following primary question:

“How is the death of a client by suicide a disenfranchising experience for therapists?”

Given the breadth of this inquiry, a series of corollary questions were also formulated so that a more detailed investigation of this broader, primary question might occur.

These secondary questions included:

- a) How does this disenfranchisement occur within the therapist's professional life/role?
- b) How does this disenfranchisement occur within the therapist's personal life?
- c) When therapists describe their experiences of disenfranchisement, which voice do they speak from: their professional, their personal or both?
- d) What are the dominant discourses in relation to client suicide that lead therapists to experience disenfranchisement?
- e) What factors increase the risk of disenfranchisement occurring?

- f) What factors reduce it?
- g) What changes need to be made (for example, to existing training programmes and ways of supervising and supporting therapists), to reduce the risk of disenfranchisement occurring in instances of client suicide?

Potential Benefits of the Study

As will become evident in Chapter 2, there is a paucity of systematic research into therapists' experiences of disenfranchisement in relation to client suicide. It was hoped that the stories and data collected through this study would provide important insights into:

- a) The nature and meaning of these experiences.
- b) Therapists' responses to them.
- c) The types of support therapists require, both professionally and personally, to navigate through this process.
- d) The resources needed to assist therapists integrate this experience into their personal and professional lives.

Furthermore, by permitting therapists to have a personal voice within their professional contexts, it was hoped that the aspects of their professional lives that currently remain hidden and implicit would be made visible and explicit. It was also felt that this research had implications for education, training and supervision since the insights gained through this study could be used not only to inform educators and supervisors about the professional needs of therapists in relation to disenfranchisement after client suicide, but also to alert them to the personal stories and voices that exist within the professional realm that must be legitimised and responded to accordingly.

Finally, and perhaps most significantly, it was hoped that by undertaking this research and disseminating the findings, other therapists might author accounts of their own experiences of disenfranchisement, and in doing so, have these heard, honoured and understood.

Definition of Terms

Throughout this thesis, reference will be made to a number of concepts relevant to the loss and grief field within western society. So that confusion regarding the meanings of these terms may be minimised, the following definitions have been provided:

Grief

Grief arises in response to the loss event and can be viewed as the mourner's attempt to adjust to changed life circumstances in light of the loss. Grief and grieving will be used synonymously in this thesis to encapsulate the mourner's affective, physical, cognitive, social and spiritual adaptations to the loss experience (Valente & Saunders 2002:9).

Bereavement

Bereavement refers to the death-related loss of a significant person. It represents the totality of the mourner's response to the death encompassing the physical, psychosocial, spiritual and cultural. Bereavement includes the anticipatory period, the death itself and the post-death adjustments to living (Valente & Saunders 2002:9).

Mourning

Mourning refers to the *process* that the bereaved individual must engage in, both short- and long-term, to accommodate and assimilate the loss experience in their lives. It encompasses and is influenced by an array of social and cultural norms and rules pertaining to the expression of grief (Valente & Saunders 2002:9).

Survivors of Suicide

The term ‘survivors of suicide’ refers to individuals who have been bereaved through the suicidal death of another (Maple 2005:4). In this thesis, ‘survivors of suicide’ will be used in reference to therapists who have been bereaved through the suicidal death of their client.

Disenfranchised Grief

Disenfranchised grief refers to loss experiences that are not openly acknowledged, socially sanctioned or publicly shared. In such instances, mourners are often left to grieve silently, privately and unsupported (Doka 1989; Martin & Doka 2000).

Overview of Thesis

The aim of this thesis was to examine therapists’ experiences of disenfranchisement in relation to client suicide. Through the use of a narrative approach to both interviewing and data analysis, the study illustrates that therapists’ stories about client suicide contained *all* of the key characteristics of disenfranchisement. That is, the loss itself was not recognised, it was not socially sanctioned by others, and it was not publicly acknowledged or shared.

The current chapter provides the context, rationale and overview for this research and includes definitions for the terminology used throughout the thesis. Chapter 2, the first chapter in the literature review, presents an overview of the major conceptual frameworks for understanding the experience of loss, including the ways in which they inform the mourner how their grief is to be experienced, accommodated and storied. The concept of disenfranchised grief is then examined, together with the ways in which it can impede the mourner’s story-making process in relation to their loss. Chapter 2 concludes with an examination of the factors that are unique to mourners

who are therapists as these also influence the post-loss narratives that can be told. In Chapter 3, the second of the literature review chapters, the focus is suicide bereavement, with particular emphasis upon therapist bereavement in relation to client suicide and the elements that shape it. The chapter closes by discussing the shortfalls in the current literature that provided the impetus and rationale for the current study.

In Chapters 4 and 5, attention turns to the research design and data analysis employed in this study. The theoretical orientation of narrative inquiry, the qualitative approach used to inform and guide this research, is described together with a detailed account of the research design implemented and the data analysis undertaken using a combination of narrative-type narrative enquiry (Polkinghorne 1995; White & Hede 2008), component story analysis (Nuttgens 1997) and paradigmatic-type narrative enquiry (Polkinghorne 1995; White & Hede 2008).

Chapter 6 introduces two of the participants' in-depth component stories. These narratives were chosen as they illustrate the polarities of the spectrum in relation to the experience of disenfranchisement after client suicide. The first story, that of Jude, represents the least disenfranchised story heard, the second, Murray's, the most. Whilst, ideally, I would have liked to include the stories of the remaining eight participants in this chapter, adherence to word limited prohibited this. These stories are therefore presented, in their entirety, separately (see Appendices E to L). Readers are encouraged to engage with these stories before continuing to Chapter 7 as they too provide valuable insights into therapists' experiences of disenfranchisement.

In Chapters 7, 8 and 9 the three plotlines identified in relation to therapist disenfranchisement after client suicide are examined. Plotline One: Invisible Losses (Chapter 7) explores the ways in which the death of a client by suicide becomes a

hidden experience for therapists, broadly reflecting the first characteristic of disenfranchised grief that, 'the loss experience is not openly acknowledged' (Doka 1989 quoted in Martin & Doka 2000:13). Plotline Two: Invisible Relationships (Chapter 8), reflects the second characteristic of disenfranchised grief, that 'the loss experience is not socially sanctioned' (Doka 1989 quoted in Martin & Doka 2000:13) and explores the ways in which the therapeutic relationship impedes therapists' bereavement. Plotline Three: Invisible Mourners (Chapter 9), corresponds with Doka's (1989)(cited in Martin and Doka 2000:13) third characteristic of disenfranchised grief that, 'the loss is not publicly shared', and examines how the therapist's role in relation to the deceased inhibits the visibility of their grieving process.

The final chapter of this thesis, Chapter 10, examines the potential risks to therapists, both personally and professionally, of experiencing disenfranchisement in relation to their client's death. In light of these findings, the chapter concludes by offering a series of recommendations with regard to changes that must be made within the field of thanatology, current codes of ethical conduct, therapist training programmes, supervision and the supervisory role if the risk of therapist disenfranchisement in relation to client suicide is to be minimised. Directions for possible future research are also suggested as part of this discussion.

Chapter 2

Literature Review

Storying Our Experiences of Loss And The Loss of Our Storied Experiences

'Grieving [is] a graceful and deliberate walk backwards

while keeping a sure foot in living forward'

(Moules et al 2004 quoted in deKlerk 2007:53)

This chapter begins with an overview of the major conceptual frameworks for understanding the experience of loss, including the ways in which they shape and inform societal expectations about how bereavement is experienced, accommodated and storied by the mourner (Costa, Hall & Stewart 2007; Neimeyer 2001d). The concept of disenfranchised grief is then examined, together with the ways in which it can impede construction of the mourners' stories in relation to their loss. Finally, factors unique to mourners who are therapists are explored since these too inform and influence the post-loss narratives that can be told.

Historical Grief Frameworks – Constructing Universal Stories of Disengagement and Detachment

Since the early 1900's, the stories of those who grieve have been significantly influenced by the theoretical evolution that has occurred within the field of thanatology with regard to the ways in which grief and mourning are conceptualised and understood. It was Freud's (1917, 1961) psychoanalytic approach, which viewed mourning as an individualised, relatively uncontrollable, internalised process through which the bereaved relinquished their bond with the deceased, that was one of the first

to be offered. From Freud's (1961) perspective, 'healthy' stories of mourning were those which reflected the bereaved's capacity to free their ego from their attachment to the deceased and to establish a life separate from them. 'Pathological' stories of mourning, by way of contrast, were those containing feelings of ambivalence towards the individual who had died or in which 'negative' emotions such as depression and anxiety were expressed (Freud 1961).

Freud's theoretical assumption that mourning was a highly individualised experience was subsequently challenged by Bowlby (1961), who argued that mourning was, in fact, a highly interpersonally based experience, deeply influenced by the degree of attachment that the mourner had held towards the deceased. When viewed through this lens, the inclusion of grief responses such as anxiety, depression, anger and confusion within a mourner's story were regarded as being perfectly normal and appropriate since they reflected the pain being experienced in relation to the loss of the bonds that had previously existed. Like Freud (1961), Bowlby (1961) believed that the purpose of mourning was to sever these bonds with the deceased. Thus mourners who continued to make mention of the deceased rather than removing them from their life stories were deemed to have grieved unsuccessfully, having failed to 'move on' by detaching themselves completely from the individual who had died.

The notion of needing to move through and move on from a place of initial disorganisation to a place of new attachment, new reality, and new life stories was further developed by Kubler-Ross (1969) whose seminal five stage model of mourning (denial, anger, bargaining, depression and acceptance) was to have a major impact upon the way in which grief would be conceptualised and narrated thereafter. Parkes (1996), for example, built upon Kubler-Ross' stage-based paradigm by

viewing mourning in terms of four psychosocial transitions: shock and numbness; yearning and searching; disorganisation and despair; and reorganisation. According to this model, grieving was a process in which the mourner moved through a pre-programmed series of behaviours, together with their accompanying pre-programmed stories. Whilst acknowledging that the internalisation of the deceased was an important part of the early grieving process, Parkes (1996), like those before him, believed that successful grieving ultimately involved breaking this attachment. The dominant discourse, that 'healthy' grief stories were those that reflected the absence of the deceased from the mourner's new life, was thereby perpetuated.

Whilst supporting the concept of mourning being a definable, delineated process, Worden (1991, 2001) subsequently proposed that bereaved individuals had to proactively engage in a series of tasks, rather than move through a sequence of stages, if they were to grieve successfully and re-engage with life. These tasks, which could be completed in any order, were to accept the reality that a loss had occurred; to engage in a process of working through to the pain of the grief; to adjust to an environment in which the deceased was absent; and to emotionally re-locate the deceased. From Worden's (1991, 2001) perspective, full resolution of the mourning process could only occur when the tasks of mourning had been accomplished.

Rando's (1992) Six 'R' model, whilst similar to Worden's (1991, 2001) four tasks, divided the tasks into three separate phases. From Rando's (1992) perspective, the resolution of mourning required the disconnection of the psychosocial ties that had bound the mourner to the deceased. These phases included the revision of the mourner's assumptive world; the modification of their previously held roles, behaviours and skills; and the development of a new identity so that new psychosocial

ties could be formed. Like other proponents of grief models based on stages, phases, or tasks, any desire by the mourner to maintain their relationship with the deceased was viewed by Rando (1992) as being pathological. Bereavement narratives, which contained such relational information, were therefore regarded as being clear indicators that the mourner had failed to successfully complete their mourning and needed to re-engage in the process until this disconnection occurred.

Whilst models such as these would suggest the existence of a clearly delineated mourning process in which pre-determined ways of reacting could be expected, the rigidity and restrictiveness of such paradigms has been increasingly debated. Those who oppose these traditional models of mourning (see Elison & McGonigle 2003; Middleton & Raphael 1987; Payne et al 2002; Servaty-Seib 2004; Silverman & Klass 1996; Stroebe et al 2000; Thompson 2002; Worden 2002) argue that such cookie cutter templates pressure mourners into shaping, sequencing and censoring their grief narratives in order to fit within these pre-ordained, pre-storied, one-size-fits-all approaches. The literalism created by these dogmatic 'dictates of mourning' (Servaty-Seib 2004:129) generates a 'should, ought, and must grieve properly' mentality which can create complications rather than prevent them (for example, "You must/must not cry"). Furthermore, since such models are based on the perspectives of the observer, an individual who is external to, and removed from, the actual lived experience of loss (DeSpelder & Strickland 2002), the mourner's own encounter with grief may become entirely subjugated, depersonalised and disempowered (Hagman 2001).

By failing to take into account the physical, social, and cultural contexts in which the mourner lives, these models also 'neglect the totality of the person's life in favour of the supposed stages' (Corr, Nabe & Corr 1997:153) and in doing so, engage in

‘psychological reductionism’ (Thompson 2002). This reductionism, and the reduced stories it produces, is compounded by the fact that the dominant worldview of Western society is that autonomy, individuation and independence are the ultimate goals of human development and that dependence is undesirable (Miller 1986). Such insistence on separateness and stringently clear boundaries, Silverman and Klass (1996:15) argue, ‘requires a mechanistic view of human functioning that fails to appreciate the importance of connection and relationship’.

Furthermore, the assumption that successful grief resolution occurs only by completing all the phases or tasks required to ‘let go’ and ‘get over’ the loss, implies that mourners who do not adhere to this prescriptive formula are somehow abnormal and must be experiencing some form of complicated or pathological grief response (Wortman & Silver 1989). Thus grief-related stories of separateness and disconnection become the expected and endorsed discourse whilst those of inclusiveness and connectedness are regarded as being faulty and in need of re-narration.

Contemporary Grief Frameworks – Constructing Unique Stories of Connection and Continuation

In light of the criticisms outlined above, there has been a growing movement away from the dominant stages, tasks, and phases paradigms towards more flexible, phenomenological frameworks – ‘cutting edge conceptualisations of grief and mourning’ (Servaty-Seib 2004:125) - that prize the unique, idiosyncratic, organic ways in which mourners’ stories of grief unfold. The most prominent of these are Meaning Reconstruction and Loss (Neimeyer 2001d, 2006), Dual Process Theory (Stroebe & Schut 1999, 2001a, 2001b) and the resurgence of Attachment Theory (Fraley & Shaver 1999). These approaches, together with the ways in which they

enhance a mourner's capacity to tell their stories of loss, are discussed in greater detail below.

Grieving as a Process of Meaning Reconstruction

Drawing upon contemporary constructivism and narrative conceptualisations, advocates of a meaning reconstruction approach to mourning (see Guterman & Rudes 2005; Neimeyer 1997, 2001a, 2001b, 2001d, 2006; Neimeyer & Keesee 1998; Neimeyer & Anderson 2002) argue that it is the uniquely personal meanings that the mourner attaches to the loss which shape and inform their grieving process and not the imposition of a predetermined trajectory of responses as theorists such as Kubler-Ross (1969), Rando (1992) and Worden (1991, 2001) would suggest. In relation to loss, meaning-making encapsulates both the *context* in which the loss has occurred (that is, the loss itself, the sense made of it, the ensuing identity reconstruction, life lessons learnt and post-traumatic growth experienced (Attig 1996; Neimeyer 1997a; Tedeschi, Park & Calhoun 1998)); and the *narrative processes* through which the mourner engages in their search for meaning and significance (Neimeyer & Anderson 2002).

Within this framework, narrative processes refer to the 'distinctive styles of storytelling that give self-narratives their unique form and which contribute to the transcendence of tragedy' (Neimeyer & Anderson 2002:52). Both Angus, Levitt and Hardke (1999) and Neimeyer and Levitt (2001) have distinguished between three types of narrative processes – external narratives (which refer to the concrete, overt and often sequentially presented account of the loss event itself); internal narratives (which encompass the mourner's affective reactions to the loss); and reflexive narratives (which include the mourner's efforts to reflect upon, analyse and interpret

the loss in their search for meaning and their desire to make sense of it all). Thus attention must be paid to the cognitive aspects of the mourning process as well as the emotional elements upon which traditional theories tended to focus their attention (Janoff-Bulman 1989; Viney 1991).

According to Neimeyer (2001b), in the aftermath of loss, meaning reconstruction is, in fact, the *central* feature of grieving for the majority of mourners. Furthermore, since reality and truth within the mourning process are viewed within this meaning-making process as being relative rather than objective and absolute (Stroebe et al 1996), the mourner becomes the expert on his or her own bereavement, the 'person who best knows their stories and is most adept at interpreting them through their own cultural lens' (Ravalico 2006:23). In light of this, theorists and clinicians alike are required to relinquish their presumed expertise and to approach the bereaved from a position of 'not knowing' (Anderson & Goolishian 1992).

In addition, since advocates of a meaning reconstruction approach recognise the profound interplay between the social and emotional elements of loss, they refute the notion that grieving occurs in an isolated, individualised vacuum, claiming that social context impacts profoundly upon the mourning process as it is intrinsically embedded within the mourner's 'individual culture' (Glick, Weiss & Parkes 1974). As Neimeyer and Anderson (2002:47) observe, 'the often-effortful attempt to reconfigure a viable self and world in light of the loss proceeds on deeply personal and intricately social levels simultaneously.' Broader cultural discourses, shaped by the mourner's geographical and socio-economic locations, age, gender, religious or spiritual affiliations, degree of relational centrality with the deceased, and the mode of death, will therefore impact significantly upon not only what the mourner shares about the

loss (the story's content), but also how it is shared (the process of storytelling), interpreted and understood (Doka & Davidson 1998; Neimeyer & Anderson 2002). The broad and inclusive way of conceptualising and contextualising mourning that meaning reconstruction offers means that the uniqueness of both mourners and their stories as they journey towards discovering new and practical ways of re-orienting themselves with the world is honoured (Gilbert 1996; Neimeyer 2001c).

Dual Process Theory of Mourning

Stroebe's (2002), Stroebe and Schut's (2001a) and Stroebe, Schut and Stroebe's (1998) 'Dual Process Theory' of mourning is highly compatible with that of the constructivists as it too emphasises the importance that the bereaved place on meaning making. According to this theory, when an individual experiences a loss, two concurrent grief responses occur. The first, 'loss orientation', encapsulates responses typically associated with working through aspects relating to the actual loss, including the expression and exploration of emotions and the recollection of memories related to the deceased (through the use of photographs, visits to places of past significance and the like). The second response, 'restoration orientation', refers to the mourners' concurrent attempts to re-orient themselves away from their grief responses and towards the reorganisation and reconstruction of their lives in the face of the loss. Thus, according to Stroebe (2002), Stroebe, Schut and Stroebe (1998) and Stroebe et al (2001b), grieving is not a chronological, transitional event as the traditional theories of mourning would have us believe, but rather a process of oscillation between connecting with the loss and attempting to re-establish a new life in its wake. Meaning re-construction occurs as part of the movement between reflecting upon the loss and projecting oneself into the future. Since, like the constructivists, Dual Process Theory takes into account the psychological, social, political and cultural aspects of the

mourner's life, it too recognises the highly complex nature of the grieving process and the uniquely personal meanings that the mourner attaches to it. Furthermore, through the process of oscillation, Dual Process Theory is able to reconcile what DeSpelder and Strickland (2002) regard as one of the most challenging aspects of mourning, the need to both re-invest in life by moving forward whilst simultaneously remaining connected with the deceased.

Attachment Theory

Drawing upon Bowlby's (1961) earlier work, theorists are now also re-examining the critical impact that an individual's attachment style can have upon the degree of grief-related difficulties they experience within their mourning process (see Noppe 2000; Stroebe 2002). It has been noted, for example, that bereaved individuals who have an anxious/ambivalent attachment style may be more vulnerable to experiencing chronic grief than those who have secure, avoidant or disorganised/disorientated ones (Gamino, Sewell & Easterling 1998; Servaty-Seib 2004). Servaty-Seib (2004) cautions however, that since an individual's experience of mourning is intrinsically shaped by their pattern of attachment, what constitutes a healthy grieving process may vary from individual to individual depending upon their particular style. Thus, she argues, absent or minimal grief responses which would have been regarded as being indicators of a pathological story of denial within traditional grief frameworks, when viewed within attachment theory, simply become reflections of the mourner's avoidant attachment style. When understood this way, the mourner's lack of grief and grief-related stories merely indicate a lack of connection to the deceased and not some underlying complication.

Mourning as a Means of Continuing the Bonds with the Deceased

Ensclosed within these more flexible phenomenological frameworks has been the notion of maintaining, rather than relinquishing ties with the deceased (see Archer 2001; DeSpelder & Strickland 2002; Fleming & Belanger 2001; Hunter 2007/2008; Klass, Silverman & Nickman 1996; Neimeyer 2001a; Neimeyer & Anderson 2002; Stroebe, Schut & Stroebe 1998; Vickio 1999). Silverman and Klass (1996), for example, challenge the belief that the mourner must sever their bonds with the deceased in order to establish new attachments and that by wanting to maintain a link with the deceased the mourner is exhibiting a pathological grief response. To the contrary, they argue that sustaining an ongoing sense of connection and involvement with the deceased is a completely natural and normal part of the mourning process. 'The process does not end...people are changed by the experience, they do not get over it, and part of the change is a transformed but continuing relationship with the deceased' (p. 19).

Walter (1999) also challenges the historically held assumption that 'letting go' of the relationship with the deceased is a necessary corollary of grief resolution, arguing instead for the 'granting of permission [to the bereaved] to find a place for their dead' (p. 106). Thus, grief 'resolution' involves 'a movement away from not being able to think about the loved one without mental anguish and distress to a state in which thinking about them is accompanied by more neutral or positive affect' (Archer 2001:556). White (1998) reiterates these sentiments by urging that a 'saying hello again' approach to the bereaved's relationship with the deceased needs to be adopted, as do Fleming and Belanger (2001:314) who contend that the process of grieving requires 'moving from losing what we have to having what we lost'. The mourner's role, therefore, becomes one of pro-actively engaging in the conscious reconstruction

of a symbolic inner representation of the deceased whilst renegotiating the meaning of the loss over time (Neimeyer 1997, 2001a; Neimeyer & Anderson 2002; Neimeyer & Keesee 1998).

Since these continuing bonds have the capacity to inform and influence the mourner's present and future ways of living in the world it is imperative that they be normalised, legitimised and validated (Silverman & Klass 1996). Rizzuto (1979) draws attention to the critical role that those who support the bereaved play in relation to this validation process. Klass (1988) and DeSpelder and Strickland (2002) also observe the pivotal role played by others in assisting the bereaved to actively maintain their post-death relationship with the deceased, with DeSpelder and Strickland (2002:263) contending that death 'is a community event [since] people maintain connections with the deceased through memories, as well as through personal and social rituals that provide a space in their ongoing lives for acknowledging affection and love for the deceased.' Hunter (2007/2008) agrees, stressing that whilst the funerary ritual and burial provide valuable structure and support in the immediate aftermath of a death, they alone are not enough since they are 'not congruent with the long-term emotional needs and reconstruction of meaning within grief' (p. 153). Like DeSpelder and Strickland (2002), she argues that private rituals, 'reunions of the community of mourners' and 'rituals of remembrance and new meaning' (p. 153) are also required.

The fact that linking objects (Volkan 1972) that once belonged to the deceased, such as grandma's diary, dad's old dressing gown or a daughter's art work, are also such an integral part of the mourning process further illustrates the mourner's need to find familiar and continuing connections in life narratives that have been ruptured by the death (Hall 2001; Neimeyer 2000b; Schuchter & Zisook 1988; Vickio 1999). As

Rosenblatt (1999) has noted, since people use possessions to define both their place in the world and their relationship to others, when these relationships end the mourner may turn to these possessions 'both as reminders of the definitions that were maintained in the relationship with the person now lost and in search of new meanings which take the loss into account' (p. 103). Elison and McGonigle (2003:164) agree, arguing that 'just as public rituals invest objects with universally recognised symbolic value, some objects acquire private meaning every bit as potent to the individual.' Thus linking objects become a critical source of meaning for the self, solace for the changed life situation, and 'a token of triumph over the loss' (Meyers 2002:257).

Klass (1995) cautions, however, that there are certain circumstances under which the solace normally afforded by the possession of linking objects may be compromised or negated. The first is when the inner representation is not shared by the bereaved individual's natural support network because the loss is not socially sanctioned or has occurred in a socially unacceptable way. The second is when the inner representation becomes contaminated by or enmeshed within individual or family pathology. Both circumstances, Klass (1995:258) believes, can result in 'especially difficult clinical situations.' Meyers (2002:257) agrees, stating that because linking objects 'tend to mark a blurring of psychic boundaries' between the mourner and the individual who has died, they can 'impede or complicate mourning' (p. 257). Thus, linking objects 'become totemic of what was good or bad about the relationship' (Elison & McGonigle 2003:164).

As McGee (1995:18) notes, mourners exist who are quite emphatic about not wanting to let go of their past and move on, and for whom 'holding on to grief might be the most growth-producing and liberating experience.' This underscores the necessity for

‘the development of a more adequate language for talking about and to the deceased’ (Klass, 1993a, 1993b) and for the adoption of more flexible models of grief which celebrate the ongoing nature of the bereaved’s relational connections with the individual who has died.

Losing Our Storied Experiences of Loss

Unfortunately, despite the emergence of more flexible, phenomenological frameworks for conceptualising mourning, not all grieving occurs in contexts that are conducive to the construction, re-construction, and meaning-making processes that the mourner may need to engage in. For some individuals, the social dimensions in which their grief is located do not support such desires. Doka and Davidson (1998) state that the beliefs, expectations, and values imposed upon individuals by their social networks or communal ideologies mean that they will feel ‘varying degrees of authorship of the narratives of their lives’ (p. 227). Thompson (2002:8) echoes these sentiments, arguing that since ‘grief is not simply a psychological matter but has important social dimensions’ the negative influence that these dimensions may have upon the mourner cannot be underestimated.

How Our Stories of Loss Become Disenfranchised

It was Kenneth Doka (1989, 1995, 2001, 2002) who originally developed the term ‘disenfranchised grief’ to refer to loss experiences that ‘are not openly acknowledged, socially sanctioned or publicly shared’ (quoted in Martin & Doka 2000:13). Building upon Doka’s (1989, 1995, 2001, 2002) work, Thompson (2002) contends that there are three major reasons why a mourner’s experience of grief may become disenfranchised:

The Loss is Not Recognised

Firstly, the loss itself may be disenfranchised. This is often the case in non-death related losses, for example infertility (Betz & Thorngren 2006); organisational change (deKlerk 2007); the end of an adolescent romantic relationship (Kaczmarek & Backlund 1991; LaGrande 1989); the experience of mental illness (Byrne 2000; Crisp, Gelder & Rix 2000; Luty et al 2006); or the demise of health through old age (Thomas & Shute 2006) or illness such as Alzheimer's disease (Betz & Thorngren 2006; Pierce 2006). Here, the loss is not attached to the physical absence of an individual but to the symbolic loss of a dream (for example, the desire to have children); an unfulfilled role (for example, becoming a grandparent); or unfulfilled potential (for example, job demotion rather than promotion)(Walsh-Burke 2006). As Pierce (2006:18) notes, in such instances, 'grief work is challenged by the need to hide emotions and bury the grief.' For example, Sobel and Cowan's (2003) study into the impact of DNA predictive testing on the family system, revealed that since family members 'had no social sanctions for their grief [in relation to the test results received], it was disenfranchised' (p. 48). In instances such as these, the fact that the person is still alive means that the loss is not socially defined as being significant, leading to it becoming minimised, trivialised or glossed over.

The loss may also be disenfranchised in instances where the individual *is* physically absent but remains psychologically present to their family because their death has not been able to be confirmed or denied (Freeman & Ward 1998). Boss (1999) coined the term 'ambiguous loss' to describe losses which are incomplete or uncertain. Betz and Thorngren (2006:359) describe such losses as 'oftentimes cruel in their unending torment' since the ambiguity attached to them remains unresolved and unclear because they defy the meaning-making process necessary for some sense of closure to

occur (Boss 1999; Betz & Thorngren 2006). Dickerman Caldwell (2004:21) contends that the bereavement experienced by families of a missing person is that of 'unrelenting anguish', a viewpoint supported by Beder (2002:400), who argues that 'mourning the unfound' can extend, complicate, impede and pathologise the bereavement process. Not only does the not knowing prohibit confirmation about the finality of death but it may also result in preoccupation with, and continuous information seeking about, what might have happened to the person who is missing.

Furthermore, since people 'do not have the language to discuss ambiguous loss' (Betz & Thorngren 2006:361), potential support networks may be lost as people struggle both with what to say and with their lack of recognition and understanding about the depth of the loss for the bereaved individual. Additionally, since rituals 'are reserved for the clearly dead [and] there are few ceremonies to comfort us when our loved ones are partially gone' (Boss 1999:50) disenfranchisement becomes an inherent part of the grieving process. It is the very fact that there are no rituals for mourning in relation to ambiguous loss (Rycroft & Perlesz 2001) that makes it imperative for those who have suffered an ambiguous loss to be encouraged to engage in a symbolic ritual marking the absence of their loved one (Beder 2002; Betz & Thorngren 2006). Sobel and Cowan (2003:51) caution, however, that 'ambiguous loss may make rituals seem hollow.'

Even in cases where the loss *has* been death-related, disenfranchisement may still occur. The loss experienced after perinatal death (Hazen 2003; Gray 2001; McCoyd 2007) or through the death of a pet (Doka 1989, 1995; Kay 1984; Stewart, Thrush & Paulus, 1989; Weisman 1995), for example, may not be recognised as these losses are not seen as being as legitimate or as real as losses related to the death of a once living

individual. Hazen's (2003) study of perinatal loss, for example, revealed that every respondent had experienced disenfranchisement in relation to their loss, with this disenfranchisement occurring within the hospital, community and/or workplace. Insensitive comments such as "You are young, you can have another baby", "Your child might have been brain-damaged, it's all for the best" and "This part of your life is over, forget it" (p. 152) were typical of those heard by respondents and only served to heighten their sense of isolation, invisibility and disconnectedness.

In other cases, the mode of death itself may be stigmatised by some sectors of the community as being immoral or 'against God's will.' Suicide (Mehrabiy 2005) and capital punishment (Jones & Beck 2006/2007; Beck & Jones 2007/2008) are two such instances. In relation to the former, Sudak, Maxim and Carpenter (2008) suggest that whilst some arenas have become less stigmatised over the past few decades (for example, mental illness) 'the intense stigma associated with suicide attempters, completion, and being the family, close friend or therapist of someone who has attempted or completed suicide...remains nearly as stigmatised as ever' (p. 136). Thus, the grief that accompanies such losses is often exacerbated by the negative reactions, blame or complete inattention of others (Neimeyer 2000b), compounding the mourner's unwillingness to share their experiences (Ness & Pfeffer 1990; Sudak, Maxim & Carpenter 2008) and increasing their 'burden of private anguish, secrecy or shame' (Neimeyer 2000b:4).

Not all researchers, however, accept the proposition that stigma is due solely to socially imposed sanctions, arguing instead that stigmatisation can be self-induced rather than other-imposed (Dunn & Morrish-Vidners 1987/1988; Kneiper 1999; Van Dongen 1993). Seguin, Lesage and Kiely (1995), speaking in relation to survivors of

suicide, describe a vicious cycle in which the tendency of survivors to isolate themselves (more so than any other bereaved individuals) from others, leads firstly to limited contact with other family members and friends and secondly to inaccurate perceptions about the degree of support that is potentially available. Rudestam (1987), having also noted this self- or internalised-stigmatisation amongst suicide survivors, proposes that their decision not to talk with others is a way of protecting themselves against the possibility of a hostile response. Thus, it is not that social networks of support are unavailable but rather that the suicide survivor feels unwilling or unable to access them.

The Relationship is Not Recognised

The second reason why disenfranchisement may occur is because the relationship between the mourner and the deceased is not recognised as it was not based on traditional kinship ties. Such relationships may include those with an extra-marital lover, an ex-spouse, a therapist, a patient or a friend (see Anderson & Gaugler 2006/2007; Pierce 2006). De Vries (2001:78) describes these non-kinship mourners as ‘the neglected or abandoned grievers [left to] fend for themselves in a world of grief.’ Moss and Moss (2003:6) support de Vries’ (2001) assertion by noting that since the legal and social rights of kin substantially outweigh those of non-related mourners, the significance and legitimacy of non-relatives’ grief is subordinated to that of the family.

Zaslow’s (2004) study of clients faced with the death of their therapist vividly highlights the disenfranchisement created for mourners who have non-kinship ties with the deceased. Comments by respondents that they had only found out about the death ‘after coming for an appointment and finding a cryptic note [about the death] on

the office door' (p. 4) and that they had 'felt like an outsider' (p. 4) at the funeral because they hadn't been a relative, underscore the sense of isolation and discounting that may be experienced when a loss involves non-kinship ties.

Munson's (2005) personal account, as a teacher of a student who died, also starkly highlights the dynamics described above. As she notes, whilst there is much literature available on how to support parents and siblings in the event of a child's death, few articles exist in relation to educating and supporting teachers or their colleagues. It would seem that in many instances, teachers, like other non-related bereaved, are simply expected to press the pause button in relation to their grief, becoming invisible mourners in the process.

In other instances of disenfranchisement where secrecy surrounded the relationship (for example, the death of a gay partner (Hart 2001; Martin & Doka 2000; Smolinski & Colon 2006)), it may be even more difficult for the bereaved to find someone with whom they feel safe enough to share their stories of loss-related grief. Even in instances when the significance of the relationship is acknowledged, (for example between surgeon and patient), the bereaved individual may not be permitted to mourn their loss as fully or as openly as they might like. Instead, as noted above, they may be expected to remain in their professional role, supporting and comforting the other grieving family members (Clark 2001b; Doka 1995), with little recognition and support forthcoming for their own grief.

The Mourner is Not Recognised

Finally, the mourners themselves may be disenfranchised, a situation usually arising from misguided, stereotypical assumptions being made about their capacity or need to grieve (Neimeyer 2000b). Children, for example, may be seen as being too little to

understand and therefore able to cope (Lenhardt 1997). The elderly may also be disenfranchised since they are considered to be already accustomed to having lost people over their lifetime (Moss & Moss 1989, 2003), whilst the disabled are often viewed as 'not suffering from loss as do 'normal' people' (Lavin 1998:161).

Disenfranchised Grief – Ramifications for the Mourning Process

Unfortunately, because disenfranchised grief is unrecognised and unsupported, mourners may not even acknowledge their right to grieve or indeed feel a sense of loss (Betz & Thorngren 2006; Doka 1995; Rycroft & Perlesz 2001; Werner-Lin & Moro 2004). For others, a lack of certainty about what feelings they are entitled to have inhibits their ability to express the full extent of their grief or results in its complete suppression (Betz & Thorngren 2006). The central paradoxical problem this creates is that, by its very nature, disenfranchised grief both exacerbates the mourning process whilst simultaneously reducing, and at times eliminating, the sources of support so desperately needed by the mourner. Dunn and Morrish-Vidners (1987/88), in reference to survivors of suicide, describe this paradox as a 'double jeopardy' with mourners finding themselves, 'on the one hand... suffering a traumatic loss [whilst] on the other hand, the taboo act generates feelings of disapproval and shame' (p. 176).

Doka (1995:220) has identified three ways in which disenfranchised grief may impede the mourning process. Firstly, since the circumstances under which disenfranchisement occurs inherently intensify the mourner's grief responses, 'normal' grief-related feelings, particularly those of anger, guilt and powerlessness, tend to be amplified leading to complications within the mourning process. He cites studies by Geis, Fuller and Rush (1986) and Miller and Roll (1985) in support of his claim. Secondly, the fact that disenfranchised grief tends to be associated with

ambivalent relationships and concurrent crises means that the mourner's risk of experiencing a complicated grieving response is also likely to increase. Thirdly, as discussed above, the very nature of disenfranchisement precludes social support.

With regard to social support, Rando (1993) argues that by failing to acknowledge that a loss has occurred, social groups may, in fact, be attempting to insulate themselves from the anxiety, shame or embarrassment that the loss has created. Rando's (1993) beliefs fit nicely with Walter's (1999) notion of 'policing grief' and Doka's (1995) 'grieving rules', which propose that the social mechanisms which operate within the broader social contexts shape, modify, specify and regulate the mourner's grief responses in ways that are felt to be the most beneficial for all parties concerned. These rules, Doka (1995:217) argues, may be 'codified into personnel policies' whereby each society defines who has a legitimate right to grieve and for how long. For example, an employee may be granted a week of absence from work when their spouse dies but find that they have no compassionate leave entitlements when their church minister, whom they've known since childhood, passes away. Such situations force the bereaved individual to mourn, unsupported and invisibly, whilst simultaneously carrying out their normal roles and responsibilities – a situation which can lead to burnout (Munson 2005).

Clearly then, societal decisions about who has the right to grieve tend to correlate with socially sanctioned kin-based relationships rather than with the nature of the attachment, the sense of the loss or the survivor's experience of mourning (Doka 1995; Elison & McGonigle 2003). The currently inequitable and inadequate provision of bereavement and compassionate leave, Rezenbrink (2005:16) argues, is a further

example of 'the failure to recognise the complexity of a worker's personal needs at a time of crisis.'

Since the relationship with the deceased is not socially sanctioned or recognised, the mourner is also excluded from being assigned any pivotal roles in either the dying process or any post-death rituals such as funerals, anniversary dinners and the like, activities which are instrumental to the healing process (Bolton & Camp 1987; Glasscock 2001; Hall 2001; Romanoff & Terenzio 1998). Kollar (1989)(cited in Beder 2002:400) states that participation in the funeral ritual is vital for the mourner since it accomplishes four critical goals in grief resolution. These are: the physical goal of meeting the biological needs of mourners; the social goal of providing a sense of community and social support in which mourners can express their changed relationship with the deceased; the psychological goal of confirming the reality of the loss to those in attendance and the religious goal of offering a spiritual vision of life, death and the afterlife.

Romanoff and Terenzio (1998) both support and expand upon Kollar's (1989) argument, stressing that whilst rituals such as funerals are important vehicles for transition and connection, their grief resolution efficacy may be diminished if they do not also include a transformation phase, 'a recasting of the mourner's sense of self in relation to the deceased' (p. 698). This phase may include such rituals as choosing a treasured keepsake or linking object which can contain 'multiple and often conflicting and paradoxical meanings (Roberts 1988), signifying the multiple layers of relationship and representation' (Romanoff & Terenzio 1998:705). Since it is only through engaging in activities such as these that the deceased becomes transformed to an 'inner representation based on memory, meaning and emotional connection'

(Romanoff & Terenzio 1998:701), linking objects become of critical importance in instances of disenfranchisement (where there has been no social recognition of the mourner's relationship with the deceased). By providing a symbolic representation of the deceased and the mourner's relationship with them, linking objects become a way of 'honouring the self through private ritual' (Elison & McGonigle 2003:163).

Clearly, whilst ritual has the capacity to provide the mourner with a powerful medium through which grief may be resolved (Beder 2002; Lenhardt 1997), disenfranchised individuals are often denied this opportunity because their grief is not recognised, validated or socially supported (Doka 1989). In instances where either the death circumstances (for example, suicide) or the relationship in which the death has occurred (for example, a homosexual partnership) 'challenge core assumptive structures [and are] therefore not easily incorporated into cultural frames' (Romanoff & Terenzio 1998:704), it becomes extremely challenging, if not impossible, for grief resolution to occur within the context of the mourner's social system.

Neimeyer (2000b) draws attention to the fact that, in the absence of such rituals and the community support that usually accompanies them, many mourners 'are left to conclude that their continued distress is sign of personal failure' (p. 12). Whether implicitly or explicitly given, the message received by those whose grief has become disenfranchised is to 'get over it, deny the persistence of feelings of loss, and encourage breaking the ties with the deceased' (Moss & Moss, 2003:4). Romanoff and Terenzio (1998:704-705) stress that for disenfranchised grievers, successful grief resolution requires that, 'the community extend its boundaries to sanction the relationship [or the mode of death] to allow them to publicly take their place in the community of mourners.'

Whilst not disputing the serious ramifications that disenfranchisement can have upon the bereaved, Neimeyer (2000b) stresses that we must not lose sight of the fact that, as social customs change, so too do the boundaries that separate socially sanctioned losses from socially unsanctioned ones. The growing awareness of many hospitals for the need to offer psychosocial services to parents experiencing perinatal death, he argues, is a clear illustration of this ongoing process of social re-evaluation and re-negotiation.

Despite these changes within social customs, however, the fact still remains that disenfranchised grief is a growing issue (Doka 1995). This reality, coupled with the lack of availability of social support networks for disenfranchised grievers, means that grief counsellors and therapists are likely to encounter increasing numbers of clients who are struggling to have their bereavement recognised and validated. As Lenhardt (1997) observes, the absence of social support in instances of disenfranchised grief makes the central task of counselling one of validating the loss. Critical counselling interventions must therefore include opportunities for the mourner to explore and express the meanings of their loss and its impact upon them, perhaps in group counselling settings since these have been found to be an effective way of working in situations of disenfranchised grief (Lenhardt 1997; Meagher 1989; Parkes & Weiss 1983).

The concept of disenfranchised grief is clearly a critical one within the loss and grief field since not only does it illustrate the significant social foundations upon which loss, grief and mourning are based but also the ongoing impact that the mourner's social contexts have upon the ways in which their grieving process is permitted to unfold or is forced to remain hidden (Neimeyer 2000b). According to DeSpelder and

Strickland (2002), in instances where a death is viewed by society as being a non-significant loss, 'the process of adjustment is unnecessarily made difficult for survivors' (p. 255). Hazen (2003) agrees, stating that 'isolation and disenfranchisement can impede healing' (p. 153).

According to Doka (1995:222), there is an urgent need for research to be undertaken which uncovers and describes:

the particular and unique reactions of each of the different types of losses; compares reactions and problems associated with these losses; describes the important variables affecting disenfranchised grief reactions; assesses possible interventions; and discovers the atypical grief reactions, such as masked or delayed grief that might be manifested in such cases.

To date, however, little research has focused directly upon this phenomenon (Doka 1995). With regard to suicide, few studies have explored disenfranchisement per se, though its existence has been noted as part of broader explorations of family members' experiences of suicide (see Dunn & Morrish-Vidners 1987/88; Fielden, 2003; Maple 2005; Maple et al 2007).

'Reclaiming' Our Experiences of Loss – Narrative Approaches to Disenfranchised Grief

In light of the above, it is hardly surprising that narrative approaches, with their focus upon the ways in which individuals construct their personal meanings and realities through narrative structures (Guterman & Rudes 2005; Lyddon, Yowell & Hermans 2006; McLeod 1997; Neimeyer 2000a, 2001c; Tuval-Mashiach et al 2004) are ideally suited to grief work in general and disenfranchised grief in particular. Neimeyer and Anderson (2002:54) emphasise that when mourners are provided with an invitation to construct, deconstruct and reconstruct their narratives of loss they are 'assisted in their transcendence of tragedy' since such invitations afford them the opportunity to

grapple not only with the significance, meaning and reasons for the loss but also with the ways in which this loss experience has transformed them as a person. Through the process of telling and re-telling their narratives, mourners are able to re-author their life stories to accommodate and assimilate the loss event into their biographical plotlines (Neimeyer & Levitt 2001) thereby moving towards a state of greater integration and wholeness.

Murphy et al (1998) and Neimeyer (2006) argue that narrative approaches to grief work are particularly apt in instances of sudden, violent or senseless death such as suicide and homicide, since the existential angst and questions raised about why such a death has occurred require an approach which provides an opportunity to search for some sort of explanation and meaning to something so seemingly inexplicable and meaningless. Given that in instances of sudden or violent death ‘this anguishing effort after meaning can be if anything more intense, and as research documents, more complicated’ (Neimeyer 2006:62), the fact that narrative approaches have been found to increase the mourner’s levels of adjustment to the loss, at least initially (Davis, Nolen-Hoeksema & Larson 1998), underscores the fruitfulness of such an approach.

Narrative approaches are particularly adept at supporting individuals whose stories of mourning have become disenfranchised due to the ‘restraining narratives that are influenced by one’s culture’ (Guterman & Rudes 2005:4). The idiographic approaches (Archer 2001; Lyddon et al 2006) taken by narrative therapy, which seek to ‘afford new windows on human complexity’ (Neimeyer 2001c:172) allow the mourner’s story to become visible, known, sanctioned and free from the cultural constraints which may have undermined the client’s experiences, expertise and role as narrator. As Tuval-Mashiach et al (2004) observe, by viewing the client’s life story as the tool

for therapeutic change, narrative therapy locates those parts of the story that have been hindered or completely hidden, and in doing so, permits an alternate, richer and more deeply layered story to emerge.

According to Neimeyer (2001c:174 - 180), there are seven general principles that guide such an approach to grief therapy. These are to: discover and/or create new meaning in relation to both the loved one's death and the survivor's life; acknowledge the continuing bonds which exist between the mourner and the deceased; attend to implicit as well as explicit meanings in the mourner's story; assist the mourner to integrate the personal meanings of their loss into their life; facilitate meaning reconstruction as both a personal and interpersonal process; locate and ground meaning making within the mourner's intimate and cultural context; and use narrative as both a guiding concept and as a vehicle for the facilitation of the re-authoring process, post-loss. It is Neimeyer's (2002:55) contention that by approaching therapy in such a way, not only will therapists be able to hear stories that the bereaved may have felt were 'too painful to be shared in an unedited way with others' but that they will be also 'contribute to the development of new and more satisfying life stories without undermining the [mourner's] sense of authorship.'

Whilst not discounting the importance of narrative approaches, there has been a growing awareness, nonetheless, of the advantages of integrating several other approaches within meaning reconstruction grief work. Fleming and Robinson (2001) highlight the complementary nature of cognitive behaviour therapy (CBT) since it can assist mourners challenge their maladaptive beliefs and worldviews as part of their re-storying process; whilst Servaty-Seib (2004:134) contends that there are 'striking parallels' between the conceptualisations of mourning within both the meaning

reconstruction and existential approaches (May & Yalom 2000). The joint acknowledgement of a sense of knowing, which transcends the realms of consciousness and rationality (Neimeyer 2000b) and the fact that subjective reality rather than objective truth are at the heart of both approaches, Servaty-Seib (2004) argues, are two examples of such parallels.

Having now reviewed how the major conceptual frameworks for mourning influence a mourner's stories of loss, together with the ways in which these stories may become disenfranchised, in the final section of this chapter, factors unique to mourners who are therapists are explored since these too inform and influence both their post-loss experiences and the narratives told about them.

Storying Therapists' Experiences of Loss, Grief and Mourning: Factors That Influence the Bereavement Process

DeSpelder and Strickland (2002:245) state that the way in which mourners respond to loss is significantly influenced by their model of the world – that is, ‘his or her perception of reality and judgement about how the world works.’ In relation to bereavement, a number of variables within an individual’s model of the world have been identified as impacting upon the bereavement process and the stories of mourning which emerge from it. These include, the mourner’s personality (Archer 2001); the characteristics of the relationship, including the level of attachment/ambivalence that the mourner had with the deceased (Cook & Oltjenbruns 1989; Freeman & Ward 1998; Reed 1998; Reed & Greenwald 1991); the circumstances surrounding the death, particularly the degree of forewarning and/or trauma involved (Archer 2001); the mourner’s value and belief structure, including their religious and spiritual beliefs (DeSpelder & Strickland 2002); the cultural context and social roles held by the mourner (Rosenblatt 1999; Doka & Davidson 1998; Martin & Doka 2000); the mourner’s age (Archer 2001; Bonanno & Kaltman 1999; Sanders 1999), sex and gender (Doka & Martin 2001; Neimeyer 2000b); previous loss experiences (Neimeyer 2000b; Martin & Doka 2000; Wright 1996); and the level of social support received (Archer 2001).

It is clear that therapists, like any other individual faced with the death of another, are influenced by some, if not all, of the variables that research into the bereavement of surviving spouses, parents or children has identified. It is critical to remember, however, that the roles and relationship that exist within the therapeutic context inherently expose therapists to variables that do not exist within the deceased’s relationships with their family members or friends – variables which inform, shape

and at times constrain the therapist's response to loss. Whilst acknowledging the significant interplay that occurs between these variables (Bonanno & Kaltman 1999), for the purpose of this discussion, these variables have been divided into two distinct sections – those relating to the therapeutic relationship and those concerned with the therapist themselves.

Variables Associated with the Therapeutic Relationship

Confidentiality

McWilliams (2004b) states that the confidential nature of the therapeutic relationship creates 'idiosyncratic' challenges for therapists dealing with the death of a client or ex-client. In these instances, she notes, the therapist's mourning can be especially lonely since 'the pain of losing a confidential relationship is not recognised and eased by common rituals and shared norms of consolation' (McWilliams 2004b:276). McWilliams (2004b) recounts her own struggle, upon learning of a client's death, to maintain the confidentiality of that relationship whilst simultaneously supporting her client's husband and friends. The cost of this, she recalls, was that her own grief went mostly unexpressed, a situation she was partially able to redress by arriving ahead of schedule at the funeral service so that she 'would not have to socialise and could stand quietly at the back and weep at the premature loss' (p. 277).

Further complicating this unmet need to grieve is the requirement for therapists to remain vigilant about the appropriateness of both what they share in relation to their cases and with whom (Hodelet & Hughson 2001). McWilliams (2004b) observes that because therapists must protect their clients' anonymity, even when they are off duty they are constantly monitoring themselves to ensure that breaches of this privacy do not occur. As McWilliams (2004b:268) notes, 'it is an irony of being a therapist that

for all that we cherish, both genuineness and straightforward emotional expression, our occupation sometimes prohibits our behaving with either one.'

Maintaining Boundaries - The Interplay Between The Personal and Professional Selves of the Therapist

A second variable that impacts upon therapists' bereavement is the need to maintain appropriate professional boundaries, both during the therapeutic relationship and post-death. Within counselling and psychotherapy, the term professional boundaries refers to the reliable, consistent rules and role expectations that govern the ways in which both the therapist and client are expected to interact in order to promote a sense of safety and predictability within the treatment process (Zur 2005).

Unfortunately, whilst there is both an explicit expectation and an implicit assumption within social and professional spheres that very clear lines of demarcation be maintained between a therapist's professional and private roles (Lewis 2004), this expectation appears difficult, if at all possible or desirable, to uphold (Lewis 2004; McWilliams 2004b). Archer (1997) argues that it is modernist philosophy's dichotomous thinking that has played a major role in the push for the existence of a 'discrete' professional self in which it is 'clinically, ethically and legally important to keep one's personal needs out of the treatment room' (O'Connor 2001:346). However, whilst this clear-cut delineation between professional and personal selves may be objectively mandated by professional organisations, regulatory bodies and training programmes (for example, The Australian Psychological Society (APS)(2007) and The Australian Counselling Association (ACA)(2004)), it is not subjectively experienced this way (Lewis, 2004). Furthermore, since there is a current dearth of literature relating to the link between therapists' personal and professional selves (Lewis 2004), much remains to be explored in this area.

It is because the 'inevitable insufficiencies in our professional codes' (McWilliams 2004b:163) make the rules of professional conduct neither clear cut nor black-or-white (Schank & Skovholt 1997) that leaves therapists having to second-guess about the ethics of their behaviours and interventions (Schank & Skovholt 1997). Furthermore, since the breaching of professional boundaries remains such a controversial and taboo subject (Cleret 2005), engaging in such breaches can be 'professionally ruinous' (Glass 2003:429) for therapists who do so. The fact that the majority of literature on the topic is also 'terse, rigid, pathologising [and based on] fear tactics' (Cleret 2005:48) means that therapists are also extremely hesitant about discussing any ethical dilemmas they might be having with regard to their roles or boundaries (Schank & Skovholt 1997).

Whilst not denying that therapists can practice effectively when they deviate from the expected framework, as long as reliable boundaries are maintained, the general consensus amongst professional bodies and clinicians alike is that, left unchecked, boundary violations run the risk of causing damage to both parties (Glass 2003; McWilliams 2004b). However, as Gutheil and Gubbard (1998) point out, in condemning those who have allegedly breached their professional boundaries, 'the matter of context is all too often disregarded by fact finders and decision makers in this area' (p. 411). This may be particularly pertinent for therapists practicing in small communities or working within multi-disciplinary organisations where the need for boundary violations in the form of dual roles and dual relationships is often unavoidable (Zur 2005). Unfortunately, the increased profile and role flexibility required from therapists in such situations can make them highly susceptible to blurring of, or conflict between, their personal and professional roles (Schank & Skovholt 1997).

In instances of client death, this confusion, hesitancy and fear is likely to be heightened, since whilst rules and codes currently exist in relation to what constitutes appropriate professional conduct and boundaries within the therapeutic relationship, there is a void in the literature about what constitutes appropriate therapeutic conduct after a client has died. Therefore, challenges often arise when the different roles in which they find themselves conflict during the mourning process (Neimeyer 2000b). Thus, whilst remaining in the professional role of therapist to *others* bereaved by the death or adopting additional professional grief-related roles is regarded as being apt, occupying the personal role of mourner is likely to be considered inappropriate and unprofessional.

As O'Connor (2001:346) observes, the fact that the role of therapist requires:

a heightened sensitivity to people and the environment, a willingness to meet other's needs before one's own, the ability to withhold emotional response in the face of reported trauma and intense emotion, and the ability to tolerate intense emotion with limited or no outward personal response

means that in instances of loss and grief, therapists are often required to 'repress [these] basic human responses' (p. 346) to a degree not expected within any other profession. Doka (2006:5) describes a similar dynamic, noting the need for carers (including therapists) to have to 'simultaneously oscillate between containing their grief and experiencing their grief.' This dynamic, he argues, puts these mourners at risk of becoming either engulfed by their grief if they remain constantly open to it or cut off and detached from it if they try to stifle or ignore it. It is only through oscillating between expression and containment, he proposes, that carers can 'maintain effectiveness and humanity' (Doka 2006:5).

Figley (1987, 2002) provides a different perspective on the professional versus personal selves issue by drawing attention to the fact that it is therapists, more than any other professionals, who have the greatest difficulty in separating their personal and professional roles and negotiating the transitions between them. It is precisely because ‘practitioners *are* never really out of their role’ (McWilliams 2004b:168) that creates additional pressure for therapists already struggling to negotiate the transition between their personal and professional selves. This, coupled with the fact that almost three-quarters of practitioners continue to adopt a therapeutic-style of engagement within their social contexts (Farber 1983), highlights the difficulty for many therapists of switching from their professional to their civilian role (including that of civilian mourner).

In an attempt to minimise the stigmatisation that Glass (2003) believes occurs for therapists when terms such as boundary violations are used, a broadening of the conceptual framework has been undertaken to include the notion of boundary crossings (Glass 2003). Within this definition, boundary crossings represent an extension to (rather than a breach of) both the therapeutic relationship and treatment process thereby reducing the need for ‘inflexible adherence to a prescriptive black-or-white definition of boundary constraints’ (Glass 2003:430). Glass (2003) cautions, however, that clinicians need to remain open to supervision and peer review to assist them in clarifying the purpose for, and value of, engaging in any form of crossed boundaries.

Countertransference

A further factor felt to influence therapist bereavement is the degree of countertransference that was present during the therapeutic alliance. Reed (2005:32)

describes countertransference as the process whereby ‘emotions in the therapist interfere with the ability to provide a therapeutically neutral frame.’ Corn (2001:257) notes that when there are strong similarities between the client and the therapist, the therapist, ‘brings their own armentarium of defenses as well as life problems into the therapeutic space [resulting in] a parallel process being acted out by the therapist and patient in the transference-countertransference encounter.’

As the generalist bereavement literature illustrates, the greater the degree of similarity perceived by the mourner between themselves and the deceased, the greater their grief reaction (Cook & Oltjenbruns 1989; DeSpelder & Strickland 2002; Worden 2001). This is no less true in instances where the mourner is a therapist grieving the loss of their client. Under such circumstances there are at least three ways in which a therapist might be impacted by the death. Firstly, the loss of their client might reconnect them with previous losses in their own life. Moloney (2005:26) notes that not only does grief have a habit of ‘triggering other sadnesses from the past [but] anticipated losses as well.’ This process often amplifies the impact of the current loss, leaving the mourner feeling overwhelmed, confused and helpless. Secondly, if the loss mirrors one feared by the therapist, this fear may be difficult for them to contain. Finally, a therapist’s existential angst around their own death may get triggered if the client who died was an individual of similar age, sex, appearance or status to them (Worden 2001).

Reed (2005) argues that the risk of harmful countertransference reactions occurring during therapy also increases significantly for therapists working with traumatised clients (who may also be at greater risk of dying), as therapeutic encounters with these individuals are ‘intense, difficult, distressing and emotionally charged... [and]... can

expose therapists to overwhelming feelings of failure, shame, guilt and a sense of compromising themselves' (p. 32). In addition, Reed (2005) contends, since over-investing one's self when working with traumatised clients is easy to do, because the nature of the work inherently requires closer attachments, the perils of this over-investment and increased attachment include blurred boundaries and the experience of an intensified sense of loss in instances when this relationship ends abruptly, for example, through client death.

Whilst not denying that, at times, the projected dimensions of countertransference can be a useful therapeutic tool that helps the therapist better understand the inner world of the client, themselves and the therapeutic alliance (Gelso & Hayes 2001; Fauth 2006; Masterson 1993), recent studies have illustrated that, if left unmanaged, countertransference can seriously compromise both the therapeutic alliance and treatment outcomes as it places the therapist's needs ahead of the client's (Friedman & Gelso 2000; Gelso & Hayes 2001; Ligiero & Gelso 2002; Rosenberger & Hayes 2001).

Gelso and Hayes (2001:418) argue that effective countertransference management can occur, however, when the following five, interrelated factors are taken into account: 'self-insight, self-integration, anxiety management, empathy and conceptualising ability.' Once these five factors are in operation, they argue, therapeutic treatment will be optimised. Miller (1998) states that therapists who are able to work effectively with traumatised clients are those who engage in ongoing education and in-service training, and whose self-help strategies include regular, daily, stress-reduction techniques as well as the use of formal or informal group support networks and supervision.

With regard to supervision, Fauth (2006) urges that greater focus be placed upon the therapist's emotional responses and the personal meanings they attach to the therapeutic context. By doing so, not only will it empower therapists by normalising the 'personal and confronting nature of countertransference' (Gould 2007:67) but also help redress the 'outdated but still widespread view that countertransference is pathological' (Fauth 2006:29). Given that, historically, supervisors have been trained to regard countertransference as being detrimental and something which should be avoided at all costs (Ligiero & Gelso 2002), one possible positive flow-on effect from de-pathologising it may be that, in instances of client death, supervisors will become more understanding and amenable towards its existence. Unfortunately, despite the fact that countertransference can have a profound impact upon both the therapeutic alliance and the grief experienced by therapists after a client has died, to date, this area has not been extensively studied (Fauth 2006; Ligiero & Gelso 2002).

Organisational Rhetoric

It is ironic that the organizations to which therapists belong may also contribute to the difficulty felt in expressing grief in relation to their client's death (Ashby 2005; Becvar 2003; Charles-Edwards 2000; Miller 1998). Becker (1973, 1975) was one of the first to draw attention to the fact that the denial of death within organizations means that conversations relating to death and dying become silenced. Within such a conspiracy, normal grief reactions such as crying, confusion, lack of motivation and withdrawal are viewed as being inappropriate within the workplace (Wolfelt 2005). Furthermore, given that the majority of organizations (80% in a study reported by Sunoo and Solomon 1996) provide a maximum of three days paid leave for immediate relatives of the deceased only, employees (including therapists grieving the death of

their client) wishing to take extended leave from their positions may be viewed as being bad for productivity (Wolfelt 2005).

According to Eytsemitan (1998), this lack of organisational sensitivity and the use of 'tokenistic gestures' (Ashby 2005:7) of professional support promotes 'stifled grief' (p. 470), since it denies the bereaved the opportunity to allow their grief to take its natural course within its natural timeframe. This is no less true within the helping professions (Kaplan 2000; Walsh-Burke 2006). Morrison (1993)(cited in Shaw 2004) argues that whilst employees anticipate that a degree of professional distress will be an inherent part of their role, the lack of organisational understanding and support that they encounter when this arises is often more disturbing than the stressor itself. At these times, he contends, the diametrically opposed needs and viewpoints of the organization and the employee may leave both parties feeling bitter and frustrated.

Numerous researchers and clinicians support this viewpoint, arguing that at a time when an employee clearly requires therapeutic help, legal and insurance issues may compel the organization to invoke disciplinary action instead (Miller 1998; O'Connor 2001). In O'Connor's (2001:345) words, in cases of professional distress or impairment, 'current [policies] tend to emphasize code enforcement more than prevention and education.' Since, in cultures such as these, 'arguments for time and resources to be devoted to thinking and feeling are not always heard' (Ashby 2005:7), the likelihood that professionals will seek assistance when they need it decreases even more so.

Moss et al (2003) contend that when this distress is grief-related, it is not just social and cultural expectations that thwart its expression but also institutionally imposed values including, 'boundaries between living and dying, professional distance, power

differentials between staff and patients and a lack of rituals associated with death, dying and bereavement' (p. 291). With regard to compromised mourning rituals, since, institutionally, the topic of death is 'muted and avoided' (Moss et al 2003:290), staff are often left to initiate their own rituals in order to acknowledge their loss. Whilst there is a void in the current literature in relation to rituals after client death, observations by Moss et al (2003:295) within nursing homes suggest that these 'quasi-rituals' might include brief and informal conversations about the positive and negative attributes of the deceased.

According to Moss et al (2003) the need to maintain professional distance disparages close emotional connections between staff and patients. Instead, it demands detachment, self-control and the containment of feelings (Vachon 1998) in an effort to maximise work-related productiveness and to minimise the risk of staff behaving with impropriety (such as contaminating or overshadowing the family's grief with their own)(Moss 2003). However, as both Michel (1997) and Sidell, Katz and Komaromy (1998) have noted, the imposition of stringent boundaries and the need for professional distance can leave caregivers struggling to ascertain just what are acceptable ways and levels of expressing their emotions in the presence of the deceased's relatives, their colleagues, and their own families, a situation that can result in them feeling unacknowledged and ultimately disenfranchised (Stein & Winokuer 1989; Hazen 2003). Extracts from Berman's (1995) case studies illustrate this experience quite poignantly. One psychotherapist, describing his feelings in relation to his client's death admitted, 'I cannot yet feel rage, I am suppressing it, still in the therapeutic harness, bridled by the ethics and mores that plague this fucking profession.... Is the restraint in my tears professional distance? Is it the therapist maintaining an observing posture?' (pp. 90 – 91).

Myers and Fine (2007) provide a different slant to the challenges that experiencing grief in a professional context evoke. These authors claim that the fact that the language of the professions in relation to loss is expected to be technical, cognitively-focussed and emotionally distant, whilst that of the mourner is personal, anecdotal and subjective, means that it can be ‘distancing, highly intellectual and devoid of feeling’ (p. 123). In the aftermath of their client’s death, therapists may become caught in the gap that this jargon creates between the profession they find themselves operating within and their own ‘humanness and vulnerability’ (p. 124) in relation to the loss.

Variables Associated with the Therapist

Whilst not underplaying the significant influence that certain attributes of the therapeutic relationship can have upon therapists’ responses to a client’s death, it is critical to remember that the social construction (Hunter & Kottler 2007) of the therapist also plays a pivotal role in shaping the ways in which their mourning process both unfolds and is narrated. According to Hunter and Kottler (2007:24), these social constructions are multi-faceted, in a state of constant flux and may include such factors as ‘the therapist’s upbringing, significant relationships, clinical experiences and social support.’ Several of these key factors are examined in greater detail below.

Motivation for Becoming a Therapist

Over the past ten years, increasing attention has been paid to the ways in which an individual’s personal history motivates, influences and impacts upon their choice of profession. With regard to the field of counselling and psychotherapy, Sheean (2004) argues that whilst some ‘fabulous stereotypes’ exist about what drives individuals to become therapists (for example, “Wanting to help others” or “To give something back to the community”), the reality is that their real motivations are often much more

narcissistic, arrogant and grandiose. McWilliams (2004b:264), for example, declares, tongue-in-cheek, that her own motivation for becoming a therapist was less about altruism and empathy and more about her recognition that, as an ‘ungenerate voyeur’, she would also be able to ‘sort herself out.’

Sheean’s (2004:2) contention that the choice to work in this arena is not likely to be a purely selfless one but one influenced by the individual’s person history and resultant needs is supported by observations that many individuals are motivated to work within this field because of their family scripts (Chandler 2005; Kottler 2008; O’Connor 2001; Shaw 2004; Wosket 1999). O’Connor (2001:346) notes that a traumatic childhood, a history of addiction, or parentification in one’s family of origin may draw an individual to the role of mental health professional as they have already been prepared for it and may see the profession as a means of both helping those they identify with and of healing their own old wounds. Berman (1995:97) echoes O’Connor’s (2001) beliefs by arguing that, since ‘in each of our intimate autobiographies we harbour narcissistic wounds, at some level of our shared consciousness we might agree that in seeking to “save” others we secretly wish to be likewise nurtured.’

Jackson and Nuttall’s (1997) research with individuals who had been either sexually or physically abused as children, for example, revealed a strong correlation between these individuals’ personal histories and their subsequent decisions to work in trauma-related professional contexts, lending further weight to the argument that choosing this pathway facilitates a ‘process of meaning-building out of personal experience’ (Lewis 2004:25). Lewis’ (2004) phenomenologically-based study of the motivation behind eighteen clinical social workers’ decisions to work within psychotherapeutic

arenas supports Jackson and Nuttall's (1997) findings. As Lewis (2004) notes, participants had either experienced a history of personal difficulties, familial disadvantage and marginalisation or had grown up in a familial culture where altruistic values related to the service of others were emphasised. In the light of such observations, McWilliams (2004b:70) goes so far as to propose that 'psychotherapy is one of the few professions in which one's greatest misfortunes can be retooled into professional assets.'

The strong interconnections which exist between a therapist's personal and professional selves, however, almost inevitably increase their risk of having their own 'fears and stresses [triggered] through the witnessing their client's suffering' (Lewis 2004:22). This is particularly true if they have been drawn into the profession believing that the remediation of their own pain will occur through their servitude to others. McWilliams (2004b:265) cautions that if therapists 'hang their self-esteem on making a difference' and this doesn't occur (for example through self-inflicted client death), a 'depressive aftermath' may be evoked. After all, when a therapist has invested a substantial amount of time, effort and skills into a client, it can feel both devastating and despairing to realise that the client has not improved, let alone deteriorated (Kottler 2008; McWilliams 2004b).

Miller (2004) strongly urges therapists to therefore relinquish any misguided beliefs that they might hold about being able to guarantee a positive outcome for their clients, cautioning that *no* amount of training, experience, therapeutic tools and the like can ensure such a result. Omnipotent beliefs such as these, he asserts, indicate little more than the presence of high levels of narcissism and conceit. According to McWilliams (2004b:260), 'the editing of one's more grandiose rescue scripts cannot start too early'

since, as Rothchild (2004:19) notes, ‘if we don’t know ourselves psychologically [and are] unconscious of our motives...we’re susceptible to re-enacting our past with our clients in ways that benefit no-one.’

Unfortunately, however, there is a current failure within the counselling profession to explore the issue of personal vulnerability amongst its practitioners, driven, Lewis (2004:22) believes, by ‘its potential to cast doubt on the public credibility of the profession.’ Lewis’ claim illustrates the implicitly stated, yet widely accepted message, that therapists must somehow be immune from personal vulnerabilities or woundedness if they are to be regarded as being professionally competent to practice. Therefore, whilst the archetypal term of the wounded healer (Smith 1998) is repeatedly used within discussions relating to personal motivations for the choice of an individual’s professional pathway (Miller & Baldwin 2000; O’Connor 2001; Wolgien & Coady 1997), to date, little information relating to this issue exists within the counselling and psychotherapy literature (Jackson & Nuttall 1997).

Previous Loss Experiences and Coping Styles

According to Neimeyer (2000b) and Martin and Doka (2000), the way that a bereaved individual has responded to previous loss experiences is perhaps *the* most significant predictor of the length, pattern and intensity that their current mourning will take. Allen and Hayslip (2001:103) note that bereaved individuals will confront their grief by selecting coping strategies ‘that best fit their situations and personal styles.’ Thus, in the aftermath of their client’s death, therapists who have previously demonstrated a strong sense of control and confidence in their own abilities to cope with traumatic life events (for example: seeking support from family and friends, developing new skills, re-establishing social networks and ongoing projects) will fare better in terms

of bereavement outcome than those who have relied on maladaptive coping strategies in the past (for example: use of illicit drugs or alcohol, over-medication with prescription drugs or self-blame)(Allen & Hayslip 2001; Caserta et al 1989; Hayslip, Allen & McCoy-Roberts 2001). Papadatou (2000:59) cautions, however, that bereavement is not only influenced by the mourner's loss history ('life style') but also their work environment ('work style'). Thus, 'when a person's life style is in harmony with their work style, grieving behaviours are supported and validated in the workplace' (p. 59).

The inclusion of death within a therapist's philosophical approach to life may also help mitigate the grief experienced. Since, according to Doka and Davidson (1998:7), the search for, and reconstruction of meaning after a loss is 'inherently a spiritual task', a mourner's faith or philosophical system (Doka 1998) will also profoundly shape their bereavement response (Doka & Davidson 1998; Neimeyer 2000b). While some therapists will find that the intrinsic comfort and stability that their faith affords them will facilitate their mourning process, others will be thrown into a spiritual crisis as they struggle to seek answers to the many questions that the death has raised for them.

Whilst the spiritual or religious beliefs held by the mourner are an integral part of this belief structure, it also incorporates the meanings one attaches to the death (for example, "It was a blessing in disguise as they're no longer suffering") and perceptions about the circumstances surrounding the death (that is, its degree of preventability). Bugen (1979:36) defines preventability as 'the general belief that the factors contributing to the death might have been avoided', with the types of deaths likely to be considered as 'preventable' including homicides, suicides and accidents.

Hadfield (2007:340) argues that when a mourner perceives the death to have been preventable, feelings of responsibility, self-blame or anger may arise. In instances of client death, therefore, if the therapist perceives that their actions (or lack of them) have contributed in some way to the death, their grief-related responses are likely to be intensified.

Therapists who regard bereavement as an opportunity for growth, and who are able to reformulate the death in a way which does not exclude new possibilities and attachments, may also move more easily through the grieving process (Wright 1996). Furthermore, by re-contextualising loss within the framework of growth, 'grief becomes a unifying rather than an alienating human experience' (Despelder & Strickland 2002:261) with mourners describing higher levels of self-confidence, self-awareness and maturity and an increased capacity to face other crises in their lives (Despelder & Strickland 2002). In light of this, unless a therapist has reviewed and attended to their own history of loss (Walsh-Burke 2006), including their philosophical assumptions and past coping strategies employed, it is unlikely that they will be able to deal effectively with any future loss-related events.

Therapist-As-Mourner: Increased Risk of Stress, Vicarious Trauma and Burnout

There is a universal concern amongst thanatologists that working with issues of loss and grief is uniquely challenging for therapists because the intensity of personal distress it can evoke is greater than that associated with other issues (Becvar 2003; Kirchberg & Neimeyer 1991; Kirchberg, Neimeyer & James 1998). It is hardly surprising, therefore, that repeated exposure to the suffering of others, constant reminders of one's own mortality, the reactivation of old, personal losses and the experience of grief in relation to a client's death can quickly deplete those working in

the helping profession of the physical, psychological and emotional resources required for their role (Doka 2006; Gamble 2002; Radeke & Mahoney 2000). As a result, those who come face to face with the traumatised, the dying and the bereaved inevitably run the risk of experiencing stress, vicarious trauma (Figley 1995, 2002; Chamie 2004; Hagon 1997; Myers & Fine 2007; Nelson 1996) and/or burnout (Anderson 2008; Doka 2006; Gaston 2005; Maslach 2003; Meyer & Ponton 2006; Rothchild 2004; Thompson 2005; Walsh-Burke 2006), a risk 'not taken sufficiently seriously' within the fields of loss and grief (Thompson 2005:9).

According to Figley (1995, 2002), this risk is particularly high for those working with traumatised clients because of the following four factors. Firstly, the deep empathising required when working with the client or their family opens therapists up to the traumatic content of the story being shared. Secondly, if the therapists has experienced trauma in their own life, they may overgeneralise their experiences to the client. Thirdly, any unresolved trauma may be re-triggered in the therapist and finally, those working with traumatised children may be exposed to attendant stressors. The lack of opportunities that therapists have to 'excrete emotionally a portion of the affect that they soak up all day' means that they are often left feeling depleted and 'desperate for a different kind of relating' (McWilliams 2004b:263). As a result, not only may a therapist's professional life be impacted (causing clinical errors, poor boundary retention, countertransference and the like)(Hagon 1997; Meyer & Ponton 2006) but the effects may also contaminate their personal life (Cerney 1995; Meyer & Ponton 2006) by altering their basic psychological needs for safety, trust, independence, intimacy and beliefs in humanity (Hagon 1997; Trippany, Kress & Wilcoxon 2004). Exhaustion, increased alcohol and drug use, somatic complaints such as headaches and stomach upsets, nightmares and a sense of feeling

overwhelmed and overburdened may result in physical and emotional withdrawal, inattentiveness and irritability (Miller 1998; Sexton 1999; McWilliams 2004a). Tan (2005:82) refers to this experience as a 'haemorrhaging of the self' and emphasises the need for therapists to develop and sustain their personal and professional selves in order to prevent it.

Whilst there is a paucity of research relating to burnout rates in Australia (Gaston 2005), Hannigan, Edwards and Burnard (2004) found clinically significant degrees of psychological distress in four out of ten psychologists interviewed. Other researchers have found burnout rates of between 6% and 25% for individuals working within the helping professions (see Cushway, Tyler & Nolan 1996; Kahill 1986) with Louie et al (2007) contending that psychiatrists have the highest predisposition to burnout within the mental health field.

At its most extreme, work-related stress and burnout have been associated with therapist suicide. Rezenbrink (2005:15) reports on Victorian Coronial findings which linked work-related stress to 21% of suicides where work factors (such as 'over work, inadequate supervision, exposure to trauma and grief at work') were present; whilst Ukens (1995 cited in O'Connor 2001:346), referring to a report by the Occupational and Safety Hazard Administration, observes that male psychologists have the highest suicide rate of any profession.

Whilst health professionals may try to protect themselves from work-related trauma and loss by either minimising or denying its impact upon them, Remen (1998) warns that adopting this approach is, in fact, one of the major causes of work-related stress. Participants in Lonergan et al's (2004) study, for example, admitted that whilst, as beginning counsellors, they had interpreted grief and pain as signs of weakness and

‘evidence that they were not fit to be therapists’ (p. 361), with experience they had come to recognise that emotional expressiveness was an invaluable coping mechanism in their line of work. These findings reflect Valente and Saunder’s (2002:11) observation that if a clinician’s grief remains unresolved, ‘impaired personal and professional relationships, an increased sense of isolation, secrecy, suicidal feelings and use of substances’ may result.

A review of the literature, however, demonstrates mixed opinions about just who is responsible for managing these issues (Hunter & Schofield 2006). Advocates of self-care argue that it is the therapist’s responsibility to develop and engage in self-coping strategies in order to reduce the risk of stress, vicarious trauma and burnout. Remen (1998) recommends that professionals openly grieve their losses to avoid their occurrence, a strategy supported by both Dunn (1987) and Rezenbrink (2005). Worden (2001) also stresses that whilst burnout is a risk for therapists, it can be avoided by practising ‘active’ grieving when a client dies, a viewpoint supported by Becvar (2003:473-474) who recommends that therapists create ‘mourning spaces - opportunities to resolve their own grief before moving on to work with that of another.’ Worden (2001:178) also recommends that therapists attend the funerals of their clients and pursue their own support networks, strategies they are known to avoid or to find exceedingly difficult to engage in.

Rezenbrink (2005:14) cautions, however, that if too much emphasis is placed upon the need for staff to take responsibility for their own grief and grief-related needs, ‘there is a danger of ignoring the institutional and organisational arrangements that contribute to, or even create the distress in the first place.’ Thus, she argues, sources of stress in the workplace need to ‘be managed in a collaborative partnership between

workers and employers' (p. 13). From Thompson's (2005) perspective, organizations and institutions need to provide training opportunities in relation to stress and its management, not from a restricted, individualistic perspective but from one that recognises stress as an organisational and social problem as well. Skovholt (2001) contends that social support in the form of professional relationships (colleagues and supervisors) is also a significant protective factor against work-related stress and burnout. Only once organisations and institutions recognise their role in stress management, Thompson (2005) argues, will the pressure health professionals currently feel to cope unaided, be reduced.

It is because stress in the workplace has been the focus of numerous studies, Guthrie et al (1999) believes, that researchers have tended to ignore the impact of non-work related stressors upon mental health professionals. Their study of psychiatrists' sources of stress and burnout found that personal life events such as bereavement could lead to increased stress levels, making workplace functioning much more challenging, particularly when clients presented with similar issues to the ones that they were struggling with. Thus, they argue, it is not enough to focus upon work-related stress alone, personal factors must also be taken into account, including those relating to bereavement.

Whilst recommendations within the literature to avoid stress, vicarious trauma and burnout generally include such strategies as receiving regular supervision, seeking collegial support, undertaking psycho-education, case conferences or psychological autopsies and implementing personal self-care strategies (Gaston 2005), infrequently are therapists advised to seek therapy (McWilliams 2005). Tindle (2006) argues that in order for therapists to feel supported, both supervision and personal therapy need to

be available for those who need it. As Miller (1998:142) observes, in complex cases or those involving trauma, 'good therapists may need good therapy.'

Rothchild (2004:19-20) regards the current lack of availability of personal therapy for therapists as an 'unfortunate omission', arguing that, 'some professionals are struggling with old, traumatic issues that won't resolve themselves through discussions with supervisors or colleagues' and which need therapeutic intervention if the physical and emotional repercussions are to be adequately ameliorated. Unfortunately though, because symptoms relating to stress, burnout and vicarious trauma are often viewed as signs of 'weakness' which may damage one's career, there is a tendency to try to hide them for fear of being stigmatised (Courtenay & Stephens 2001; deKlerk 2007; Williams 2001).

Given the significant role that the therapist plays in treatment outcome (May & O'Donovan 2007) and the negative correlation that has been found between personal distress and therapeutic effectiveness (Sherman & Thelan 1998; Thomas et al 2007), maintaining high levels of physical and emotional wellbeing becomes an issue of paramount importance. As therapists in Hunter and Schofield's (2006) study acknowledged, establishing a balance between their personal and professional lives was critical for the maintenance of emotional wellbeing and a sense of perspective. Unfortunately, despite the fact that training curriculum for health care professionals need to include skills in self-care to foster the development of resilience, coping and balance (Louie et al 2007), very few programmes currently exist which meet these needs (Hassed 2007; Lonergan et al 2004).

Summary

In this chapter the major conceptual frameworks for understanding the experience of bereavement have been presented to illustrate the ways in which they influence an individual's stories of mourning. Disenfranchised grief has also been explored, together with factors unique to mourners who are therapists. Finally, the risks posed to therapists of working with the traumatised and dying have been examined since these too influence the post-loss narratives that can be told. In the following chapter of the literature review, bereavement specific to suicide, with particular emphasis upon therapist bereavement in response to client suicide is the focus. After examining the elements that make suicide-related bereavement a more 'intensely' felt experience than bereavement associated with other sudden, unexpected losses, factors unique to therapists mourning the suicidal death of their client will be explored. In the closing stages of the chapter, and in light of the 'gaps' identified in the existing literature, the rationale for the current study will be presented.

Chapter 3

Literature Review

Suicide – Secretive Stories of Stigma and Shame

'In the not too distant past...fear, superstition and the desire to punish self-murderers was such that people who committed suicide were buried at a crossroads and a stake driven through their body'

(Gates 1988 quoted in Kleespies, Smith & Becker 1990:257)

This second chapter of the literature review focuses on suicide bereavement, with particular emphasis upon therapist bereavement in response to client suicide. After providing an overview of the experience of bereavement after suicide, attention will turn to the impact of client suicide upon therapists, including factors that shape their bereavement process. In the final section of the chapter, shortfalls in the literature, which provided the impetus and rationale for the current study, are discussed.

Setting the Scene

It has been estimated that suicide accounts for the deaths of approximately one million people worldwide per year (World Health Organisation 2002) and that a further six million individuals are impacted by the intense grief that such deaths afford (Clark & Goldney 2000). With regard to Australia, the Australian Bureau of Statistics (2006) states that in 2004, 2098 deaths were registered as being suicide-related, 80% of which were male. Whilst the number of suicides has decreased in recent years, it nonetheless accounts for the largest percentage of death from any cause in specific age groups. In 2004, for example, males aged 30 – 34 years had the highest age-specific suicide rate whilst for females it was the 45 – 49 years age group. Methods of suicide, in order of frequency, were found to be hanging, poisoning, drugs, firearms,

drowning, and jumping. Suicides rates in rural areas remain higher than those in urban areas.

Although the act of suicide is as old as humankind itself, it still remains ‘one of the most complex behaviours within the human repertoire’ (Stillion & McDowell 1995:345). In fact, death by suicide has been identified as being the most difficult bereavement crisis a family can face (Worden 2001) because ‘the person who commits suicide puts his psychological skeletons in the survivor’s emotional closet’ (Shneidman quoted in Cain 1972:x).

Edwin Shneidman (1995), one of the leading scholars of suicidology, has observed that the most striking aspect of suicidal events is that they are ‘multidimensional, multifaceted and multidisciplinary, containing concomitant biological, sociological, psychological (interpersonal and intrapsychic), epidemiological and philosophical elements’ (p. 372). It is little wonder, therefore, that Williamson and Shneidman (1995) regard death by this means as being the most ‘enigmatic’ and ‘cryptic’ of all modes of dying. Irrespective of whether a suicide is carefully planned and executed or arises impulsively, it is still ultimately ‘an intensely private act which creates unbearable public pain’ (Grollman & Malikow 1999:3).

Determining When A Suicide Has Occurred

Since the mid-1600s, when the term ‘suicide’ first emerged, there has been ongoing debate about its terminology (Cantor & Baume 1997; De Leo et al 2006). Definitions such as the World Health Organisation’s (1998 quoted in De Leo et al 2006:8), for example, that suicide is ‘the act of killing oneself deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome’, would suggest that those who complete suicide have actively chosen to do so

(Leiberman 2003). When viewed through this lens, determining death by this means should be a relatively straightforward process. The reality, however, is far from clear-cut. Certainly, in some instances, the fact that a suicide has occurred is obvious (for example, death by hanging, auto asphyxiation, self-inflicted gun shot). However, in other cases (for example head-on car crash, plunging a vehicle into a river, inciting a police shooting) suicide remains one possible reason amongst many as to the cause of death, and a psychological autopsy (Valente & Saunders 2002) may be requested by the medical examiner or coroner in an effort to reconstruct all the factors leading up to the death.

Unfortunately, in today's 'death-phobic' society (Elison & McGonigle 2003), death by suicide is still regarded as being even more 'shocking, frightening and unspeakable' than death due to other circumstances (Donaghy 2000:5). That 'it is *with reluctance* that a medical examiner or coroner classifies a death as a suicide' (Grollman & Malikow 1999:16; emphasis added) attests to this fact. As a result, the 'suffocating stigma' (Donaghy 2005:5) that is already attached to death by this means is perpetuated, with many cases of suicide subsequently going unreported (Cantor et al 1999).

The Experience of Bereavement after Suicide

Whilst the general consensus is that individuals who experience bereavement are more likely to suffer from reduced mental health and the intrusion of grief-related symptoms than those who have not experienced a loss (Clark & Goldney 2000), little consensus exists with regard to the bereavement which can be expected in relation to a death by suicide.

Although early case studies into the impact of suicide upon the grieving process suggested that it was an extremely difficult type of bereavement that often led to major pathologies amongst family members and friends (Cain & Fast 1972), the validity of these findings was subsequently challenged on methodological grounds (Clark & Goldney 1995, 2000). More recently, attention has turned towards identifying the similarities and differences that exist between the bereavement experienced in relation to suicide and that associated with other sudden death-related losses, though here too, agreement has been hard to find.

Whilst numerous clinicians and researchers (see Farberow et al 1992; Worden 2002) argue that the grief attached to suicide bereavement is unique since it tends to be more intense (Farberow et al 1992; Grad 1996; Henley 1983; Jordan 2001), more difficult to assimilate because of its violation of the mourner's assumptive world (Van Dongen 1990), and of a longer duration (Farberow et al 1992) than the grief associated with other types of loss, others contend that this is not actually the case. Those who oppose drawing distinctions between suicide bereavement and bereavement arising from other sudden death-related losses argue that the results of studies in this area have been inconclusive (Callahan 2000; Clark & Goldney 2000; Ellenbogen & Gratton 2001) and that, on balance, no discernable differences can be found.

Rather than engaging in a protracted debate about the relative merits of either standpoint, it is the contention of this author that whilst those mourning the death of an individual from suicide do experience many of the core grief responses associated with any significant loss, the fact still remains that there are a number of qualitative differences which set it apart from the bereavement associated with other forms of loss (Clark & Goldney 1995; Cleiren 1993; Dunn, McIntosh & Dunn-Maxim 1987;

Jordan 2001). Taking its orientation from both Berman's (1995:92) premise that, 'grieving normally is not easy [but] grieving a suicide is a torment' and Rando's (1984) observation that the intensity of the emotions that are evoked as a result of suicide often creates such problems for the bereaved that they are referred to as victims or survivors of suicide (see Grad 1996), the following section examines what it is specifically about suicide that amplifies a mourner's response to death by this means and puts them at increased psychological and physical risk (Dunn & Morrish-Vidners 1987/1988). As Leenaars (2005:35) notes, it is perhaps because suicide happens 'in a person and between people' that 'the pain of the suicide becomes the pain of the survivor' (p. 43).

Suicide - A Sudden, Unexpected, Unpredictable Event

With few exceptions (see Cotton et al 1993; Grad, Zavasnik & Groleger 1997; Maple 2005; Reed 1998) the dominant discourse within the field of thanatology is that suicide is a sudden, unexpected and unpredictable event for which survivors are totally unprepared (Ellis, Dickey & Jones 1998; Grad 1996). According to Wright (1996:142) the lack of time to prepare for the loss may result in a 'double kind of grief – grief for what is lost and grief for what might have been.' The suddenness of the loss means that mourners are also denied the opportunity to engage in any anticipatory grief responses (Worden 1991), complete any unfinished business between themselves and the deceased (Clark & Goldney 1995; Wright 1996) or 'say goodbye' (Cook & Oltjenbruns 1989; Kleespies, Penk & Forsyth 1993).

Recent research by Maple (2005), however, has challenged the fundamental premise that suicide is sudden, unpredictable and unexpected. Her study of parents bereaved by the suicide of their young adult child found that participants had different degrees

of 'preparedness' in relation to the death, with some suicides having been both anticipated and expected and others having been anticipated after their occurrence. In light of these findings, Maple et al (2007:128) argue that, 'the often-used premise of suicide death being sudden and unexpected applies in some instances but not all.'

Suicide: 'Amplified' Grief Responses

As stated above, quantitatively, bereavement after suicide includes many of the grief-related responses associated with any sudden, death-related loss. Qualitatively, however, these responses may be felt more intensely and for a longer period of time due to the circumstances surrounding this particular type of loss. Nine of these more amplified grief responses are examined in greater detail below.

Shock

Since death from suicide is frequently sudden, unexpected, and at times violent (Kleespies 1993; Range & Calhoun 1990; Sudak, Maxim & Carpenter 2008) the shock experienced by the bereaved prolongs the grieving process and creates extreme physical and emotional trauma which compromises the bereaved individual's capacity to cope (Morris 1995; Myers & Fine 2007; Parkes & Weiss 1983; Rando 1983; Sanders 1989). In some instances the strength of this shock is so intense that it has been associated with Post Traumatic Stress Disorder (PTSD)(see Brent et al 1993a, 1993b; Clark & Goldney 2000; Ruskin et al 2004; Ireland 2007). PTSD symptoms such as flashbacks relating to the scene of the suicide, attempts to avoid reminders of the trauma and persistent negative arousal, for example, are not uncommon in survivors (Becvar 2003; Cooper 1995; Grad 1996).

Guilt

Immense and irrational guilt is associated more strongly with death by suicide than any other type of death (Ping Tsao, Tummal & Weiss Roberts 2008; Wright 1996). Whilst this guilt may be due to feelings of responsibility for having missed something or for not having prevented the death (Clark & Goldney 2000; Ellenbogen & Gratton 2001; Holmes 1987; Maple et al 2007; Thornton, Whittlemore & Robertson 1989), it may also manifest as blame (towards doctors or other family members, for example) as the survivor attempts to make meaning out of an otherwise incomprehensible situation (Worden 2001).

Whilst survivor's guilt amplifies and perpetuates the stigma being felt in relation to the death (Sudak, Maxim & Carpenter 2008), Clark and Goldney (1995:29) observe that much of the guilt being experienced by survivors is both imagined and unrealistic since it is based on the 'mistaken assumption that they should have been totally responsible for and in control of the life of the loved one.' Whilst telling the survivor that no-one can accurately predict who will commit suicide (Furst & Huffine 1991) can substantially reduce this guilt, it can simultaneously draw attention to the impotence of those in the helping professions who may also have been involved in the case (Clark & Goldney 1995).

Shame

Given the intense stigma attached to death by suicide (Campbell & Fahy 2002; Jordan 2001; Wright 1996) it is hardly surprising that one of the strongest emotional reactions experienced by those left in its wake is the 'self-effacement of shame' (Smolin & Guinan 1993:14). In fact, according to members of Clark and Goldney's (1995:30) support group for suicide survivors, a sense of shame was felt to be a

'unique burden' to suicide bereavement because of this stigma. Often there is also an overriding concern about what others are thinking and a fear that others (be they family or the wider community) may blame or condemn the survivor for its occurrence (Bailey, Kral & Dunham 1999; Jordan 2001) or regard them as being sick or strange for being associated with someone who has killed themselves (Grolman & Malikow 1999).

Anger

Intense anger is also more strongly felt by the mourner in relation to death by suicide. This anger may be directed towards the individuals who committed suicide (since they are regarded as having wilfully chosen to end their life) or towards themselves for not having made the deceased happy or satisfied enough to choose to remain alive (Cook & Oltjenbruns 1989; Faberow 1992). The anger may also be due to the sense of rejection that such a death affords ("Why did you do this to me?") (Clark & Goldney 1995; Jordan 2001) and may exacerbate the feelings of guilt already being experience.

Abandonment/Rejection

Feelings of being rejected or abandoned (Faberow 1992; Grollman & Malikow 1999; Wright 1996), coupled with fears of not having been loveable enough for the deceased to have chosen not to die, are also common after suicide. These feelings may lead to low self-esteem and intense grief reactions (Reed 1993; Clark & Goldney 1995), culminating in a crisis of personal and spiritual values (van der Wal 1989). Questions may also arise regarding previously held assumptions about the quality of the relationship (Cook & Oltjenbrun 1989) resulting in a reduced sense of trust and a mistrust of investing in future relationships (Clark & Goldney 1995).

Fear and Horror

Farberow et al (1992) have identified fear as being another common response after a suicide, often attached to the survivor's own suicidal thoughts. Worden (2001) states that those bereaved by suicide can also develop a preoccupation with death by this means with survivors often worrying that they, or another family member, may have some genetic predisposition to this tendency. This fear can also lead to a sense of over-protectiveness towards remaining family members, particularly children (Clark & Goldney 1995).

Clark and Goldney (1995) have also noted that horror relating to the death scene has been documented by a number of researchers (see McIntosh & Wroblewski 1988; van der Wal 1989). Horror may also be evoked by the survivor's acknowledgement of how despairing the deceased must have been to have committed suicide, their inability to recognise this, and their failure to take preventative measures.

Relief and Happiness

Relief may also be a strong emotional reaction experienced by survivors since not only do they no longer have to worry about the deceased's emotional lability or the stressful consequences of their pre-death destructive behaviours (Clark 2001b; Clark & Goldney 1995, 2000; Cleiren 1993; Ellenbogen & Gratton 2001; Elison & McGonigle 2003; Hawton 1986; Maple 2005; Maple et al 2007) but they have also been released from the burden of having to try and rescue the bereaved from the struggles into which they too had been drawn prior to the death (Farberow 1992; Smolin & Guinan 1993; Wright 1996). However, as Elison and McGonigle (2003:103) observe, the fact that feeling relieved is regarded as being taboo means that 'people have problems both admitting it and living with it.' Maple's (2005) study

of parental bereavement after suicide supports this contention, since feeling relieved that your child had died was seen by these parents as being an unacceptable viewpoint to hold, further compounding the intensity of the emotions already being experienced.

A sense of happiness in response to the suicidal death of another has also been reported (see Lester 2005) but with less frequency than reports relating to relief. Whilst either a sense of happiness or relief is hardly surprising given the tenuous nature of many of the pre-death relationships, the guilt that these responses evoke (Campbell & Fahy 2002) may add to the survivor's ambivalence in relation to the death.

Suicide – A Social Stigma

In addition to the often sudden and unexpected nature of the death and the amplified grief responses it evokes, the fact that suicide is regarded as being a social stigma also contributes to qualitative differences observed between suicide bereavement and bereavement associated with other forms of loss. Stigma is a social construction, occurring within relationships, that diminishes and devalues individuals by associating them with some form of disgrace (Biernat & Dovidio 2000; Ping Tsao, Tummal & Weiss Roberts 2008). This may include certain types of death such as manslaughter, murder, suicide, and cancer (Valente & Saunders 2002) and predisposes the mourner to greater risks of both mental and physical problems than non-stigmatised individuals (Major & O'Brien 2005). As Chin and Balon (2006 quoted in Ping Tsao, Tummal & Weiss Roberts 2008:70) observe, 'the added burden of stigma imposed on the struggle to recovery can alter behaviour, generate anxiety, and ultimately cause isolation from the mainstream culture.'

In relation to suicide, even those who *attempt* it are stigmatised. A recent survey of 160 undergraduate students by Lester and Walker (2006) revealed that over 52% of respondents would not date an individual who had attempted to take their own life, whilst 20% would not let an immigrant become an American citizen if they had attempted suicide. These results reflect those of earlier studies (see Lester 1992/1993) and highlight the pervasiveness of this prejudice. In instances where the attempt has been successful, Grad et al (2004:136) propose that there are a variety of factors that might contribute to the ‘sentence of stigmatisation for suicide survivors [that] may be universal throughout the world.’ These factors, which are culturally defined and influenced, include religious sanctions, juridical laws and discrimination by religious and social communities and insurance companies (Grad et al 2004). As Cantor and Baume (1997) point out, it has only been since the 1970’s that suicide has been decriminalised in most states in Australia.

The stigmatisation surrounding suicide (Fielden 2003; Sanders 1999; Sudak, Maxim & Carpenter 2008) may also be responsible for the distorted thinking that suicide survivors sometimes engage in as they attempt to keep the cause of death hidden (Grad et al 2004; Sudak, Maxim & Carpenter 2008). Rather than viewing the death as a suicide, bereaved individuals may recast it as having been due to an accident or some more natural phenomenon (Mehrabian 2005; Valente & Saunders 2002; van der Wal, 1989; Worden 1982, 2001). Worden (2001) observes that when individuals challenge the accidental death pretence operating within their family they are often met with resistance and anger from those wishing to retain the myth. Unfortunately, whilst engaging in this distorted thinking may afford some short-term protection against some of the powerful emotions evoked by the suicide, it also perpetuates the vicious circle of denial, secrecy, isolation, stigmatisation and disenfranchisement both

within and outside the family (Smolin & Guinan 1993; Wrobliski & McIntosh 1988). Fielden's (2003) study of family members bereaved by suicide vividly highlights this dynamic, leading researchers like Maple (2005) to conclude that because open discussions about death by this means are quashed, particularly when it is unexpected, 'there is no language to deal with suicidal individuals or those bereaved by suicide' (p. 53).

Whilst, on the whole, stigma in relation to suicide remains deeply socially entrenched, Grad et al (2004) report on a developmental phenomenon in Norway in which increased openness towards suicide is emerging. Openness in this context refers to 'the willingness to speak openly about being a survivor of suicide' (Grad et al 2004:135) and may include the publication of the actual cause of death in obituary notices, speaking frankly and honestly about the suicide with work colleagues and friends and being both proactive and specific when asking for support in an effort to facilitate the bereavement process. According to these authors, however, the fact that engaging in such openness still feels 'risky, controversial and courageous' for survivors illustrates that the fight against the oppression of suicide-related stigma has only just begun (Grad et al 2004:136).

Suicide – A Search for Meaning

Given that every suicide is the result of the interaction of a number of motivating factors and is therefore a 'multi-determined' event (Smolin & Guinan 1993:22), survivors cannot help but be left with an endless litany of whys as they attempt to find the definitive answer or reason for the death. Preoccupation with, and ruminations about the death, which is a normal part of a grieving process, are therefore also heightened for survivors of suicide (Farberow 1992; Jordan 2001; Wrobliski &

McIntosh 1988). They may become obsessed with mentally rehearsing the ways in which they could have prevented the suicide (Cook & Oltjenbruns 1989; Ellenbogen & Gratton 2001) and may continue to search relentlessly for answers to the cause of the suicide (Dunn & Morrish-Vidners 1987/1988). Survivors often also feel obliged to be able to rationally explain the suicide to others (Moore & Freedman 1995) and may therefore suffer from additional pressure if they are still struggling to make sense of, or find meaning in, the death themselves.

In relation to this search for meaning, Clark and Goldney (1995) found that many of their participants could find very little meaning shortly after the suicide. Whilst this was ameliorated for some individuals over time, particularly if there were opportunities to talk with the police, doctor or coroner involved in the case, for others, the sense of devastation and bewilderment that had been experienced at the time of the suicide remained relatively unchanged, leaving them continually struggling to negotiate the 'Canyon of Why' (Campbell quoted in Myers & Fine 2007: 121).

Suicide – An Unsupported Experience

With regard to social support, Brasted and Callahan (1984:541 quoted in Cook & Oltjenbruns 1989:68) have noted that for most bereaved individuals 'their natural support systems and perhaps time will be the most effective therapy.' However, as Lund (1989) notes, the effectiveness of social support upon bereavement outcome is less related to quantitative factors (such as size of the support network) and more to the qualitative dimensions of perceived closeness, sense of mutuality and degree of self-expression permitted.

Tragically, whilst social support has been found to be the most critical factor in assisting individuals during their grieving process (Kneiper 1999), in instances of

suicide, survivors often feel shunned rather than supported (Smolin & Guinan 1993; Ping Tsao, Tummal & Weiss Roberts 2008), becoming 'socially helpless' (Grad et al 2004) because of society's 'inability to deal [with them] in an honest and caring way' (Campbell 1997:330). Calhoun, Abernathy and Selbys' (1986) study into societal reactions relating to different types of death found that interacting with suicide survivors was something that many individuals would avoid doing for fear of saying or acting in inappropriate ways towards the bereaved. These 'inappropriate' responses could include failing to offer help at all, avoiding the use of the deceased person's name, making thoughtless or dismissive remarks, giving advice and minimising the survivor's pain (Grad et al 2004). Unfortunately, such reactions only lead to a greater sense of isolation and stigmatisation for those mourning the loss.

For individuals whose relationship with the deceased has been hidden (for example, extra-marital lover, gay partner, therapist, estranged spouse, prison inmate) obtaining support after the suicide becomes even more difficult (Sudak, Maxim & Carpenter 2008). Thus the loss of previous support networks, or their total absence to begin with, both perpetuates the stigma attached to the loss and inhibits the survivor's bereavement (Campbell & Fahy 2002:87). As Berman (1995) notes, because of the ongoing stigma surrounding death by suicide, 'survivors, including helpers, are asked to surrender parts of themselves in payment for the act of the patient's suicide.'

It is perhaps because of this that support groups for survivors of suicide have developed to meet the needs of those bereaved in this way. However, unlike the myriad of other support groups set up for physical and mental problems, the social stigma attached to suicide has hindered the growth of such groups (De Fauw & Andriessen 2003: Grad et al 2004). Farberow (1998) notes, for example, that as

recently as a decade ago, only slightly more than a quarter of member countries of the International Association for Suicide Prevention had any support programmes in operation, most of which were volunteer-based.

Once established, however, such groups help lessen the stigma attached to suicide by reducing the loneliness felt by survivors and normalising their responses. Longer-term group members are also able to model constructive grief recovery, coping strategies and problem-solving for those who are more recently bereaved (Clark & Goldney 1995; Sudak, Maxim & Carpenter 2008; Ping Tsao, Tummal & Weiss Roberts 2008). Clark and Goldney (1995) caution, however, that suicide survivors who are wracked with guilt and have low self-esteem may find it difficult to share their experiences, at least initially, in a group situation.

Whilst the provision of groups for survivors of suicide is one means of offering support it is by no means all that is required. Clark (2001a) reports that at the annual conference of Suicide Prevention in Australia held in 2000, delegates, consisting of 30 survivors and 80 professionals and service providers, offered the following recommendations in relation to improving suicide postvention: less patronising, more compassionate attitudes and service provision by professionals when attending to survivors' emotional needs; less adversarial coronial processes; increased provision of training and education for professionals; greater flexibility in service delivery (including workplace support and upon-demand availability); and increased support networks for special groups.

Suicide Survivors and the Risk of Experiencing Complicated Grief

Given both the situational factors relating to death by suicide and the qualitatively different, amplified grief responses it evokes in survivors, this population of mourners

is considered to be at risk of experiencing a complicated grief response, together with its associated adverse health effects (Jacobs 1999; Mitchell et al 2004; Prigerson & Jacobs 2001). Complicated grief, which has been identified as an important and distinct subcategory of bereavement (Prigerson et al 1997), is characterised by ‘prolonged intense separation distress, pre-occupation with images of the deceased and distress or avoidance of reminders’ (Kritjanson & Lobb 2004:58). Prigerson et al (1999) state that in addition to avoidance of reminders of the deceased, the mourner must also exhibit at least three further traumatisation symptoms (for example shock, numbness and raging anger) for a diagnosis of complicated grief to be considered.

A recent pilot study by Mitchell et al (2004), exploring complicated grief in adults surviving the suicide of a family member or significant other, revealed that those more closely related to the deceased had higher levels of complicated grief than those more distantly related. In light of their findings, Mitchell et al (2004:17) recommend that, clinically, ‘assessment of complicated grief should take into account the bereaved’s familial and/or social relationship to the deceased.’

It is worth noting, however, that given complicated grief’s recent emergence within the loss and grief field, there is currently both considerable, ongoing debate regarding its conceptualisation, assessment, classification and treatment (Kritjanson & Lobb 2004) and a dearth of controlled studies investigating the effectiveness of different treatment approaches (Jacobs & Prigerson 2000).

When a Client Commits Suicide – Therapists’ Experiences of Grief and Bereavement

‘Conventional wisdom holds that there are two types of clinicians – those who have had a patient commit suicide and those who will.’

(Valente and Saunders 2002:5)

Having now explored the experience of bereavement after suicide, including the ways in which death by this means can amplify and complicate the mourner’s grief responses, in this final section of the literature review specific attention is paid to the grief and bereavement experiences of therapists in response to the suicidal death of their client. As will become apparent, whilst a growing body of research is emerging in relation to this phenomenon, little attention has been paid to the ways in which therapists’ grief and bereavement post-suicide become disenfranchised. It is the paucity of research in this area that provides the impetus for the current study, the rationale for which will be discussed in the closing stages of the chapter.

Statistics relating to major mental illness lethality suggest that not only is the death of a client by suicide a likely occurrence for both therapists-in-training (Chemtob et al 1989) and those who have been working in the field on a long-term basis (McWilliams 2004b; Walsh & McGoldrick 1995) but that it has remained the crisis most frequently faced by mental health professionals for the past thirty years (Knox et al 2006). Furthermore, the death of a patient through suicide is purported to be the most impactful incident that a therapist can encounter, irrespective of years of practice or level of seniority (Gitlin 1999; Kaye & Soreff 1991; Coverdale, Louie & Roberts 2005) and is as difficult to negotiate as a death experienced in personal life (Pilkinton & Etkin 2003).

As Szasz (2006:34) notes, however, because wanting to end one's life is currently regarded within the psychiatric profession as being 'a severe mental illness' and 'a preventable medical tragedy', in instances where completion has been successful, it has come to be regarded as a 'quasi-crime.' Perhaps this is why 'the field has been relatively silent about this phenomenon' (Gitlin 1999:1634), with client suicide being rarely discussed at either an individual or group level. This fact, Campbell and Fahy (2002:45) believe, has 'far-reaching implications for mental health professionals, the families of patients who have committed suicide, and the patients themselves.'

Incidence of Client Suicide

Given that the World Health Organisation estimates that over 90% of people who commit suicide have a mental disorder (Merhaby 2005) and that the majority of people who commit suicide have accessed mental health care professionals shortly before their death (Gitlin 1999), it is hardly surprising that the reported frequency of client suicide has been over 80% (Cryan, Kelly & McCaffrey 1995; Grad, Zavasnik & Groleger 1997; Linke, Wojciak & Day 2002) though a broad range of percentages exists within the literature.

In the lower frequency range, Kleespies, Smith and Becker's (1990) study found that 17% of psychology interns had had a client commit suicide whilst under their care; Kleespies, Penk and Forsyth's (1993) survey of psychologists-in-training revealed that 11% had encountered the death of a client by this means; and Trimble, Jackson and Harvey's (2000) Australian study found that over one third of the clinical and counselling psychologists surveyed had experienced at least one completed suicide. In the middle frequency range, both Tanney (1995) and Yousaf, Hawthorne and Sedgwick (2002) found that 43% of respondents had had experience with suicide;

Dewar et al (2000) 47%; Ruskin et al (2004) 50%; and in Courtenay and Stephen's (2001) sample, 54%. Studies revealing higher frequency rates include those of Pilkinton and Etkin (2003) in which 61.4% of Canadian psychiatric residents had experienced one or more completed suicide during their residency; Kozłowska et al (1997) and Alexander et al (2000) in which 68% of respondents had experienced the suicide of a client; and Cryan, Kelly and McCaffrey (1995) in which 82% of the one hundred and nine consultant psychiatrists surveyed had experienced such a death, with 81% of these having had more than one patient die by this means. Grad, Zavasnik and Groleger's (1997) survey of sixty-three psychiatrists and psychologists working in hospitals and clinical settings produced even higher rates for client suicide with all but one respondent reporting that they had experienced such an event.

Ruskin et al (2004) caution, however, that the prevalence of client suicide may actually be under-represented in the literature since, as Henn (1978) has noted, a large percentage of therapists remain unaware (an estimated known to unknown ratio of 1:12) of the fact that the subsequent deaths of their clients have been deemed by the coroner to have been due to suicide.

Despite the fruitfulness of the information that studies such as these provide, strong criticisms exist, nonetheless, in relation to a number of methodological issues including the following:

- a) Much of the research to date has focussed upon psychiatrists and psychologists with little attention being given to therapists outside these disciplines (Knox et al 2006; McAdams & Foster 2000; Michel 1997; Valente & Saunders 2002).

- b) The majority of studies have been conducted in North America, Canada and New Zealand and may not reflect the experiences of therapists in other countries (Alexander et al 2000; Cryan, Kelly & McCaffrey 1995).
- c) Since the majority of research has been undertaken in psychiatric settings with high-risk patients, information relating to patients being treated by nurse psychotherapists, for example, remains largely undocumented (Valente & Saunders 2002).

Of the few studies undertaken within the wider therapeutic population, McAdams and Foster's (2000) national survey of professional counsellors found that 23% of counsellors (including those still in training) had had a client commit suicide whilst under their care, whilst Linke, Wojciak and Day's (2002) survey of forty four staff, including community psychiatric nurses, social workers and occupational therapists working within multi-disciplinary community mental health teams, found that 86% had had a minimum of one patient suicide, with an average client suicide rate of 4.2. Jacobson et al's (2004) more recent study of mental health social workers also illustrated that client suicide was far from being a rare occurrence for individuals working within this professional field.

Although an initial study by Chemtob et al (1988) suggested that the frequency of client suicide was influenced by therapists' gender, with males more likely than females to encounter the death of a client by this means, subsequent research (see Chemtob et al 1989:298) refuted these claims. Instead, the characteristics of the profession (psychiatrist versus psychologist), work setting (psychiatric hospital versus private practice or research) and patient type (organic disorder/substance abuse versus anxiety or personality disorder) were found to be the critical predictive factors, not

gender, age, experience or theoretical orientation. More recent studies have replicated these findings with both Cryan, Kelly and McCaffrey (1995) and McAdams and Foster (2000) noting no difference with regard to gender and years of practice between therapists who have had a client suicide and those who have not.

Therapists' Responses to Client Suicide

Without question, the ripple effects of an individual's suicide extend well beyond the immediate family circle, impacting those who have been involved in the deceased's mental care at levels comparable to those witnessed in other human relationships (Cryan, Kelly & McCaffrey 1995; Dunn, McIntosh & Dunn-Maxim 1987; Little 1992; Ness & Pfeffer 1990; Worden 1991). Despite this fact, suicide survivors who are significant others rather than family members are 'usually the ones that are most neglected [since] not only do they receive no help, they often have to help those who are supposedly closer to the deceased to cope with loss and distress' (Grad 1996:138).

It has only been since Litman's (1965) seminal report, highlighting the personal and professional impact of client suicide upon psychiatrists, that researchers have come to acknowledge the profound effect that death by this means can have amongst those working within the mental health field. As Garvey (2000:32) notes, 'suicide is unarguably that issue which most acutely challenges our mandate as a helping, analytical and responsive professional.' In light of such challenges, McWilliams (2004b:266) argues that the death of a client through suicide creates 'monumental anguish for the therapist whose patient dies this way' whilst Knox et al (2006:547) and Kleespies, Smith and Becker (1990:257) describe client suicide respectively as 'an often extraordinarily painful process for clinicians' and 'a difficult and complicated matter.' Having experienced the death of several patients, Courtenay's

(2002:235) admission that ‘patient suicide does not necessarily become easier to bear’ is testament to the profound impact that death by this means creates for therapists.

So profound is the impact believed to be, that McAdams and Foster (2000) go so far as to argue that suicide should be regarded as a crisis, a viewpoint echoed by McWilliams (2004b) who claims that the death of a client by suicide is a traumatic event. These claims are supported by research findings, with Chemtob et al (1988) reporting that 57% of psychiatrists studied had experienced posttraumatic stress symptoms (such as flashbacks) comparable to those found in clinical populations; and Ruskin et al’s (2004) finding that one quarter of their sample of trainee and qualified psychiatrists had approached morbid levels on a posttraumatic stress disorder checklist. It is because the suicide of a client *is* so traumatic that it has the potential to ‘increase or constrict [the] development’ of the therapist, both personally and professionally (Kleespies, Penk & Forsyth 1993:293), with some clinicians ‘swearing off’ specialising in psychiatry after experiencing such an event (Valente 1994 cited in Ellis, Dickey & Jones 1998:182).

In light of the above, it is heartening to observe that research surrounding therapists’ responses to client suicide has been expanding (Clark & Goldney 2000; Grad, Zavasnik & Groleger 1997) although, as Bultema (1994) points out, as recently as the mid-1980’s, the ratio of research studies into family members’ bereavement versus that of therapists’ was only 1:25. Further research in this area is therefore still highly recommended (Yousaf, Hawthorne & Sedgwick 2002).

The Immediate Impact of Client Suicide upon Therapists

The widely held viewpoint of both researchers and clinicians alike is that mental health professionals react to a client’s suicide in two ways, ‘as people who have lost a

significant other, and as professionals experiencing a critical event in their professional development' (Horn 1994:190).

Whilst not discounting Berman's (1995) observation that the impact of client suicide upon helpers is 'idiosyncratic', a review of the literature reveals strong consensus amongst researchers with regard to the responses typically experienced by both therapists and therapists-in-training in the aftermath of their client's suicide, with shock, anger, sadness, disbelief, denial, guilt, anxiety, shame, doubt, self-blame and depression being some of the most typically noted reactions (Anderson 1999; Berman 1995; Bloom 1967; Brown 1987a, 1987b; Chemtob et al 1988; Chemtob et al 1997; Cryan, Kelly & McCaffrey 1995; Gitlin 1999; Goldstein & Buongiorno 1984; Hendin et al 2000, 2004; James 2005; Kleespies, Smith & Becker 1990, 1993; Knox et al 2006; Little 1992; McAdams & Foster 2000; Midence, Gregory & Stanley 1996; Tanney 1995; Yousaf, Hawthorne & Sedgwick 2002). The fact that clinicians who work with suicidal clients can also struggle with feelings of 'not giving a damn anymore, hate, loss of hope, and the secret – or not so secret - desire for the patient to die' (Bleiberg 2003:224) may exacerbate these responses even further.

With regard to guilt and shame, female clinicians have been found to have a more intense experience than males (Grad, Zavasnik & Groleger 1997; Hendin et al 2004; Kovac & Range 2000) with Hamel-Bissell's (1985) study of thirty-six female psychiatric nurses revealing that these feelings of guilt may never completely abate. As Grad, Zavasnik and Groleger (1997:384) point out, however, the experience of shame is likely to be an under-reported phenomenon since 'shame is 'too shameful' to be self-recognised and acknowledged...[so] even trained professionals are likely to suppress or deny it.'

McWilliams (2004b) claims that a degree of paranoia is also quite common after a client's suicide with many therapists fearing that they will become the topic of conversation within the entire mental health community or the target of revenge for the client's family. Michel (1997:129) describes developing a paranoid fear of his client's husband after her suicide, with thoughts that 'one day he would turn up and assault me or even kill me becoming more and more obtrusive.' However, given the shame he had felt about experiencing these irrational thoughts, Michel had 'never mentioned them to anyone' (p. 129).

In light of Persons and Mikami's (2002) observation that treatment failures (which suicide is often regarded as being) are rarely discussed or managed effectively by therapists, some degree of paranoia seems quite justifiable. Whilst this paranoia is completely unwarranted, since a review of the research reveals no one cue exists from which therapists can establish their client's suicidality (Hoffman 2000), the fact that *attempted* suicide is still regarded as being a 'near catastrophe' (Ramsay & Newman 2005:416) can only serve to exacerbate a therapist's paranoia about having failed to prevent this 'catastrophe' from occurring.

Doubts about competence and knowledge (manifesting as ruminations about the need to prevent further suicides and a reluctance to treat highly suicidal clients) have also been regularly noted (Tanney 1995). Grad, Zavasnik and Groleger's (1997) observation of higher levels of doubt in women than men led them to conclude that women appear to be more threatened by client suicide than men and seem to require greater consolation and reassurance because of this.

Given that a large proportion of the lawsuits filed against mental health professionals are in relation to client suicide (Baerger 2001) and that 'legal liability for failure to

prevent suicide is now very much part of the suicide prevention business' (Szasz 1987:886), fears about clinical, legal and ethical responsibilities relating to the death have also been observed (Berman 1995; Cryan, Kelly & McCaffrey 1997; Grad, Zavasnik & Groleger 1997; Hendin et al 2004; Kleespies, Smith & Becker 1990, 1993; Linke, Wojciak & Day 2002; Midence, Gregory & Stanley 1996; Tanney 1995; Yousaf, Hawthorne & Sedgwick 2002). Jobes and Berman (1993:91) note that the blame for suicide's occurrence is 'increasingly falling on mental health professionals who fail to 'prevent' the suicide of their client', making them 'ripe targets' for retribution in the form of malpractice litigation. Ruskin et al (2004) found that 9% of psychiatrists in their study had had legal action instigated against them (two of which had gone to trial) whilst Bongar et al (1998) found that the suicidal death of a client ranked sixth in the claims category for the American Psychological Association's Insurance Trust. Jobes and Berman (1993) observe that such a claim is the second most costly to settle.

Whilst mental health professionals' fears about being sued for malpractice cannot help but be heightened by such statistics, the fact remains that lawsuits against them remain relatively rare (Baerger, 2001; Cantor & McDermott 1994; Clum 1987). With regard to Australian statistics, Cantor and McDermott (1994) estimate that approximately 1 in 900 psychiatrists per year are involved in suicide-related litigation. In the majority of suicide-related deaths, it is the hospital, rather than the therapist, who is named as the defendant (Cantor & Baume 1997). Unfortunately, the rarity of such claims appears to be of little comfort to those contemplating a career in the mental health field. As Bristow (2001:413), speaking in relation to declining numbers of trainee psychiatrists observes, given the 'atmosphere of blame and the unlimited sense of liability that currently pertains' it is hardly surprising that we are witnessing a

decline in numbers entering the profession. If, as Jobes and Berman (1993:95) contend, 'litigation of malpractice liability can be professionally and personally devastating as well as financially ruinous', findings such as Bristow's (2001) are likely to increase.

As a result of the loss, therapists may also engage in a prolonged and intense search for meaning (Cryan, Kelly & McCaffrey 1995). Since this meaning-making process is a critical aspect of bereavement (Neimeyer 2001), Moss et al (2003) argue that it is imperative for individuals whose work brings them into contact with death and dying to find ways of making sense of these experiences. According to Moss et al (2003:294), since 'both dying, an intimate process, and death, an ultimate event, are tied in with the personal feelings and life experiences of each individual', in the face of professional losses such as client suicide, therapists will automatically draw upon their own personal histories in an effort to make sense of the current death. In doing so, these authors argue, they will also reconnect with and re-activate past losses. Moss et al's (2003) ethnographic study of nursing home staff, for example, found that, in the aftermath of a patient's death, participants 'spontaneously told stories of deaths in their own families, and described how the meanings of resident deaths and family deaths were inter-related' (p. 290). Kolodny et al (1979:466) also report of thinking about 'relatives who had died and of concerns for [their own] parents' after client suicide whilst Pilkinton and Etkin's (2003:97) study of Canadian trainee psychiatrists found 'recurring thoughts of previous deaths' reported by some respondents in light of their patient's suicide.

Whilst a sense of relief has been noted in the general survivors of suicide literature, few references (see Gitlin 1999; Kleespies, Smith & Becker 1990; Kleespies, Penk &

Forsyth 1993; Midence, Gregory & Stanley 1996; Takahashi 1997) are made with regard to therapists' feelings of relief after client suicide. Furthermore, those studies that do acknowledge its occurrence provide little, if any, information about it. Kleespies, Penk and Forsyth (1993:297) state in their study of pre-doctoral psychology interns that, 'no group reported having experienced much 'relief' after the patient suicidal events', but fail to provide possible reasons for this. Of the few researchers who do provide possible explanations, Gitlin (1999) suggests that the relief may be due to being freed from the chronic struggle of having to deal with a patient's ideations and threats whilst Takahashi (1997) contends that it is because the therapist is no longer locked into a transference-countertransference stalemate.

The existence of medico-legal assumptions that 'life must be protected at all costs' (Rycroft 2005:83) may also shed some light on the reluctance of therapist's to express feelings such as relief which may be construed as being supportive of a person's choice to take their own life. Szasz's (2006:35) scathing assertion that suicide is currently seen within psychiatric circles as being '*lese majeste* against the Therapeutic State, the supreme representation of legitimate authority for people who worship health and want to stay alive as long as possible' certainly supports such a hypothesis.

Also reported, though with less frequency, have been increased feelings of disengagement and depersonalisation (Gitlin 1999; Knox et al 2006; Linke, Wojciak & Day 2002; Midence, Gregory & Stanley 1996; Takahashi 1997); embarrassment (Gitlin 1999; Hendin et al 2000; Kolodny et al 1979); dreams relating to the client's suicide (Chemtob et al 1988; Litman 1965; McAdams & Foster 2000; Sacks et al 1987); hallucinations (Gitlin 1999); heightened feelings of protectiveness towards remaining clients (Kolodny et al 1979; Knox et al 2006); accident proneness (Gitlin

1999; Litman 1965); an increased desire to change occupations (Anderson 2005; Clark 2001b; Linke, Wojciak & Day 2002; Tanney 1995); the development of fatalistic attitudes such as 'No suicide is preventable' (Takahashi 1997); preoccupation with searching for omens – 'clues that might have alerted the therapist to the client's incipient suicide' (Gitlin 1999:1631); and consideration of taking early retirement (as was the case for 15% of the Scottish consultant psychiatrists in Alexander et al's (2000) study). Feelings of horror have also been reported (Grad, Zavasnik & Groleger 1997). In Ruskin et al's (2004) study of trainee and qualified psychiatrists, for example, 55% of respondents stated that not only had they experienced horror in relation to the suicide but also that this feeling had been a recurrent one. Within the family arena, poor sleep, irritability and an inability to deal with the everyday problems of family life have also been noted by researchers (see Alexander et al 2000).

Intensity of Therapists' Responses to Client Suicide

It is important to note that whilst general agreement exists between researchers about the types of responses evoked by client suicide, the intensity of these responses appears to be influenced by a number of factors. Therapists' years of professional experience, for example, has been found to influence response intensity, with less experienced therapists (typically those still in training) exhibiting stronger reactions than fully certified therapists (Brown 1987a; Chemtob et al 1988; Foster & McAdams 1999; McAdams & Foster 2000; Hendin et al 2004; Kleespies, Smith & Becker 1990; Kleespies, Penk & Forsyth 1993; Ruskin et al 2004). Brown (1987b) observed that 77% of the psychiatric trainees in his study had been impacted either strongly or severely by their client's suicide whilst Kleespies, Smith and Becker (1990) noted that the stress levels of psychology interns after client suicide was equivalent to that

observed in bereaved clients and higher than that found in qualified practitioners. In the case of the psychiatric trainees surveyed by Yousaf, Hawthorne and Sedgwick (2002), over 50% were found to be clinically stressed immediately following their client's suicide with 'no statistically significant reduction over time' (p. 53). In light of this, conclusions such as Kleespies, Smith and Becker (1990:257) that, 'if managing the feelings associated with patient suicide is difficult for most seasoned professionals, it is probably even more trying for the less experienced and less established clinician-in-training' are hardly surprising. Dewar et al's (2000) study of psychiatric trainees in Scotland substantiates such claims since, of the 47% of respondents who had had a client suicide, 31% had admitted to its detrimental effect upon both their professional and personal lives.

One possible explanation for such results is proffered by Brown (1987a) who suggests that it is because trainees must rely on their personal qualities, rather than on any well-established professional skills to assist their clients, that strong feelings of personal failure and challenges to previously held narcissistic aspirations in response to their death result. Foster and McAdams (1999) support Brown's contention, arguing that trainees are, in fact, less equipped than their fully qualified, more professionally experienced counterparts to differentiate 'personal failure from the limitations of the therapeutic process' (p. 24). A second possible reason for the higher intensity of reactions experienced by trainees is that they are likely to have had less formal training in, and contact with, death-related issues than experienced therapists and as such 'feel significantly higher levels of discomfort in responding to client situations involving death and dying' (Kirchberg, Neimeyer & James 1998:99). Ellis, Dickey and Jones (1998) add to these conjectures by suggesting that it is a lack of

clinical experience, together with a lack of perspective for responding to the suicidal event, which places trainees at greater emotional risk.

Building upon their previous studies (Kirchberg & Neimeyer 1991; Terry, Bivens & Neimeyer 1995), Kirchberg, Neimeyer and James's (1998) study of fifty-eight Masters level counselling students not only replicated their earlier findings (that death and loss-related client issues can evoke higher stress levels than non-death related ones in beginning counsellors) but that these levels were exacerbated in counsellors with higher personal fears about death. This is not to suggest, however, that 'seasoned' therapists are somehow more prepared for the impact that their client's suicide will have upon them. As Midence, Gregory and Stanley (1996) suggest, despite the death of a patient by suicide being a common occurrence, the fact that coping with it is one of the most difficult challenges that clinicians, irrespective of years of training and experience can face, means that they are often left feeling ill prepared for the powerful personal grief responses and existential angst that they encounter.

A second factor to influence the intensity of a therapist's response to client suicide is the issue/s that they had been addressing with the client. Chemtob et al's (1989) study revealed that therapists responded with less intensity in cases where the client's issues had related to substance abuse. In these instances, Chemtob et al (1989) proposed, therapists may have felt less able to influence either their client or the treatment outcome and therefore felt less responsible for the suicide.

The third factor to impact upon response intensity is the therapist's workload at the time of the suicide (Horn 1994). Chemtob et al (1989) identified positive correlations between client caseload and elevated therapist stress levels post-suicide, an

unsurprising finding given the links that have been established between work-related stress and burnout.

A further factor influencing the intensity of therapists' responses is the schemas (core beliefs and expectations about self and others) that they operate from (Meyer & Ponton 2006). Sommers-Flanagan and Sommers-Flanagan (1995:41) state that, 'clinical objectivity and effectiveness is enhanced when practitioners have a high level of self-awareness about their underlying personal biases and vulnerabilities.' Drawing upon McCann, Sakheim and Abrahamson's (1988) model of psychological adaptation, Horn (1994:193) argues that, in relation to suicide, since these schemas influence therapists' beliefs about themselves, their clients and their role, therapists who believe that they are responsible for their client's death may experience higher degrees of emotional turmoil and distress than those whose schemas place the choice and responsibility squarely upon the client's shoulders. Horn's (1994) argument finds support in the studies of both Hendin et al (2004) and Trimble, Jackson and Harvey (2000). Whilst Hendin et al's (2004) study found higher levels of severe distress in therapists who believed that their client's suicide had been due to their failure to hospitalise their client or their poor treatment decision, Trimble, Jackson and Harvey's (2000:227) study of Australian clinical and counselling psychologists found that 'recognising that they were not responsible [for their client's death and] an increased acceptance of suicide as a possible outcome' were two of the most helpful strategies employed after the suicide.

Other factors which have been suggested to influence the intensity and complexity of the therapist's response include the quality of the client-therapist alliance/attachment (Berman 1995; Horn 1994); the length of time that the therapeutic relationship has

been established (Gitlin 1999; Takahashi 1997); the intensity of the conflicts, transference and countertransference operating within the therapeutic relationship (Bloom 1967; Gitlin 1999; Takahashi 1997); the degree of publicity in the media about the suicide (Alexander et al 2000); the level of involvement in legal and disciplinary proceedings (Alexander et al 2000); and the therapist's individual psychological makeup, for example, 'obsessional personality style, tendency to internalise, vulnerability to anxiety and depression' (Gitlin 1999:1634).

The Longer-Term Impact of Client Suicide upon Therapists

With regard to the longer-term effects that client suicide has upon therapists, the experience may result in an outcome of either growth or debilitation (Grad, Zavasnik & Groleger 1997; Tanney 1995) with Prigerson et al (1996) contending that a therapist's grief symptoms at the time of the suicide are strong predictors of whether or not the therapist's future physical and mental health will be positive or lead to depression. An early study by Goldstein and Buongiorno (1984) found that after their client's suicide, psychologists had to incorporate the trauma into both their professional and personal lives, whilst Linke, Wojciak and Day's (2002:51) survey of community health mental workers found that 45% of respondents had experienced 'long lasting [and] adverse effects' in both their professional and personal lives as a result of their clients' suicides. Linke, Wojciak and Day's (2002) findings are supported by those of Ruskin et al (2004:106), who found that 29% of respondents acknowledged that their client's suicide had had 'an enduring effect' on them; Berman's (1995:96) participant, Marissa, who stated that she 'realised that [she] would never stop reworking the loss'; and Hendin et al (2000:2027), who described their participants' need to 'explore and resolve long-lasting feelings connected with their patients' suicides.'

In relation to the more negative legacies of client suicide, Kleespies, Smith and Becker's (1990:259) trainee therapists listed, in order of frequency, increased anxiety when evaluating and working with high risk clients; recurrent thoughts about the suicide; and ongoing feelings of helplessness and guilt. Eighty-eight percent of participants reported such responses still occurring eight to ten years after the suicide, illustrating the ongoing influence of the event on their lives. It is Brown's (1987b) study of psychiatrists, however, which most vividly highlights the profound and ongoing impact that client suicide can have upon therapists. This study found that, without exception, respondents were able to vividly recall their client's name and the specific details surrounding the suicide as much as thirty years after the event.

Despite the negative consequences outlined above, 75% of respondents in Kleespies, Smith and Becker's (1990) study also reported a number of significantly positive outcomes arising from their client's death including 'increased realisation that suicides occur, a sensitisation to the issue of suicide, an increased cautiousness when working with high risk patients' (p. 260) and 'feeling humbled' (p. 259) by the experience. Similar findings, with regard to increased cautiousness and greater acceptance of suicide's occurrence, have been reported by other researchers and clinicians (see Courtenay & Stephens 2001; Brown 1987b; Hendin et al 2000; Kleespies, Penk & Forsyth 1993). More thorough note-taking, earlier hospitalisation for high-risk cases and greater second opinion seeking from colleagues has also been noted (Anderson 1999; Cryan, Kelly & McCaffrey 1995; Hamel-Bissell 1985; Kolodny et al 1979; McAdams & Foster 2000) although these interactions may feel awkward (Midence, Gregory & Stanley 1996).

Numerous researchers have also argued that, in the aftermath of client suicide, any sense of power or omnipotence previously held by the therapist is reduced by their heightened awareness of a client's capacity to act upon their suicidal impulses (Berman 1995; Gitlin 1999; Kolodny 1979; Kleespies, Penk & Forsyth 1993; Takahashi 1997; Tanney 1995). According to Berman (1995:99), it is only by remaining untouched by trauma, that a therapist's omnipotence can be reinforced, for once it occurs, they are 'forever reminded of how little control they truly have over the lives and choices of their patients.' This fact is graphically illustrated by Grad's (1996) personal reflections in relation to the suicidal death of his supervisor. His imploring questions ("Do we really help people in distress or is it an illusion?", "If we couldn't help him, how could I ever help my patients adequately?" and "Can there ever be a complete guarantee in life against suicide?" (p. 137)) reflect the loss of faith he experienced in relation to his previously held assumptions about therapists' power and knowledge. Such challenges to one's omnipotence may explain the increased frequency of support-seeking and peer supervision by therapists, post-suicide.

More recently, Knox et al's (2006:553) study of pre-licensed doctoral psychologists extended the list of positive longer-term outcomes by observing that, as a result of their client's suicide, these trainee therapists had experienced 'more acute awareness of client distress and pain' which had lead to enhanced service provision on their part. Like Kleespies, Smith and Becker (1990), Knox et al's (2006:553) participants also acknowledged the ongoing influence that the death had had upon their lives including the 'continued pain in telling the story of their client's suicide.'

The fact that both credentialed therapists and trainees *are* so markedly impacted by client suicide (Knox et al 2006) has led researchers and respondents alike to view

client suicide as an inherent ‘occupational hazard’ for those involved in mental health care (Chemtob et al 1988, 1989; Clark 2001b; Hamel-Bissell 1985; Kleespies 1993; Kozłowska et al 1997; Ramsay et al 2005; Ruskin et al 2004; Valente et al 2002). Kozłowska et al’s (1997) Australian study found that patient suicide, together with patient assault, was *the* most significant stressor identified by respondents, with 75% being moderately or severely impacted by their client’s death. Yousaf, Hawthorne and Sedgwick (2002:53) argue, however, that trainees are more vulnerable to this hazard because of their ‘relative inexperience, inadequate support and limited understanding of normal reactions to client suicide.’

Whilst the majority of research to date regarding the intensity of a clinician’s grief reactions to client suicide has focussed upon characteristics relating to either the therapist or the therapeutic relationship, these are not the only significant variables. In the following section, a number of postvention factors, operating within both the personal and professional lives of therapists, and which also influence therapists’ experiences of bereavement, will be examined.

Before turning our attention to these factors, it is worthwhile noting Garcia-Lawson, Lane and Koetting’s (2000:88) observation that the post-termination phase of therapy has received very little attention in the literature, despite the fact that ‘there is much to learn about this phase and the problems that are likely to emerge during this potentially difficult period’. Given that the majority of therapists regard the post-termination stage as an integral part of the therapeutic process (Garcia-Lawson, Lane & Koetting 2000), the impact of a client’s suicide on this post-termination phase clearly warrants further investigation.

Postvention Variables that Influence Therapist Bereavement

It was Shneidman (1993, 1998) who first developed the concept of suicide postvention, which he described as ‘those appropriate and helpful acts that come after the dire event itself’ (1993:165) and which help facilitate survivors’ mourning in relation to the death. With regard to the postvention needs of therapists in the wake of their client’s suicide, a review of the literature suggests that these ‘helpful acts’ may include the provision of support networks, supervision, psychological autopsies and/or clinical reviews, contact with the client’s family, engaging in community rituals such as funerals and receiving pre- and postvention education and training about client suicide. As the following discussion will illustrate, however, the degree of ‘helpfulness’ of these acts remains a contentious issue amongst researchers and practitioners alike.

Prior to examining these variables, it is important to firstly acknowledge that research into the experience of suicide survivors and how to respond to their needs has been severely precluded (Dunn & Morrish-Vidners 1987/88; Valente 1994). As Hodelet and Hughson (2001:43) note, the fact that a paucity of postvention literature exists to help health professionals negotiate through such an event means that ‘developing expertise in dealing with it is difficult.’

Support Networks

Consensus exists within the trauma literature that the ways in which the traumatised individual responds in the period immediately following the event are critical to their longer-term recovery (Tuval-Mashiach et al 2004). In light of this fact, it is now widely acknowledged that in the wake of their client’s suicide, therapists require skilled and committed support if negative personal and professional outcomes are to

be minimised. Of the studies undertaken, talking with colleagues and supervisors, followed by speaking with partners, friends or family have been found to be the most common sources of support sought (Alexander 1991; Alexander et al 2000; Berman 1995; Brown 1987; Chemtob et al 1988; Goldstein & Buongiorno 1984; Grad, Zavasnik & Groleger 1997; Hendin et al 2000; Kaye & Soreff 1991; Kleespies, Smith & Becker 1990, 1993; Kolodny et al 1979; Knox et al 2006; Linke, Wojciak & Day 2002; Menninger 1991; Midence, Gregory & Stanley 1996; Pilkinton & Etkin 2003; Ruskin et al 2004; Tanney 1995; Trimble, Jackson & Harvey 2000).

Menninger (1991) found that 90% of respondents chose to share their experience with colleagues whilst a third sought clinical consultation. Campbell and Fahy (2002:46) cite similar findings by Ness and Pfeffer (1990) that ‘with striking unanimity [psychiatrists] have said that formal and informal consultations with colleagues is one of the most important and helpful actions to take in coping with a client’s suicide.’

Linke, Wojciak and Day (2002) also reported positive outcomes in their study of multi-disciplinary community mental health team workers with ‘peer support, case reviews, dedicated staff meetings and support from senior colleagues being of most value’ (p. 50). For respondents in Kleespies, Smith and Becker’s (1990) study, four categories of support were identified as being useful: immediate peers, supervisors, other staff members and family members. Whilst support from supervisors was rated as being the most supportive avenue available to trainees, family support was rated as least helpful since respondents felt that family members ‘did not understand the significance of losing a patient to suicide’ (p. 260).

Several case studies also exist which indicate that being able to share the experience of client suicide with another therapist who has either been a mutual acquaintance of

the client or who has had a client die under similar circumstances proves helpful (Alexander 1991; Berman 1995, Hendin et al 2000; Jones 1987; Kleespies, Smith & Becker 1990). Therapists in Hendin et al's (2000:2025) study stated that sharing in this way had been 'more useful' than the reassurances they had received from supervisors or colleagues whilst one psychotherapist in Berman's (1995) investigation acknowledged that the 'kindest thing' his clinical director had done for him was to share his own experience of having had a patient commit suicide. Not only had this helped relieve his self-reproach, by allowing him to recognise that such traumas were unavoidable for even the most qualified of therapists, but through the process of talking about and listening to these stories, his own journey of healing had begun.

Being able to share the experience within group supervision sessions has also been found to provide solace (Berman 1995; Cotton et al 1983; Rosenbauer 1997) since a client's suicide has a profound impact not only on the therapist but also on every other team member involved in the case (Campbell & Fahy 2002). Through the guidance of an experienced facilitator, group participants are able to explore the meanings of their client's suicide, express their fears and feelings and begin to rebuild their confidence and self-esteem (Valente & Saunders 2002).

Despite the fact that studies such as these illustrate that support can be of benefit, it is not always forthcoming. Courtenay and Stephen's (2001) study of trainee psychiatrists found that whilst respondents would have been grateful to receive almost any form of support, in 40% of cases, their requests for assistance were ignored whilst Takahashi (1997:136), speaking in relation to patient suicide in Japan, states that it is 'often seen as an 'ordeal' that the psychiatrist has to deal with alone.' Similar results regarding feelings of emotional, professional and personal isolation were reported by

the majority of therapists in Hendin et al's (2000) study; a quarter of respondents in Kozłowska et al's (1997) study and by trainee psychiatrists in Pilkinton and Etkin's (2003:97) investigation, with one respondent stating that their programme had suggested that they 'just get on with things.' As Ruskin et al (2004:109) conclude, 'colleagues need to cut through the silence and reach out supportively to their peers whenever such a tragedy is experienced.'

McWilliams (2004b:261) also draws attention to the 'destructive office politics, unsympathetic administrators, arbitrary policies, changing rules, bureaucratic impingements' and the prioritising of 'litigation-resistant' files maintenance over patient care that therapists must contend with in dysfunctional organizations. Respondents in Pilkinton and Etkin's (2003:97) study described the 'conspiracy of silence' operating within their facility, with 'the procedures in place [being] for appearance and legal protection' rather than to support the therapist, post-suicide. Hendin et al (2000) have observed similar outcomes, with some therapists being met with hostility and defensive medicolegal investigations intent on discovering the clinician's wrongdoing. Clearly, such 'deficits in institutional culture' (Michel 1997:130) not only create gaps between an organisation's philosophical stance and the perceptions and experiences of those within it (Lawton 2000) but may also result in caregivers, such as therapists, failing to receive the post-suicide care and support they so desperately need.

Knox et al's (2006) qualitative study of therapists'-in-training also vividly illustrates the negative impact that workplace protocol can have upon a trainee's sense of support, post-suicide, with over half the respondents identifying the debriefings offered to their agency's staff and supervisor as having been 'callous, non-supportive'

(p. 553) and counter-productive to their attempts to cope. Courtenay and Stephens (2001) report similar findings, with adverse comments being made by respondents with regard to the 'debriefing' provided by external counsellors, whilst Pilkinton and Etkin's (2003) study of psychiatric residents found that they were resistant to the use of Employee Assistance Programmes because of confidentiality and insurance concerns. Hodelet and Hughson's (2001) advice to fellow health care professionals who have faced the suicide of a client to 'wait a *few days* before completing an [incident] report, to *get over* the emotional impact of the suicide' (p. 44; emphasis added) also does little to dispel the grief rules currently ensconced within many personnel policies which place organisational time-frames ahead of employees' legitimate rights to grieve.

Unfortunately, it is not just the higher echelons of the workplace that can impede a therapist's need for support. McWilliams (2004b) and Courtney (2002) both highlight that within many organisations an already stressful situation can be made significantly worse by the attitudes and derisive comments of work colleagues, a phenomenon that has received little attention in the literature. As Grad et al (2004) note, in instances of client suicide, the compassion and support that might have been offered by colleagues to a therapist under different circumstances of loss may be replaced by fear and hostility due to their realisation that 'this could also happen to them with one of their clients' (p. 137).

Kleespies, Smith and Becker's (1990) survey revealed that 'unhelpful support' was regarded as that which was 'overly intrusive, judgemental or overly philosophical' (p. 260) whilst Knox et al (2006) found that judgement from graduate peers about where the fault lay in relation to their client's suicide left many therapists-in-training having

to 'fend for themselves as they processed their client's death' (p. 553). Linke, Wojciak and Day (2002) also note that since therapists who have had a client commit suicide have a heightened sense of vulnerability and anxiety about being blamed or judged by colleagues, they 'must be handled carefully' (p. 51).

McWilliams (2004b) postulates that this derision may arise from the narcissism and misplaced sense of grandiosity that many therapists bring with them to the profession. Thus, according to Smolin and Guinan (1993), the death of a client through suicide cannot help but raise questions amongst the therapist's colleagues about whether or not they could have done a better job identifying the potential for suicide, intervening and preventing it. Such distain, whether self- or other-driven, seems ironic if, as Appleby and Sherratt (2001) contend, 'there is scepticism amongst mental health professionals regarding their role in suicide prevention and the common view persists within clinical practice that most suicides are *not* preventable' (p. 41).

In light of such findings, Valente and Saunders (2002) argue that the fear of being blamed for not having prevented the suicide's occurrence, feelings of isolation within the workplace and concern about being criticised over actions or omissions, can leave the professional 'hesitant to verbalise their grief and bereavement' (p. 8). Results of Ruskin et al's (2004:107) study reflect this hesitancy, with 70% of respondents stating that they had 'pretty much kept to themselves' after the suicide; 13% describing having felt strongly alienated; and 27% acknowledging that they had felt unable to ask for assistance, despite acknowledging that someone had been available to them. Experiences such as these, coupled with training programmes that stress the need for mental health professionals to be strong enough to deal with accidents/emergencies/crises such as suicide on their own and to continue to work as

usual, may give others the false impression that therapists are coping when, in fact, they may be struggling with the actual intensity of their emotional response to the death. As Michel (1997) observes, the cost of having to deny his personal reactions at the time of his clients' suicides was that, many years down the track whilst talking about these deaths with a colleague, he had been surprised to find that 'all the emotions were still there, unresolved [and that] the shock and pain [he had] suddenly experienced were so intensive that [he] was hardly able to finish [his] narrative' (p. 129).

In order to change the current situation, Weinstein (2002:204) underscores the necessity for practitioners and practitioners-in-training to 'challenge each other's accepted professional norms' and to recognise that the culture that exists in relation to death within an organization profoundly impacts upon the ways in which loss is either managed or mismanaged. Linke, Wojciak and Day (2002:15) reinforce Weinstein's (2002) plea by recommending that, 'senior staff publicly acknowledge how disturbing a suicide can be for teams and team members.' More recently, Hazen (2003:16) has joined the groundswell by urging organizations to change their policies and practices so that employers and employees can 'transcend denial and defence and consciously support bereaved co-workers.'

Clinical Reviews and Psychological Autopsies

Despite warnings such as Chemtob et al's (1988) that there is an urgent need for mechanisms such as psychological autopsies and clinical reviews to be established post-suicide if therapists are to effectively deal with its impact, a search of the literature suggests that few have heeded this call. Cryan, Kelly and McCaffrey's (1995) study of consultant psychiatrists revealed that a mere 24% of respondents were

offered a formal review after their client's suicide whilst Ellis and Dickey (1998) reported only 47% of psychology and 46% of psychiatry programmes surveyed required mandatory reviews to occur after an intern's patient committed suicide. More recently, Yousaf, Hawthorne and Sedgwick (2002) have reported a rate of review of only 39% in their study of trainee psychiatrists, however trainees did not provide feedback regarding the outcome of these reviews.

With regard to psychological autopsies, the few studies undertaken to investigate their usefulness have evoked mixed responses. Kleespies, Smith and Becker (1990) and Kleespies, Penk and Forsyth (1993) report that their studys' respondents had found the process moderately to extremely beneficial, as had 30% of respondents in Ruskin et al's (2004) study, although details about the specific nature of these benefits were not provided. Goldstein and Buongiorno (1984), on the other hand, found that such autopsies exacerbated, rather than relieved therapist doubt. Rosenbauer (1997), speaking in relation to her role as co-ordinator during a psychological autopsy, underscores the ripple effect that engaging in this process can have upon those who facilitate it. For Rosenbauer (1997:134), the fact that the participants' comments during the autopsy had remained with her for several weeks, led to her realisation that she 'had listened to everyone but [had] not recognised the need to debrief [herself].' In light of her experience, Rosenbauer (1997) stressed the need for facilitators, as well as mental health care practitioners, to have access to debriefing 'in order to achieve a complete process' (p. 136).

Contact with Members of the Deceased Client's Family

Despite research indicating that family members feel a real need to meet with the therapist after the suicide (Grad et al 2004) many therapists avoid engaging in such

meetings (Midence, Gregory & Stanley 1996; Saunders & Valente 1994). In relation to funeral attendance, for example, Kleespies, Smith and Becker (1990) report low attendance rates and mixed outcomes with regard to its value to therapists. Of those respondents who chose to attend, only one found it helpful with the remainder finding it either minimally so or not useful at all (although reasons for this were not provided). Those who chose not to attend cited fear of being a target for the family's anger and concern about being seen as having been responsible for the death as the reasons for their decision. In a later study, Kleespies, Penk and Forsyth (1993:299) found similarly low rates of attendance at the client's funeral or wake by trainee psychologists (18%), however, those who had attended had rated it 'definitely helpful in their own efforts to cope with the death.'

Cyran et al (1995) also found low funeral attendance rates amongst therapists, with only 15% of respondents in their study choosing to go and only slightly more than half finding it personally helpful (though 62% felt that it had been helpful to their client's relatives). In offering reasons for this surprisingly low attendance rate, particularly since these therapists lived 'in a culture, [Ireland], where funeral attendance is the accepted norm in everyday life' (p. 6), these researchers suggest that the avoidance may have been due to therapists' fears about being blamed for the death and of legal proceedings being instigated against them. Yousaf, Hawthorne and Sedgwick (2002) also hypothesise that the low direct contact rate (26%) observed in the psychiatric trainees they surveyed may have been due to the therapists' fear of accusation, whilst Alexander et al (2000) and Pilkinton and Elkin (2003) offer similar reasons for the low rates of funeral attendance witnessed in their studies, 15% and 14% respectively. Given that suicide is still seen by many as representing a failure of treatment (Hendin et al 2000) it is hardly surprising that therapists fears about having

feelings of hostility directed towards them by the family members was a driving force for many of them not to make contact.

Not all interactions with family members are fraught with negativity however. Kleespies, Smith and Becker's (1990) and Hendin et al's (2000) studies demonstrated that contact with family members provides opportunities for therapists to be absolved of responsibility for the suicide and permits them to provide support to these family members. Berman (1995) supports these findings, arguing that through such meetings, therapists can be given clear messages from the client's family about their concern for the therapist's wellbeing, their lack of blame towards the therapist and about 'letting them off the hook' (p. 91) in relation to the death. For Hendin et al's (2000) participants, the trepidation that they had initially felt in relation to meeting their client's family disappeared when they were met, not with anger and criticism, but with gratitude for their assistance in the deceased's life. Ruben (1990) also notes that a greater reduction of displaced anger by surviving family members towards therapists occurs when therapists make contact immediately after the death. The fact that, by attending the funeral, the therapist is provided with the opportunity to 'grieve in a group setting' (Campbell & Fahy 2002:46) is offered as a further benefit of making contact with the client's family post-suicide.

Markowitz's (1990) personal account also echoes that of Kleespies, Smith and Becker's (1990) and Hendin et al's (2000) respondents. The gratitude of the client's family towards Markowitz for having chosen to attend the funeral, the benefit they appeared to have derived from this, and the opportunity it had provided for him to offer them ongoing support in his role as a psychiatrist, 'eased laying to rest not only the patient but my guilty retrospection about the treatment' (Markowitz 1990:123).

For Markowitz (1990) therefore, attending the funeral, which he had regarded as ‘a hallowed, honorable extension of the physician’s role’, permitted him to ‘experience the commonality of loss’ with fellow survivors (p. 123). Kaye and Soreff (1991) reported similarly positive reactions from a client’s family whilst attending the funeral, though these authors stress that the needs of the family, rather than those of the therapist, must guide the decision-making process about whether or not to attend. Walsh-Burke (2006) reiterates Kaye and Soreff’s (1991) viewpoint, stating that the therapist’s decision about whether or not to attend a ceremony planned by their client’s family ‘should always be based on an assessment of how it will meet the grieving family’s needs rather than their own’ (p. 87).

Whilst Hodelet and Hughson (2001:43) also support the idea of therapists attending their client’s funeral, they are quick to remind health care professionals that ‘the importance of ‘institutional’ obligations should not be underestimated.’ If, as some contend, patient-therapist confidentiality continues even after death (LoboPrabhu et al 2008; Schacht 1992), Schacht’s (1992:282) assertion that the therapist is liable for harm caused by disclosures about the deceased person suggests that professional roles, boundaries and responsibilities must remain at the forefront of any decisions made in relation to contact, not only with the client’s family but also with other staff members.

Pearlman (1992) also raises concerns about the therapist’s role in relation to funeral attendance. Despite acknowledging that ‘it is humane and appropriate to meet with the family and attend the funeral’ (p. 282), he questions the appropriateness and ethics of therapists offering grief work to remaining family members, believing that the creation of therapeutic relationships with these individuals may influence their

decision about whether or not to instigate legal proceedings. Counsel such as Pearlman's (1992) and Schacht's (1992) is refuted by Kaye and Soreff (1992:283) who argue that since 'human' responses are required in the face of client suicide, talking with family and staff is 'the natural thing to do' and is not about 'trying to influence potential witnesses.' These authors urge all therapists to have the courage to overcome their 'malpractice paranoia' (p. 283) and to honour the fact that they must make time for themselves (in addition to being there for others) to share in the loss experience.

Such dissent with regard to what constitutes appropriate contact with family members post-suicide is hardly surprising given that therapeutic practice is a discipline 'rife with ambiguity' (Schank & Skovholt 1997) to begin with. In the face of an individual's suicide, survivors, including therapists, inevitably 'struggle with role uncertainty' ("How should I behave as a suicide survivor?") (Grad 1996:137). Furthermore, given traditional ethics of practice that expect the professional to prioritise their patient's needs above their own (Louie et al 2007), the necessity of having to attend to the needs of others bereaved by the loss means that the therapist's professional roles and responsibilities can easily usurp their personal need to grieve, making it difficult, if not impossible, to maintain an appropriate balance between the two (Jones 1987; Ruben 1990; Saunders & Valente 1990). The fact that 'both personal and professional responses *are* present, intermingled and blended in highly individual combinations and patterns' (Tanney 1995:107) means that, in instances of client suicide, the therapist occupies a 'delicate role' (LoboPrabhu 2008:134), one that simultaneously requires them to support the family whilst coping with their own grief-related responses.

Supervision

Despite supervision being ‘universally attested to throughout the counselling profession’ (Lawton & Feltham 2000:5) as the means by which valuable professional development, core competencies and optimal client outcomes are maintained (Bambling 2000; Bambling et al 2006; Barletta 2007; Falender et al 2004) a review of the literature demonstrates that formal training, education and research with regard to what constitutes effective supervision is, at best, minimal (Goodyear & Bernard 1998; Knapp 1997; Nelson, Johnson & Thorngren 2000; Peake, Nussbaum & Tindall 2002; Pearson, 2004; Winstanley & White 2003). Furthermore, in relation to client suicide, the literature provides no appropriate models of supervision for counselling supervisors to refer to (Bambling 2000). As a result, despite supervision often being mandated by licensing boards and professional associations (Gonsalvez & Freestone 2007; Pearson 2004), acquiring supervisory skills remains a largely ‘haphazard endeavour’ (Knapp 1997:590) with the role of supervisor being based more upon clinical seniority than skills and expertise (Carroll & Gilbert 2006).

Regardless of these shortcomings, research relating to coping with a client’s suicide illustrates that supervision still ‘plays an important role in [the] overall experience of such an event’ (Knox et al 2006:548). Furthermore, since the majority of therapists appear to have received minimum training with regard to client suicide and therefore require guidance in its aftermath, supervisory support may be of particular benefit for intern and trainee therapists (Kleespies, Smith & Becker 1990, 1993; Pilkinton & Atkin 2003) who have little professional experience to draw upon.

In light of his literature review of therapists’ psychological adaptation to client suicide, Horn (1994:190) argues that the primary task of the supervisor is to ‘create

experiences that will positively impact therapists' beliefs about their professional role'. Kleespies, Smith and Becker's (1990) and Kleespies, Penk and Forsyth's (1993) studies of intern psychologists found that they described 'good' supervision as that in which the supervisor acted as both a reviewer of the case (including sharing the responsibility for the eventual outcome) and a supportive figure to whom the therapist could turn, whilst Hewson (2007), drawing upon Tracey, Ellickson and Sherry (1989), states that in highly anxiety-provoking situations (such as working with suicidal clients) therapists, regardless of their years of clinical practice and experience, prefer to engage in a well-structured supervisory experience.

The importance of these factors, together with the supervisor's capacity to offer a "safe" environment in which the therapist's thoughts, feelings and fears in relation to the suicide are normalised, have been repeatedly illustrated in the literature (see Kleespies, Smith & Becker 1990; Kleespies, Penk & Forsyth 1993; Kleespies & Dettmer 2000; Knox et al 2006; Kolodny et al 1979; Shaw 2004). Takahashi (1997), speaking from a psychiatrist's perspective, argues that supervisors must also uncover any countertransference issues that the therapist may hold in relation to the deceased client since if these issues are left unaddressed, warning signs for suicide in their future clients may be missed.

Poor post-suicide supervision, by contrast, has been identified as that which occurs when supervisees feel forced to discuss the case before they are ready (Kolodny et al 1979); when the topic is not followed up in subsequent sessions by the supervisor (Michel 1997); when supervisees are inundated by the supervisor's own accounts of client suicide (Kolodny et al 1979); when supervisors break the news of the client's death to the supervisee in a callous or non-empathic way (for example, by leaving a

message on their answering machine) or focus more upon the potential legal implications of the death (for example, making sure the client's case notes are up-to-date) than on the needs of the therapist (Knox et al 2006). The value of supervision after a client's suicide may also be limited by the organisation's or supervisor's fears that disclosures within the supervisory session may be used against them in any subsequent litigation (Ellis & Dickey 1998). Not only might this fear hinder a supervisor's capacity to provide the degree of emotional support required by the therapist but it may also censor, if not completely eliminate, the therapist's desire to tell their story in the first place. Ellis and Dickey (1998:496) admonish those who use the fear of litigation to justify a lack of post-suicide support for the therapist involved, arguing that, at the very least, it deprives them of 'an important emotional and clinical learning experience.'

Another unsatisfactory supervisory experience can arise through the occurrence of a 'parallel process' in which the negative therapeutic dynamics experienced within the therapist-client relationship are mirrored in the therapist-supervisor one (Pearson 2004). This risk may be particularly high in instances where the therapist, believing that they haven't been good enough to 'save' their client's life, engages in a parallel process by assuming that their supervisor will regard them as not being a good enough supervisee. This dynamic, Corn (2001) contends, can result in the therapist-as-supervisee viewing their supervisor as a critical, judgemental other, whom they must remain silent around in order to avoid criticism or punishment.

Furthermore, as Carroll (2007, 2008) and Peake, Nussbaum and Tindell (2002) note, the increased emphasis being placed upon accountability, litigation, cost containment, monitoring and manualisation of treatment within supervision has meant that the

original aim of supervision to be a reflexive, experiential forum in which supervisees can explore their concerns, express their emotions and engage in optimal learning, has been severely compromised. By replacing reflection with authority, and ‘experiential learning’ with ‘audit learning’, Carroll (2007:26) argues that supervision has lost ‘its personhood and soul [with] destinations becoming more important than journeys.’

In light of the above, Foster and McAdams (1999) draw attention to the fact that a supervisor’s response, post-suicide, may have a significant impact upon the therapist’s future personal and professional development. Given this significance, McWilliams (2004b) suggests that decisions about a supervisor’s appropriateness should be based, to a degree, upon how safe the supervisee feels when they are with them, for as she points out, ‘supervision can be an empty ritual if the supervisee cannot be open about what is happening in the treatment hours and about how he or she feels about clients’ (p. 54). This is especially true in instances of client suicide where a therapist’s vulnerabilities about both their professional practice and their personal responses to the death have, understandably, been heightened.

Postvention Recommendations

In an effort to minimise the impact of client suicide on therapists, numerous researchers are calling for a multi-faceted approach to postvention to be adopted. Brown (1987b) suggests ‘psychological first aid’ for the therapists during the acute phase after the death, followed, two to six months later, by a psychological autopsy whilst Grad, Zavasnik and Groleger (1997:385) propose a two stage approach involving an initial review of the therapeutic process with an external supervisor followed by the provision of ongoing supervision and support to ensure that the personal and professional needs of the therapist are met ‘in every way possible’ (for

example, assistance with report writing, listening whilst they express their feelings, accompanying the therapist when they meet the patient's doctor or family or the police)(p. 385).

Ellis, Dickey and Jones' (1998) national survey of training and postvention practices in 166 psychiatry programs revealed the existence of similar protocols, with notification of supervisors/clinical directors and the filing of an incident report form being part of over 50% of these programs' procedures whilst the provision of clinical supervision and the recommendation that therapists seek counselling support was included in just over 40% of protocols. Interestingly though, in only 4.7% of programmes was attendance at counselling a mandatory requirement, a finding similar to that of Ellis and Dickey's (1998) national survey, in which only 8% of psychology programmes and 5% of psychiatry programmes required therapists to attend counselling for post-suicide support.

Education and Training

Despite the challenge that working with issues relating to loss, grief and mourning can present for therapists, mental health programmes continue to omit death-related training from their curriculum (LoboPrabhu et al 2008; Walsh-Burke 2006). With regard to working with suicidal clients, even though the need for formal training mechanisms to be put in place for therapists was raised by Light (1976) over thirty years ago, therapists, educators and supervisors still face a dearth of research to draw upon in relation to meeting therapist's personal and professional needs both pre- and post-suicide (Dexter-Mazza & Freeman 2003; Knox et al 2006).

Pre-Suicide Training in Suicide Risk Assessment and Intervention

Numerous researchers have drawn attention to the fact that formal training at both undergraduate and post-graduate level in suicide risk assessment and intervention is still conspicuously absent (see Laux 2002; Rosenberg 1999; McAdams & Foster 2000; Somers-Flanagan et al 2000). Trimble, Jackson and Harvey's (2000) study of Australian psychologists found that only 42.9% of respondents had received any formal university training in this area with a further 41.4% having received no education at either undergraduate or post-graduate level. Dexter-Mazza and Freeman (2003) report similar results with only 53% of participants from Psy-D programmes and 51% from Ph.D. programmes having been offered any formal training in suicide risk assessment. In light of such findings, it is hardly surprising that respondents stated that they had felt ill-equipped to deal personally or professionally with the suicidal behaviour and subsequent suicidal death of their client.

In addition to the dearth of training on offer, criticism has also been raised in relation to the type of training currently being provided. Neimeyer (2000c:551) argues that training is 'typically limited to a recitation of risk factors and a cursory discussion of 'no-harm' contracts, coupled with the ethical necessity to report and prevent client self-injury' whilst Tanney (1995) observes that the emphasis training programmes place upon intellectual mastery has been assessed as being 'minimal or only moderately helpful by helper-survivors' (p. 117). Yousaf, Hawthorne and Sedgwick (2002) also draw attention to the fact that therapists in their study did not find training in the form of didactic teaching to be of benefit. It is this inadequacy in current training approaches, Neimeyer (2000c) argues, that leaves therapists completely ill-prepared for the complexity of real-life suicidal crises.

However, given that *no* amount of training or intervention will eradicate the risk of suicide (Graham et al 1999; Little 1992), Scottish psychiatrists in Alexander et al's (2000) study highlighted the need for training programmes to emphasise the inevitability of suicide rather than the mere risk of its occurrence. By changing this focus within training programmes, they argue, mental health professionals will gain more realistic expectations about, and be better prepared for, the likely occurrence of such an event in their clinical practice. Thus, whilst the implicit message within current training programmes and ethical guidelines for working with suicidal clients is that by 'recognising the limits of their own competence and referring clients on when appropriate' (Graham et al 1999:28) suicide can be prevented, future programmes and guidelines need to include the impossibility of such a guaranteed outcome (Little 1992).

Post-Suicide Training and Education

According to Ellis and Dickey (1998) training in relation to client suicide has two major responsibilities - to minimise the risk of suicide happening in the first place and to provide both emotional support to the therapist and the skills for retrospective analysis when suicide does occur. Thus, for training programmes to be effective, they need to include both education in suicide assessment and intervention *and* 'active intervention' (p. 495) for the therapist in the aftermath of the suicide.

With regard to post-suicide training and education, however, a national survey of 166 psychiatric training programmes revealed not only that postvention practices varied substantially amongst training settings, particularly with regard to the procedures trainees should follow post-suicide, but that few postvention procedures were actually specified within policy and procedure manuals (Ellis, Dickey & Jones 1998).

Interestingly, whilst this survey indicated that training in suicide awareness and prevention was more prevalent than postvention education, it was still 'relatively superficial in nature' (p. 187) with most programmes offering suicide-focussed education 'in contexts less specifically devoted to the topic of suicide' (p. 184) such as supervision, case conferences and generalist seminars. Furthermore, according to Ellis, Dickey and Jones (1998), less than half (46.9%) of these programmes instructed trainees on how to actually respond in the event of client suicide, a finding supported by Dexter-Mazza and Freeman's (2003) subsequent study which revealed that only 50% of pre-doctoral psychology interns reported that formal training about client suicide had been part of their curriculum.

Kleespies, Smith and Becker's (1990) survey of psychologists' experiences of client suicide during their intern years also found that 'preparatory efforts at suicide education were minimal and inadequate' (p. 257), offering little in the way of helping them with how to respond to the emotional impact and pragmatic aspects of the death. More recent studies (see Kleespies, Penk & Forsyth 1993; Knox et al 2006; Linke, Wojciak & Day 2002; Pilkinton & Etkin 2003) support these earlier findings, with the majority of respondents stating that their initial professional training had left them ill-prepared for dealing with the death of their client. Furthermore, as Knox et al (2006:551) note, on the rare occasions when client suicide is discussed, it is done so in a reactive rather than a proactive way. Such observations led these researchers to conclude that 'this apparent scant attention to preparing therapists-in-training to manage client suicide is worrisome' (p. 551). Both Westefeld (2000) and Trimble, Jackson and Harvey (2000) share these concerns, arguing that within psychology programmes it is rare to find any comprehensive, agreed-upon suicidology education and training.

Ellis, Dickey and Jones (1998) caution, however, that additional complications may arise through the provision of training and education to therapists, since not only might questions be inadvertently raised about the therapist's competency levels in relation to current skills and supervision, but also their awareness might be heightened about the potential legal ramifications of having a client commit suicide. A recent article by Symons (2007) in the Bulletin of the Australian Psychological Society entitled 'Health Professionals and the Coroner's Court – Your Responsibilities' is a pertinent example of the dilemma that raising therapists' awareness about the legal ramifications of client suicide might create. Whilst the intention of this article is clearly to provide psychologists with guidelines in relation to responding appropriately if contacted by the Coroner's Office, the fact that the article urges them to seek advice from the Psychological Society's risk management 'as soon as possible' (p. 32) and to consider having a lawyer present during the coronial interview, cannot help but elevate any pre-existing anxiety held by the therapist. In light of the increased focus and awareness articles such as this create, the risk of the therapist choosing to leave the profession might also be heightened (Ellis, Dickey & Jones 1998).

In offering further reasons for postvention's 'poor relation' status to prevention, Clark (2001b:105) suggests that it may be due to the devaluing of the volunteers who generally provide the interventions, the lack of an attention-grabbing label for those bereaved by suicide, the stigma still attached to death by this means and the generally invisible nature of grief within the community.

In light of the above, studies into the impact of client suicide upon therapists unanimously endorse the need for greater training and support opportunities to be

made available (see Brown 1987; Clark 2001b; Kleespies, Penk & Forsyth 1993; Linke, Wojciak & Day 2002; Midence, Gregory & Stanley 1996; Yousaf, Hawthorne & Sedgwick 2002). Ultimately, however, it is important to recognise that *no* amount of pre- or post- suicide training can completely prepare or inoculate a therapist against the impact of client suicide since, as Kolodny et al (1979:469) point out, ‘the process of mourning is, and must inevitably be, a lonely one.’

Some Final Reflections on the Literature Review – Impetus for the Current Study

As the literature review has demonstrated, whilst research into the impact of client suicide on therapists has been growing over the past ten years, this research has been limited by several factors. Firstly, the fact that participants have historically been drawn from the psychiatric and psychological professions has meant that the experiences of therapists practicing outside these two mental health streams have, by enlarge, been ignored. Secondly, the fact that research has been conducted predominantly in North America within psychiatric settings with high-risk patients, has meant that information relating to the suicide of patients being treated in the wider population has remained largely undocumented (Valente & Saunders 2002).

Thirdly, whilst studies to date have increased our understanding of the ways in which the suicidal death of a client suicide can impact upon the therapist, to my knowledge, no research has been undertaken which specifically focussed upon how therapists’ stories in relation to this experience become disenfranchised. Whilst a recent publication entitled ‘What Therapists Don’t Talk About and Why: Understanding Taboos That Hurt Us and Our Clients’ by Pope, Sonne and Greene (2006) attempts to rectify the current dearth of information about the plight of therapists struggling with ‘taboo’ subjects (such as sexual feelings towards clients, problems with fees, feeling

bored/angry/incompetent), apart from a brief, hypothetical exercise in ‘Passages and Scenarios for Exploration’ (p. 140 – 141) and some discussion within the Appendix relating to client suicide, no reference is made to the disenfranchisement therapists may experience in relation to it. The fact that this type of disenfranchisement, (or indeed *any* research that directly focuses upon the experience of disenfranchised grief) remains disenfranchised in the literature (Doka 1995) accentuates the urgent need for this under-examined phenomenon to be explored in much greater detail.

Finally, the fact that the primary method of data collection used in the studies reviewed above has been by survey, has meant that therapists’ stories have been shaped, edited and potentially disenfranchised by the researcher’s preconceived notions about what needed exploration rather than by the respondent themselves. Trimble, Jackson and Harvey’s (2000:229) survey of Australian psychologists, which consisted of ‘twenty statements of the kind *one might expect psychologists to make* about the impact of client suicidal behaviour on them [emphasis added]’ vividly highlights this shortcoming as does Knox et al’s (2006:549) comment that ‘responding to items using a Likert scale may not capture the essence of the therapist’s full experience of client suicide.’

In light of the above, in the following chapter the impetus for and methods used to undertake the current study into therapists’ experiences of disenfranchisement in relation to client suicide are presented. As will soon become apparent, this research takes up McAdams and Fosters’ (2000) suggestion that qualitative methodologies, which provide respondents the opportunity to elaborate upon their uniquely personal stories, provide the way forward.

Chapter 4

Research Methodology

'We live in stories, not statistics.'

(Gilbert 2002:223)

This chapter describes the theoretical orientation of narrative inquiry, the qualitative approach used to inform this research. The subsequent discussion provides details of the research design implemented, including sampling techniques, the interview process, and data collection procedures. Since qualitative research acknowledges and celebrates the integral and influential characteristics that both participant *and* researcher bring to the enquiry, it would have been remiss to focus solely upon the research methods employed without consideration of the unique impact that the personhood of the researcher has upon the study's focus, shape, and outcome. The chapter begins, therefore, by introducing the researcher, from both a personal and professional perspective, in the hope that it might make me more 'visible' to the reader.

Making Visible the Personhood of the Researcher - Personal and Professional Underpinnings of this Study

Whilst the impetus for this study did not come from having been exposed to suicide within my immediate or extended family, or within the counselling context in which I practice, I *have* known individuals who have died this way or been involved with the family members of these individuals. In every instance, I have been both deeply saddened by the individual's decision to end their life and simultaneously relieved that the angst that led them to make this choice has now ceased. I have also been repeatedly struck by the agony endured by the family members left behind in the

wake of the suicide. The shock, horror, numbness, disbelief, powerlessness and constant need to search for some clue or answer to help them make sense or meaning out of the death is often palpable and connects me with my own feelings of helplessness in relation to the loss. I, too, have observed the difficulty that many of these family members have in firstly accepting that the death has been by suicide and secondly, in sharing their stories about this loss with others.

In my roles as a psychologist and educator in a counsellor training programme in a large, rural city, I have been exposed to, taught about, provided supervision for, and undertaken post-graduate studies in the field of loss, grief and mourning – roles which have continued to stimulate my interest in this area from both a practice-based and theoretically-based standpoint.

My weekly private practice caseload is likely to include several clients who are either struggling with strong suicidal ideations or are at a high risk of attempting suicide. I can recall several instances in which I have had to drive clients directly from my counselling room to either their general practitioner or to the hospital in an effort to keep them safe. Phone calls from distressed family members concerned about their relative's wellbeing and urgent messages left by clients on my answering machine or voicemail to "please ring them as soon as I get this message" are also part of my professional life. These experiences, together with post-session de-briefs with colleagues about what I have done, or sometimes failed to do in relation to a client's disclosure about their suicidality, cannot help but quicken my heart rate and increase my level of anxiety. I was all too aware therefore, as I listened to my participants' stories unfold that "there but for the grace of God go I".

Looking Through the Lens of a Narrative Approach to Research

‘Narrative is fundamental to our understanding of the world...How one grasps and makes sense of oneself as a person existing over time, assigning purpose and meaning to one’s affairs, occurs through story forms.’

(Norton 1998:7)

The Narrative Research Approach

This study is designed to explore the stories that therapists tell in relation to their clients’ suicides and the ways in which these stories might become disenfranchised. To realise this goal, a research approach was sought that would permit participants to construct and reconstruct their experiences, and the meanings they attached to these, in as rich and as deeply layered a way as possible (Denzin 1989). In doing so it was hoped that a process would be facilitated whereby these ‘personal experience stories’ could become integrated into a ‘self story’ and ‘life history’ (Grbich 2004).

Narrative inquiry, borne out of a social constructionist viewpoint (Becvar & Becvar 2003), offered such an approach, since its aim is to understand the complexity of the events, behaviours and objects of an individual’s real world experiences and the meanings they attach to these (Haynes 2006; Neimeyer & Anderson 2002; Riessman 2006a; Tuval-Mashiach et al 2004; Schwandt 2000; White & Hede 2008).

Kirkman (2002:3) argues that despite the ongoing debate about what precisely defines narrative inquiry, four characteristics typical of the approach can still be inferred.

These are:

- a) The value placed upon the individual person.
- b) The significance of the subjective dimension and its meanings.
- c) The influence of context to meaning.

d) The co-construction of personal accounts.

Those who support narrative inquiry contend that it is through an active process of verbal and non-verbal engagement with others, and their environment, that individuals come to make sense of their world (Andrews, Sullivan & Minichiello 2004), 'creating order in disorder and establishing meaning in what can sometimes seem a meaningless situation' (Gilbert 2002:224).

The social constructionist concept of the relational person rather than the more traditionally accepted autonomous self (McLeod 1997:91) within a narrative framework, means that the emphasis within narrative inquiry is placed upon the impact of the social and cultural contexts in which the individual exists. Essentially, narratives of the self are not seen as being 'fundamental possessions' of the individual; rather they are viewed as being 'products of social interchange' (Gergen & Gergen 1988:18). In fact, since an essential characteristic of narrative is that it is a 'highly sensitive guide to the variable and fleeting nature of human reality' (Harre 1997:278), narratives are viewed as 'both models of thresholds and models of self...stories [through which] we construct ourselves as part of the world' (Harre 1997:279). Recounting one's life through storying therefore becomes a reflexive, interpretive act (Haynes 2006).

Bruner (1987) observes that the 'instability' of an individual's stories, due to their susceptibility to interpersonal, cultural and linguistic influences, often creates challenges for both storyteller and listener as they struggle to share some 'deep structure' in which these individual stories 'mesh within a community of life stories' (p, 21). Narrative inquiry necessitates, therefore, that the researcher's role becomes one of gatherer, collaborator and interpreter since it is through this process that the

purpose and meanings of an individuals' language and actions can be uncovered (Grbich 2004; Schwandt 2000).

In light of the above, the selection of a narrative approach felt critical for a number of reasons. Firstly, as alluded to at the beginning of this chapter, since the study's aim was to explore therapists' experiences of disenfranchisement, it was vital that a research approach be adopted that did not run the risk of *re*-disenfranchising participants because of its theoretical framework and/or design. Narrative inquiry, with its invitation for participants to explore and share their experiences in a deep, unedited way, appeared to be the best means of minimising this risk (Betz & Thorngren 2006; Neimeyer & Anderson 2002; Silverstein et al 2006) since its inclusionary approach is particularly suited 'when dealing with the disadvantaged or the unheard voice' (Jones 2004:97).

Secondly, as I suspected that at least some of the study's participants may not have had an opportunity to share their story in relation to their client's suicide (or had only been able to do so within a pre-determined framework, for example, a clinical autopsy within their workplace), I anticipated that I may need to approach my interviews in a similar way to those conducted with clients attending their initial session; that is, through the creation of a very open, non-threatening, non-directive conversation in which their stories could unfold and be co-constructed at a pace and depth chosen by them. By following such an approach, it was hoped that a recursive process would occur whereby my questions would arise out of the participant's emerging story, rather than through any pre-conceived agenda or imposed template, and in doing so, allow 'the prose of the world to speak for itself' (Denzin 1994:511). According to Burgess-Limerick and Burgess-Limerick (1998) it is because conversational

approaches to interviewing provide a powerful means of accessing participants' interpretation of their personal experiences, that researchers are provided with 'unique agendas' (p. 64) upon which their research can be based. The idiographic approach offered by narrative inquiry again provided the ideal vehicle through which these conversational interviews could occur (Archer 2001; Wharton 2006).

Furthermore, since the purpose of this study was to explore the ways in which therapists' professional and personal stories about client suicide might become disenfranchised, it was imperative that the linguistic, contextual and temporal richness and thickness of these stories be preserved by the research approach taken. According to Denzin (1989:83) for 'thick' descriptions to occur, they must capture the lived experience being given voice to by the participant in such a way that 'detail, context, emotion, and the webs of social relationship that joins persons to one another' are highlighted. As the cornerstone belief of a narrative methodological approach is that human beings create order and meaning in their lives through the stories they tell about their lived experiences, this approach was used in the hope that its capacity to capture participants' language, feelings and behaviours would not only illuminate facets of the therapists' stories that other methodologies might miss but also bring a degree of order and meaning to what, until now, has been a little understood aspect of the profession.

In addition, since the re-ordering of dis-ordered stories is particularly relevant to the study of grief (Neimeyer 2002; Neimeyer & Levitt 2001), where 'the drive to story is particularly strong' (Gilbert 2002:236), the use of narrative inquiry was therefore perfectly suited to the focus of the current study (Murphy 1998; Neimeyer 2006). As Gilbert (2002) highlights, through narrative studies, not only does the depth and

richness of the story elicited further our understanding of the personal experience of loss and grief but it also provides us with greater awareness of the themes that transcend these individual stories. Finally, because narrative accounts challenge traditional, positivist knowledge, the use of narrative inquiry meant that therapists' stories could be elicited, collected and understood in ways that did not compromise their uniqueness, diversity and complexity (Neimeyer 2001c).

The Participants

Since the aim of this research was to explore therapists' experiences of disenfranchisement in relation to client suicide, the parameters of the population under study were necessarily specific and restrictive. Because of this, a mixed purposeful sampling strategy (Llewellyn, Sullivan & Minichiello 2004; Oliver 2006a), with its emphasis on gathering information-rich, illuminative cases for in-depth study (Boyle et al 2004) was employed, with only therapists who had had a client suicide whilst under their therapeutic care being eligible for inclusion.

Since a review of the literature in relationship to client suicide had revealed that, historically, much of the empirical and theoretical focus has been in relation to psychiatrists and psychologists working with patients who had committed suicide within hospital settings, it felt important that the current study cast a wider net when recruiting participants, in order to capture a richer and more broadly-based tapestry of stories than those currently in existence. For the purpose of this study, the term 'therapist' is therefore used to refer to psychologists, counsellors, psychotherapists, school counsellors and psychiatric nurses working within private, community or government-based settings, in rural, coastal and urban contexts.

Recruiting Participants – A Multi-faceted Approach

Initially I had envisaged that participants would be sourced in a relatively straightforward manner through a single mail-out. However, both the ways in which respondents came to hear about the study, and the fact that an initial mail-out yielded a very low response rate of individuals who met the study's criteria, meant that a more flexible approach to recruitment was required.

Self-initiated Contact

The first three participants in the study approached me, without prior invitation, after hearing me speak about my research project at a conference. Whilst the third of these participants was someone I had had an affiliation with approximately three years earlier, I had not had contact with her since that time. I therefore had no current knowledge in relation to her personal or professional life.

Since my window of opportunity for interviewing these three individuals was limited by their availability during the five-day conference we were attending, their interviews were scheduled one day apart. Whilst not ideal, it was hoped that by adopting this day-on, day-off timeframe, the risk of one respondent's interview contaminating the way in which I was able to listen and respond to a subsequent respondent's story would be reduced. It was also hoped that such a timeframe would permit sufficient time and space between interviews to be able to engage in some preliminary reflections about, and journaling in relation to, the individual I had just spoken with. It was during this rather intense interviewing regime that I appreciated my prior counsellor training as it permitted me to compartmentalise each of the respondent's stories in order to be fully present for the next one.

As each of these respondents had said that they would tell their work colleagues about my research, I had hoped that some snowballing (Boyle et al 2004; Llewellyn, Sullivan & Minichiello 2004; Oliver 2006b) might occur once the conference had finished and they had returned to their workplaces. Unfortunately, this did not arise. Whether this was due to a lack of eligible participants being sourced, or a failure to pass on the details of my study, is not known.

The fourth participant to approach me without prior solicitation did so after learning about my research from a mutual acquaintance. As a fellow psychologist in the region in which I reside and practice, this respondent was someone I had had previous intermittent contact with for over ten years.

Mail-out Invitations

Upon completion of my interviews with these four participants, further potential participants were sought by way of a mail-out, targeting all individuals advertising in the Yellow Pages Telephone Directory for the New England and North West regions of New South Wales under the categories of 'Counselling - Marriage, Family & Personal' and 'Psychologists'. In total, forty-one letters of introduction containing detailed information about the research being undertaken (see Appendix A) were sent out to individuals identified in this manner, with a further two letters being posted (on the recommendation of my primary supervisor) to psychologists residing on the North Coast of NSW.

Within two weeks of this mail-out, thirteen responses had been received from individuals stating that they were not eligible to participate as they did not meet the study's criteria; two letters had been returned, stamped 'Return to Sender'; one

individual had written to advise me that whilst she was eligible to participate she had chosen not to do so:

Thank you for your invite to participate in your research project. I've given it considerable thought and have decided not to be involved. I certainly send you heaps of encouragement as you tackle quite a mighty task

and two individuals had accepted my invitation to participate. Once interview appointments had been negotiated with these two eligible respondents, each was sent a Demographic Profile form (see Appendix B) which they were asked to complete and return to me in the stamp-addressed envelope provided prior to their interviews.

Five other individuals also made initial contact with me to see whether or not they would be eligible for inclusion in the study. Whilst four of these individuals had worked with highly suicidal people, none had actually experienced the suicidal death of a client. One had, however, found herself in the *midst* of a client's suicide attempt, having rung this person shortly after they had failed to turn up for a scheduled appointment only to be told that they'd been unable to come to their session because they were currently in the process of gassing themselves in their car. Whilst empathising with each of these respondents and thanking them for their interest, I explained that I would not be able to include them in the research as they fell outside the study's criteria. I did suggest, however, that if they were interested in the study's outcomes that they keep in contact with me.

The fifth individual to make initial contact with me had had a client suicide whilst attending a group therapy programme she was co-facilitating. After discussions with my supervisor, and in the vein of what Edwards (2006) refers to as extreme (or deviant) case sampling, it was decided that this therapist be included in the study as

she could potentially provide valuable information about experiences of disenfranchisement in therapeutic relationships that did not reflect the traditional counsellor-client dyad.

A month after the initial mail-out date, a follow-up letter (see Appendix C) was sent to the remaining twenty-one non-respondents reminding them about the research and inviting them to contact me if they would still like to participate. Of these, sixteen subsequently notified me of their lack of eligibility to participate because they did not meet the criteria. The remaining five failed to respond.

Interestingly, the majority of responses received from those who did not meet the study's criteria highlighted their sense of relief at not having experienced the death of a client by suicide and/or their recognition of the enormity of this event for therapists who had. For example:

I have been fortunate, to date, and not had a client of mine suicide. I hope that will remain the case but with the amount of people who do suicide I know that may not be the case (email from a counsellor in private practice in a rural NSW town).

I'm not eligible thank God! Touch wood it stays that way! (voicemail from a psychologist in a government funded service in a rural NSW city).

Fortunately I have not counselled a client who has committed suicide, although many have talked about giving that option serious consideration (email from a counsellor in a church-based counselling service in a rural NSW city).

Fortunately I haven't had a client suicide. I hope I never do (email from a psychotherapist in private practice in a rural NSW city).

Snowballing

Throughout the study's data collection phase, the contact details of a further six potential participants were provided to the researcher by either past participants or academic and professional colleagues who had heard of my research and had raised it as a topic for discussion at conferences, seminars and training days that they had been attending. According to Silverstein et al (2006:352), the use of snowball sampling is 'especially well suited to studying marginalised groups about whom little is known [since] these subcultures reflect elaborate social networks that researchers cannot enter at random.' Thus, through the snowballing process, a further three therapists were recruited for the study.

Concluding the Recruitment Process

Participants were recruited until theoretical saturation of data occurred. In this study, saturation was achieved with ten participants since, at this point, no new data was emerging from the interviews. The following table presents the demographic profiles of these individuals. Richer autobiographical details are presented subsequently as part of the data analysis.

Table 1: Demographic Details of Participants

Therapist's Pseudonym	Age group	Professional Title	Practice Type	Practice Locale	Years In Practice	Year Client/s Suicided
Jude	48-52	Counsellor	Non-Government Organisation	Urban	16+	2001
Elspeth	63+	Counsellor	Government Organization	Coastal	0 – 5	2002
Holly	43-47	Psychotherapist	Independent Private Practice	Urban	16+	1998 and 2000
Murray	57–61	Psychologist	Independent Private Practice	Rural	16+	2006
Catherine	42-46	Psychologist	Government Organisation	Rural	0-5	2004
Aiden	37-41	School Counsellor	School	Rural	6 – 10	1998
Susan	47-51	Psychologist	Independent Private Practice	Urban	16+	1994 and 2005
Dirk	42-46	Counsellor	Independent Private Practice	Urban	6 – 10	2002 (x2) clients
Faith	52-56	Counsellor	Independent Private Practice	Urban	11-15	2003
Matt	62+	Mental Health Counsellor	Psychiatric Hospital	Urban	16+	1970

Data Collection

To maximise the opportunity for the fullest picture possible, in-depth, unstructured, open-ended interviews of between one-and-a-quarter and one-and-a-half hours duration were undertaken. Whilst, in most cases, only one interview was conducted with each participant, there were instances where follow-up interviews were required. These were used to gain further information or clarification of the details obtained in the initial conversation (Chiovitti & Piran 2003). By adopting an in-depth, unstructured, open-ended approach to data collection, not only was it hoped that the richness and thickness of both the positive and negative aspects of participants' experiences would be captured but also that a sense of ownership and authentic participation in the research process would be fostered (Dower 2003).

These interviews were audio taped so that future transcription and analysis could be undertaken. Immediately after each interview, field notes were also taken to record reconstructions of the interaction that had just occurred; highlight any key conversational excerpts, phrases or metaphors that had stood out during the interview (as these were considered central to an understanding of the therapist's experience); describe any noteworthy non-verbal behaviours; and depict the physical environment. It was hoped that by recording what was heard, seen, experienced and thought, not only would any idiosyncratic and/or unique individual differences displayed by the participants be captured and preserved, thereby reducing the risk of this data being lost during the analysis process, but that any of the researcher's subjective biases and unsubstantiated hunches could be scrutinised at a later time. Furthermore, if data analysis was to be a creative and solid process in which conjecture and verification, modification and adjustment, and suggestion and defense could occur (Morse & Field

1998), it was imperative that astute observation, accurate recording and active recall take place during the data collection phase.

Researcher as Participant

According to Denzin (1989:49), since researchers ‘work outwards from their own biographies’ it is vital that they are as aware as possible of any personal biases in relation to the research area and declare these, together with any ‘insider accounts’ (Cassell & Symon 2006) which parallel those under investigation. Prior to interviewing participants, and in an effort to increase the study’s validity, I therefore assumed the role of participant and engaged in an in-depth, unstructured, hour-long interview, conducted by an experienced researcher and counsellor, to examine my own beliefs and experiences in relation to the research topic. This interview was later transcribed and copies of it, together with the personal reflections that had arisen from my journaling after this interview, provided to both the interviewer and my primary supervisor for comment. The following focal points that emerged from my interview are presented below. Italics are used to indicate direct quotes from my interview.

Firstly, that the experiences of disenfranchisement that have arisen from my duality of roles (professional and personal) have often led to what I can only describe as a *head versus heart dichotomy* in which my personal responses and voice become silenced by the need to remain in my professional role. At these times, when it feels as if I have been compartmentalised by others into my professional role, I have been acutely aware of my need to seek out ways in which my personal experiences can be legitimised and heard, and have often wondered if other therapists have similar experiences and needs:

It's a sense of being, I guess, marginalised in a way that kinda puts me outside the experience of others. You know, puts me in the kind of the position of being the 'expert' I suppose, which makes it almost a cognitive experience...You switch into 'professional mode' and 'do what professionals do'...So the 'expert' role becomes a sabotaging one in relation to the personal voice, it creates disenfranchisement rather than reducing it...There's such a struggle around the duality of experience and the duality of roles...But does the professional part necessarily or automatically have to exclude the personal part? How might they co-exist and what hinders this?

Secondly, my belief that the role of therapist, in and of itself, increases the risk of depersonalisation and disenfranchisement within both professional and personal contexts, as it creates expectations in others (and perhaps within the therapist themselves) of an innate ability to cope:

I think it's [therapists' experiences of client suicide] disenfranchised by networks, um, organisational networks, communal networks, friendship networks and family networks where, I, my sense is that our professional role disenfranchises us. In that, well, you're the professional, it should be 'water off a duck's back' kinda thing... You're the professional, you're there to support everyone else 'cause you know what to do which for me has the implicit message of "You wouldn't need support yourself"...In conversations I've had with various people, basically all their organizations were interested in was, "Did you cross the "T's" and dot the "I's" and follow procedure?" And if you've done that, then well, that's all you needed to do. And it's that, "Well, just get on with it."..... So the experience of having to be a professional in the

context of a very personal mourning experience, I think, automatically disenfranchises the personal experience. And what impact does that have on the therapist's capacity or permission to move into a personally felt response post-suicide? Where do therapists take their personal experiences of loss? Where's their grief given voice and support?...So maybe part of the attraction, or the draw to interviewing therapists, is that it's about giving them an opportunity to unshackle from their professional masks and roles too. That I can actually provide the listening ear to them in a way that they kinda haven't had...so that it might give them a voice in a way, it might give them a different voice to the voice they were allowed to have, even if they were allowed to have a voice at the actual time.

Thirdly, my desire to explore the interplay between where the responsibility for the suicide is located and the experience of disenfranchisement:

Is the sense of responsibility [for the suicide] located within the client, within the therapist or... what's the interplay between that? So, if you've got a client who's suicided, how is that interpreted or understood by the people you work with?... I think that disenfranchisement actually starts in the training programmes for therapists. All the focus is on, well, this is what you do if you've got a suicidal client to keep them safe. It's like there's this implicit message in training programmes that somehow you're a 'failure' if you don't...It's as if there's a collusion in the profession to silence the experience... [Perhaps] this leads to greater silencing and taboo-ness?

Fourthly, my curiosity about how, in instances of disenfranchisement, therapists react to, process, come to understand and have their experience of client suicide legitimised:

I'm just fascinated about how therapists' conceptualise the reactions that they have, how they understand them. How they describe and label them and what factors influence this. How external factors like the organizations they're in, perhaps work colleagues, friends as well, how that might impede or enhance it [their professional and personal reactions to the suicide]..... And then there's the therapist's life history too, of the 'acceptability' of grief and mourning. You know? That it might not be okay in their family of origin, so that might become personally-driven disenfranchisement... And what they do with that. Where do they seek, you know, supervision or support, and what's helpful or not?

Finally, and perhaps most significantly from a purely personal perspective, my realisation that by providing an opportunity for the stories of other therapists to be heard and honoured, I was also honouring the parts of myself that have been disenfranchised in the past:

I think there's a really strong voyeuristic aspect to it [undertaking this study] as well because I haven't actually had that experience [of having had a client suicide]...Voyeuristic in terms of me wanting to understand [but also] it really is about recognising, that recognising of the unmet need for me as a professional of having an arena for personal expression and voice...and reclaiming, not reclaiming, it's probably about recognising that gap for me as a professional and wanting to provide, to fill the gap I guess, for other

professionals...but in honouring the untold stories of others, I'm honouring my own untold stories as well.

Engaging in this researcher-as-participant process provided me with a degree of reassurance about my capacity to listen in a less contaminated way to the stories that the study's participants would tell me in relation to their experiences of client suicide and disenfranchisement. Furthermore, having had the opportunity to reconnect with my own experiences of disenfranchisement, I felt confident that I could identify with the culture milieu under investigation and, in doing so, minimise the risk of acting inappropriately or misconstruing the language, actions or intentions of the participants being interviewed (Haynes 2006).

Having said this, it would be naïve to assume that an absolute degree of neutrality was attained throughout the research process. Like Peshkin (2000:9) I am aware that I can only 'conclude my work with the best construction I can create, trusting that I have steered clear of such self-deception, and self-delusion that would undermine my commitment to the reason, logic, coherence and the like that I strive for.' Further comments in relation to the possible influence of my personhood on the research findings are contained in the latter part of the following chapter where potential criticisms of the methodological approach adopted in this study are also discussed.

Conducting the Interview

Morse (1994:228) argues that 'good' research participants must not only have 'the knowledge and experience the researcher requires' but also 'the ability to reflect, be articulate, have the time to be interviewed, and be willing to participate in the study.' Given the potentially sensitive nature of the area under investigation and the fact that 'the nature and evolution of the relationship between storyteller and listener affects

the material generated' (Cottle 2000:227), it was recognised that good participant attributes could only be fostered if, during the interview, I treaded softly and ensured that the process was a highly inclusive and collaborative one.

Since in-depth research interviews have a strong resemblance to counselling interviews (Haynes 2006) each of my interviews began, as is the case in initial counselling sessions, with a joining process that centred on everyday chit-chat about the therapist's day to date or any difficulties that they had encountered in relation to getting to our appointment. Interviews that were conducted in my counselling room also generally included small talk about the shelves of symbols that surround its walls (and which are used in sandtray therapy with my clients) and the therapist's own experiences of using this approach. When interviews were held in the therapist's home or office, I often commented positively about the décor or the view from their window, or asked them about a photograph, object or piece of artwork that I had noticed as I had entered the premises. In one instance, small talk about a participant's cappuccino machine unintentionally lead into a very powerful pre-interview conversation about the direct link between this object and the client he was about to discuss (see Appendix H for the full extract of this conversation with Aiden). As part of this rapport-building process, the confidential nature of the study was also emphasised since participants are likely to be more trusting, and therefore more disclosing, when they believe that the content of their story is being collected by ethical researchers who will honour the anonymity of the interview (Israel 2006).

Once the small talk had been completed, questions about the research project answered, and offers of tea or coffee made, the research consent form (see Appendix D) was signed and dated and the tape recorder set up and tested for audibility prior to

the commencement of the formal interview. If the therapist had failed to return their demographic information sheet prior to the interview, this was also collected at this time. After a final check with the therapist to see that they were feeling comfortable and ready to proceed, the tape recorder was switched on and the interview process begun.

To ensure that every participant was orientated in a similar manner to the research's focus, all interviews commenced with the following open, invitational statement:

As you know, I'm really interested in hearing about your experience of having had a client suicide. Because it matters to me that you tell me whatever you want to in relation to this, I have no preconceived set of questions to ask you, so just start wherever you'd like.

The intentionally generalist nature of this opening statement was designed in accordance with the study's aim. Since I was interested in discovering therapists' dominant discourse in relation to client suicide, I did not want to influence this discourse by alerting them to the fact that I was particularly interested in their experience of disenfranchisement. The word 'discourse' is used here to describe 'patterns in the ways that phenomena are portrayed via words in talk' (Lupton 2004:484). Thus, a discourse comprises words, language norms, roles, rules and practices which influence the ways in which participants think, feel, behave and converse with others.

It was also feared that by using a more specific, disenfranchisement-focused question, I might run the risk of artificially skewing the entry point, focus and course of the therapists' natural storylines. Therefore, whilst I was interested in *what* they were telling me, I was also keen to discover *how* they were telling me.

Furthermore, by using non-threatening questions at the outset, it was hoped that not only would participants be put at ease but that a greater sense of control for participants with regard to the focus and flow of information would be created. In keeping with this non-threatening, non-directional approach, if, during any stage of the interview a therapist asked, "*What else would you like to hear?*" my standard response was always "*Whatever you'd like to tell me.*"

Consistent with other writers (see Jones 2002) I found that the therapists provided me with cues about when the interview was coming to its natural conclusion. Comments such as "*Well, I think that's about it*" were commonly elicited, at which point I would ask, "*Is there anything else you would like to tell me before we finish?*" using what Minichiello et al (2000) refer to as a 'clearing house' question.

Depending upon what had been shared during the interview, and if deemed appropriate, self-disclosure was also used to help personalise the end of the research relationship. At times, self-disclosure was also used during the interview itself (Coffey 2006; Haynes 2006) in an effort to minimise the occurrence of a question-answer dyad since asymmetrical relationships such as these can result in 'the power of social science determining the information given' (Denzin 1989:43).

Having made the final check to see if there was anything else the therapist wished to tell me, and after sharing my own experiences if appropriate, I then inquired about how they were feeling post-interview. Given the topic area and the depth of disclosure engaged in, I was aware of having both a professional and ethical obligation to ensure that each respondent felt sufficiently integrated to be able to leave the interview room. This line of inquiry was also intended to gauge whether or not follow-up supervision and/or counselling should be suggested, particularly in instances where I felt that the

therapist had been deeply impacted by the interview process. The need to make this suggestion, however, did not arise.

Details were also provided at this time about the subsequent contact I would be making with them, that is, sending them a verbatim copy of the transcript of their interview for comment and clarification, and of the potential need for them to engage in a follow-up interview should further clarification of issues or additional information be required. Any final questions in relation to the research project were then answered, a timeline for the study's completion provided, and the therapist encouraged to contact me at any stage in the future regarding the study's progress if they desired to do so. Once the therapist had left the room, I noted any matters requiring further follow-up and recorded both descriptive details of the interview (for example, the therapist's non-verbal behaviours) and my personal reflections about the interview and the overall research process in my fieldwork journal (Haynes 2006; Silverstein et al 2006; Van Dongen 1990, 1993).

Summary

This chapter has focussed upon the theoretical orientation of narrative inquiry, the qualitative approach used to inform and guide this research; details of the research design implemented, including sampling, the interview process and data collection; and an introduction to the researcher, from both a personal and professional perspective. In the following chapter, a detailed account of the data analysis undertaken, using a combination of narrative-type narrative enquiry (Polkinghorne 1995; White & Hede 2008), component story analysis (Nuttgen 1997) and paradigmatic-type narrative enquiry (Polkinghorne 1995; White & Hede 2008) is provided. The chapter concludes with a discussion of the ethical issues considered in

relation to this study, the potential pitfalls of adopting the approach taken and the ways in which these were addressed.

Chapter 5

Data Analysis Using Narrative Inquiry

*'In the end, the story is all that we are or, perhaps,
all that we leave behind as memory.'*

(Maguire 1998 quoted in Cottle 2000:228)

If, as Denzin (2001:23 cited in Jones 2002:1) claims, it is now a 'fait accompli' that narrative is used in the social sciences, it is hardly surprising that narrative analysis has become so broadly-based that it offers no definitive approach or methodology. In fact, a review of the literature reveals a plethora of narrative approaches to both methodology and analysis (see Bingley et al 2008; Cottle 2000; Jones, 2002; Kirkman 2002; Oplatka 2001; Palakshappa & Gordon 2006). Whilst recognising and appreciating the value of each of these approaches, it was not until I read Nuttgens' (1997) research into the experiences of individual's bereaved by the suicide of a loved one that I felt, as will be subsequently discussed, I had found the optimal means by which to analyse my participants' stories.

The upsurge in interest in the use of narrative inquiry within the qualitative research field is, Lawler (2000) believes, due to the fact that narrative provides us with a way of both knowing and understanding the world (an epistemological dimension) and a means of structuring this knowledge (an ontological dimension). Within the context of narrative inquiry, the term narrative, which is often used interchangeably with the word story, refers to 'discourses with a clear sequential order that connect events in a meaningful way' (Elliot 2005:26). Emplotment, the activity and operation of a narrative (Neimeyer & Stewart 1996) organises events and experiences so that they unfold in a coherent, though ever-evolving storyline with a beginning, middle and end

(Riessman 2006b). Freeman (1984:7-9) proposes that, through narrative, individuals are able to 'order the landscape of events', adding that 'the fact that particular forms of knowledge derive from retrospection, from an essentially backward look over the terrain of experience, is an irreducible peculiarity of the human being.'

Put simply, narrative inquiry seeks to both discover and uncover the plots within an individual's story which unify it and which create temporal movement and meaning for the storyteller. The use of story as a method of interpreting the textual data means that the complexity of the participants' experiences, including the nuances of their temporal sequences, serendipitous happenings and interpersonal and cultural contexts can be captured and preserved (White & Hede 2008). Within the current research, the focus of the inquiry was to discover and uncover both the different plotlines within each of the therapist's stories about their experience of having had a client suicide and the ways in which these plotlines were connected to create a unified and meaningful story.

Whilst a number of specific narrative analytical methods have been developed which employ differing degrees of content, form and structural analysis (Lieblich, Tuval-Mashiach & Zilber 1998), the aim of this study was to give voice to the disenfranchised stories of therapists. This meant that it was critical that these stories be presented in as intact and as whole a way as possible. Narrative-type narrative inquiry (Polkinghorne 1995; White & Hede 2008), together with Nuttgens' (1997) component story analysis, were therefore selected since they permit the collection of in-depth, explanatory, emplotted stories about the thoughts, feelings and actions embedded within participant's individual narratives (White & Hede 2008).

Having originally rejected the use of thematic narrative analysis (White & Hede 2008) for fear that it may disenfranchise participants' stories even further through its thematic-categorisation process, it became increasingly apparent during the first two phases of data analysis that not only were themes and storylines emerging *within* these individual narratives but also *across* the stories being told. Given that the strength of thematic or paradigmatic procedures is their capacity to provide a more general understanding about the topic under investigation, by constructing meta-stories that 'transcend and yet bind together individual stories' (Gilbert 2002:228), a paradigmatic-type narrative inquiry (Polkinghorne 1995; White & Hede 2008) was therefore undertaken in the final phase of data analysis. My synthesised analytical approach, based upon Polkinghorne's (1995) and Nuttgens' (1997) frameworks is described in greater detail below.

Engaging in the Analytic Process

In embarking upon the following discussion regarding the use of both Polkinghorne's (1995) and Nuttgens' (1997) approaches within my research, I am mindful of other researcher's observations (see Doucet & Mauthner 2003; Kirkman 2002) that qualitative analysis is, unarguably, a complex and messy business. Because of this, and since the 'detailed and concrete processes of data analysis' continue to receive perhaps the least attention within the research process (Doucet & Mauthner 2003:1), I have attempted to be as transparent as possible with regard to the steps undertaken in relation to the different phases of analysis used in this study.

Phase One: Transcribing the Interviews

Whilst some researchers, for reasons of expediency, espouse the virtues of having a research assistant or other third party transcribe the interviews on their behalf, I did

not find this option appealing. Having felt so intimately involved in the initial construction of the therapist's story, the thought of handing it over to someone else to convert to text felt somehow disrespectful. I chose, therefore, after each interview, to personally transcribe the audiotape verbatim. This process, whilst long and arduous at times, was invaluable as it provided me with the opportunity to re-immense myself in the story and, in doing so, exposed me to 'the actual experiences in the interviews (voices, tones, notions etc) and at the same time, to the evolving written documents whose figures and signs create additional meaning to the oral words and sentences' (Oplatka 2001:7).

Following the audiotape's transcription, I read and re-read the entire transcript a number of times so that I could become familiar with, and get a taste for, not only the overarching story and the narratives within it but also the areas that the therapist tended to overlook (Luborsky 1994). During these readings, I used my computer to bold print aspects of the story that 'jumped off the page' for me. Often these were key words, metaphors or phrases around which a narrative was built. Notes were also made alongside the text in a separate column. These notes were used to highlight the themes that were emerging within the story; reflect upon any personal reactions I was having; record questions that had been raised for me which I wanted to follow-up with the therapist; and underscore any links between the experiences the therapist was describing and the literature I had read.

Once I felt confident that I had faithfully transcribed the interview and highlighted the most salient aspects of the story, I emailed it back to the therapist for feedback and comment. Whilst the introduction to each email sent was personalised to reflect the uniqueness of the relationship I had already established with the recipient (for

example, the introduction to Elspeth's email reflected my hope that she had gotten home safely after the conference), a standardised request for their further participation followed and read:

Here's a copy of the transcript as promised. I would be really grateful if you could:

Read through the transcript and check to see that I've recorded the conversation accurately. If you have any queries about it, just type them in the adjoining column and I'll double-check the audiotape. (You're also most welcome to have a copy of it if you like).

The bits of the transcript I've 'bolded' are parts of the conversation which stood out for me as feeling significant. If there are other elements of the transcript which felt important for you and have been missed by me, can you underline them?

Having read the transcript, I'd like to invite you to do two things (only if you'd like to though). Firstly, give it a title (as if it were being submitted to become a screenplay or a book) and provide a bit of a 'rationale' about why this title 'fits' for you, and secondly, having read the transcript, write down some of your reflections (this can be as short or as long as you like).

I'd be really grateful if you could email this all back to me when you are finished. Once again, thank you for taking part.

In relation to Part A of my email, only one participant sent back comments about the way in which I had constructed the transcript of their interview and these comments were related to grammatical errors within the text. Of the ten participants who took

part in this research, five chose to respond to Part B of my email. These responses are contained within their component stories.

Phase Two: Giving Voice to the Participants' Individual Stories

Whilst my initial intent was to faithfully follow Polkinghorne's (1995:18) guidelines for undertaking a narrative-type narrative inquiry which are to 'firstly arrange the data elements chronologically; secondly, identify which elements are contributors to the outcome; thirdly, look for connections of cause and influence amongst the events; and finally, write the story', I quickly became overwhelmed by the sheer volume of text and storylines I was attempting to analyse. It was Nuttgens (1997) who offered me the means of synthesizing the data into a narrative structure that would advance an understanding of the participant's experience. After consultation with an academic versed in narrative research, Nuttgens recognised that his participants were not just telling him a single story (about their experience of having had a loved one commit suicide), but rather a collection of component stories (that is, their story about the deceased, their story about their relationship with the deceased, and their story about self).

When I applied this framework to my participants' stories, it made immediate sense, for whilst their overarching stories may have related to their experiences of having had a client suicide, these stories also contained a number of very distinct component stories which warranted their own space and attention. These were: the participant's story of self, the participant's story of their client, the participant's story of their therapeutic relationship with their client and the participant's story of their experience of their client's suicide. A four-part component story framework was therefore adopted for the purpose of data analysis.

The process I used to tease out the four component stories began with several readings of a computer printout of the raw transcription data. During these readings, and with the four distinct component stories in mind, I began to highlight, using different coloured marker pens, the portions of the conversation that belonged to each component. Once this step had been completed, I cut and pasted on the computer every aspect of the conversation that belonged to the respective stories. These component stories were then ordered temporally into: the participant's story of self; the participant's story of their client; the participant's story of their therapeutic relationship with their client and the participant's story of their experience of their client's suicide. Given that 'what is not said may become as important as what is said' (Gilbert 2002:232), through the use of Component Story Analysis I was able to amplify not only what was explicit and known within the therapist's conversation but also the implicit, yet critical, unspoken story embedded in the text (Doucet & Mauthner 2002).

It was only after this initial rough outline of the story had been constructed, that I incorporated Polkinghorne's (1995) guidelines, as outlined above, into the inquiry process. Whilst I initially wanted to present the 'right' version of the therapists' stories (Fox 2003), the fact that that these stories are in a constant state of re-narration, meant that, ultimately, no definitive 'right' story existed. Since Freeman (1997:395 quoted in Jones 2002:9) states that 'the project at hand is a project of exploring lives in their various modes of integration and dis-integration, formation and de-formation, and, on the basis of what is observed, piecing together images of the whole', my role became one of writer/storyteller, 'a weaver of tales, a collage maker, a narrator of the narrations' (Jones 2002:2). I therefore relinquished my desire for rightness, in

preference for stories that contributed to and built upon existing understandings of the area under investigation.

Deciding which items from the data needed to be kept to create the final emplotted story was therefore made by continually asking myself such questions as: “Why did they [the participant] choose to tell me this?”; “What will be lost if I omit it?”; “What will be gained by its inclusion?” and “Will I run the risk of re-disenfranchising the participant if I leave this part out?” As I had already received emailed feedback from participants about whether or not I had successfully grasped the important elements of their story, it felt critical that these elements also be retained and included in the final draft.

In summary, then, the first two phases of data analysis consisted of the following six steps:

1. Transcribe, verbatim, the audiotaped interview.
2. Arrange the data elements contained in the transcription into their respective component stories, that is: the participant’s story of self; the participant’s story of their client; the participant’s story of their therapeutic relationship with their client; and the participant’s story of their experience of their client’s suicide.
3. Arrange the data elements within each of the component stories into a (relatively) chronological sequence.
4. Identify which data elements contribute to the story’s outcome.
5. Ascertain the links of cause and influence within these elements.
6. Write the story

Phase Three: Giving Voice to the Participants' Collective Story

As stated above, whilst not wishing to deny or diminish the uniqueness inherent in each of the individual stories told, it became increasingly apparent during the first and second phases of data analysis that themes and storylines were emerging not only *within* these individual narratives but also *across* them. Because of this, a third phase of data analysis, using thematic or paradigmatic procedures (Polkinghorne 1995; White & Hede 2008), was undertaken. By comparing, contrasting and synthesizing the themes of the different stories, it was hoped that an integrated account of the experience of disenfranchisement in relation to client suicide might emerge.

Addressing Potential Criticisms of the Methodological Approach Used in this Study

Despite the strong contention of this study that a narrative approach to both data collection and analysis was the most appropriate choice in light of the topic under investigation, the decision to employ it was made in the full knowledge that a number of criticisms have been raised in relation to both qualitative research in general and narrative inquiry specifically (Bingley et al 2008). A brief review of the literature in relation to quantitative and qualitative research illustrates that, despite the upsurge of interest in qualitative research over the past ten years (Jones 2004), historically and philosophically, quantitative inquiry has been afforded a higher degree of kudos and legitimacy (Schwandt, 2000). It was therefore critical that this study meet the criteria for good research that has been established in relation to research design, data collection, analysis and communication. To this end, and in line with Chiovitti and Piran's (2003) recommendations, a number of strategies were implemented to increase this study's rigour.

Firstly, purposive sampling was employed to ensure that the participants chosen were the best fit in terms of their capacity to shed light on the area under investigation

(Oliver 2006a). Secondly, to maximise the likelihood that the phenomenon being studied was accurately identified and delineated, it was the participants, not I, who guided the inquiry process (Chiovitti & Piran 2003).

Furthermore, since both the credibility and validation of a study's design and analysis can be assessed by the quality of the verisimilitude it contains, participants in this study were permitted to speak for themselves in order for this to occur. Verisimilitude arises from the provision of 'thick descriptions' (Holliday 2002) which Denzin (1989: 83-84) defines as 'truth-like statements that produce for readers the feeling that they have experienced, or could experience, the events being described.'

To increase the study's reliability, interview and observation records were meticulously maintained and a detailed documentation of the analysis process provided (Mays & Pope 1995; Patton 1999). Particular care was taken to ensure that not only was the evaluation of actions not mixed with a description of it since, as Dower (2003) points out, this can lead to the glossing over of the actions rather than their dissection and a search for reason or meaning, but also that idiographic interpretations were made (Wharton 2006).

In order to verify and validate the analysis, multiple analyst triangulation (Flick 2006; Patton 1999) was employed. In this instance, all transcripts and their subsequent component stories were independently checked by, and discussed with, my primary dissertation supervisor in an effort to identify any selective perceptions or blind interpretive biases on my part (Johnson 1997; Oplatka 2001). The study's participants were also invited to provide feedback and comments in relation to the accuracy of their transcribed interviews as part of the triangulation process (Gee & Pelling 2007). Also known as member checking (Lincoln & Guba 1985; Polit, Tatano Beck &

Hungler 2001), this form of triangulation permits researchers to ‘learn a great deal about the accuracy, fairness and validity of their data analysis by having the people described in the data analysis react to what is described’ (Patton 1999: 1195 – 1196).

To increase the credibility and objectivity of my account, the study’s theoretical framework, methodology and context have also been presented in sufficient systematic detail for it to be recognised by participants and to permit another researcher to replicate the same experience within the same research setting (Patton 1999). By providing the reader with extensive sequences of the original data (in order to preserve as much of the participants’ conversations and meanings as possible), it was hoped that the risk of researcher bias occurring would also be minimised.

The fact that both the participants and I are intimately involved within the same professional field meant that, prior to the study’s commencement, I had already witnessed a diverse range of activities in relation to, and had become thoroughly cognizant with, the milieu being studied. It is my belief that the sense of familiarity that this created, including sensitivity to the specifics of the participants’ language and meanings, minimised the risk of a purely impressionistic account of the area under investigation being provided.

Finally, since qualitative research promotes the critical importance of researcher reflexivity (Alvesson & Skoldburg 2000; Jupp 2006), the provision of a detailed account of my own views and insights about the phenomenon under investigation, and how these might have influenced the inquiry, was included within the study to enhance its credibility, as was the use of a personal journal throughout the research process (Chiovitti & Piran 2003).

Despite these measures being put in place, I openly acknowledge Denzin's (1989) contention that the unfinished, provisional and incomplete nature of any research study means that it inherently contains flaws and inadequacies. Within the current study, for example, the limited size of the sample and the fact that it was highly context and case dependent (Patton 1999) precludes generalisation, and therefore, some would argue, its usefulness. However, given the localised nature of this study and the fact that its intention was not to construct theoretical frameworks, but rather, to collect deep and meaningful 'information rich' descriptions and cases (Patton 1999; Jones 2002; White 2000) which provide valuable insights into these particular therapists' experiences within these particular contexts, the small sample size became completely appropriate. As Burgess-Limerick and Burgess-Limerick (1998:64) note, multiple case research such as mine 'typically involves a sample of between 8 and 20 participants who represent unique vantage points on the issue under consideration.' Furthermore, as Polkinghorne (1995) points out, the aim of narrative analysis is to create understanding through movement from case to case rather than from case to any overarching general knowledge claim.

Ethical Considerations

Without question, the experience of being researched has the potential to impact either positively or negatively upon a study's participants. There were therefore a number of issues which needed to be considered as part of the study's design and implementation to ensure that the ethical code to 'Do No Harm' was upheld.

Ethics Approval

Ethics approval to conduct this study was granted by the University of New England's Human Research Ethics Committee (Approval No. HEO4/115). Due to the sensitive

nature of the area under investigation, a critical component of this approval was that participants be engaged in supervision (or have ready access to it) and that they be furnished with the contact details of services that they could access, post-interview, should they require additional support. According to Minichiello et al (2004) the inclusion of a list of possible support services is a widely used precautionary step in research studies that deal with emotional issues. Potential participants were also required to be provided with the contact numbers and email addresses of the Ethics Committee, my primary supervisor and myself should they wish to discuss the project or their participation in at any time during the research process (see Appendix A).

Informed Consent

During preliminary, informal conversations with therapists, their right to withdraw from the study at any time or to refuse to continue during any stage of the interview process was repeatedly stressed. In the Information Sheet for Participants (see Appendix A) and the Consent Form to interview and record their responses (see Appendix D), which all participants signed prior to the interview's commencement, they were again advised of their right to withdraw without penalty at any stage of the process. Therapists' attitudes towards future presentations of the research and other published works were also ascertained prior to data collection.

Confidentiality

The fact that a bi-directional relationship (Catania 1997) exists between researcher and participant highlights the importance of the need for researchers to remain alert to any factors that might influence, impact or impede the interview process. Given the nature of the material under discussion and the fact that it was highly likely that I would have ongoing contact with several of the participants through our mutual professional or academic fields, it was imperative that confidentiality be assured and

anonymity maintained in relation to the information disclosed. To this end, pseudonyms were used throughout the study to identify the therapist, their client(s) and others involved in the stories being told and, in line with Fielden's (2003) recommendation, any identifiable personal details were removed from the transcripts. Whilst every participant was invited to provide the pseudonyms of their choice, as it was felt that this would foster a greater sense of inclusion and ownership of the stories being told, only three (Holly, Matt and Dirk) chose to take up this invitation. All other pseudonyms were therefore chosen by me.

Researcher-Participant Boundaries

Since the interviews were conducted across a range of settings, including therapists' workplaces and homes, it was imperative that the scheduling of these interviews, their duration and any potential post-interview impact be thoroughly negotiated and monitored. Because I was often entering the territory of others, I had to be aware of 'the implicit and/or explicit lines of authority, symbols and rituals of legitimacy' (Kellehear, 1989:67) that were in operation if I was to behave ethically and minimise the impact of my intrusion upon others' privacy.

Furthermore, since it was probable that I would be encountering several of the therapists in contexts other than the research one in which we were currently engaged, discussions regarding future interactions were also held with these individuals. It was interesting to note, however, that despite my caution regarding boundaries and confidentiality, many of these individuals were quick to share the fact that they had been participants in my study. Jude, for example, announced his involvement at the conference we were both attending, whilst Catherine, during a training day at which

we were both present, confided to the other psychologists that she had participated in my research.

Duty of Care to Participants

Whilst informed consent was gained from the participants prior to the commencement of the interview process, it was impossible to foretell whether or not the re-telling of their stories in relation to their client's suicide would evoke a degree of emotional distress requiring follow-up counselling and/or supervision (Birch & Miller 2000; Doucet & Mauthner 2002). As Parsons and Oates (2004:102) caution, while the interview process often provides participants with opportunities to discover new aspects about themselves, it also has the potential to 're-open old wounds' and to become akin to a 'confessional', where participants 'reveal things in the interview that they never had intended to talk about or remember things they didn't want to remember.' Whilst participants were fully informed of the sensitive nature of the study and the fact that they may withdraw at any time, it was also recognised that no amount of preparatory information could guarantee that participants would not be significantly affected by the interview process (Hubbard, Backett-Milburn & Kemmer 2001; Llewellyn, Sullivan & Minichiello 2004). Because of the ever-present potential for harm created by triggering powerful memories (Oplatka 2001), time was therefore allocated at the end of each interview for debriefing and reflection. Therapists were also reminded of the fact that they may wish to access follow-up support or supervision in the post-interview period.

Duty of Care to Self

Just as Satir (1987:19) has underscored the inevitability of both therapist and client impacting upon each other as 'human beings' within the counselling context, so is the case between researcher and participant within qualitative inquiry. As a result,

listening to therapists' stories about their clients' suicides was not a neutral experience for me. Often the details provided in relation to these deaths were graphic and at times gruesome. Elspeth's account of her client suiciding by *putting a nail gun through his head* evoked strong visual images, as did Jude's description of keeping his client's ashes in his office.

Because of this, and with my prior knowledge about the risk of vicarious traumatisation, it was therefore important to have access to clinical debriefing if required. This was arranged on an as needed basis with a colleague within the psychological practice in which I work. Whilst I did avail myself of the opportunity to debrief on several occasions, the focus of these debriefs tended to be less in relation to the details of the suicides themselves (though these were often described) and more about the sense of privilege I had experienced in having been permitted by my peers, not only to interview them, but also to be privy to a range of intimate stories that had previously been unspoken or deeply censored. At times, a supervisory component was also present during these debriefs, as I was aware of the fact that in repeatedly listening to therapists' stories I could become so hyper-tuned and hyper-sensitised to the risk factors associated with suicide that I might begin viewing every client within my clinical practice through this lens.

In addition to these debriefs, follow-up phone calls and/or meetings with my supervisor and the use of post-interview journaling (to externalise my personal and professional responses to the conversation which had just taken place), were also valuable means by which to work through any residual effects that the interviews might have had upon me.

Summary

This chapter has discussed the methodological approach taken to analyse therapists' narratives of disenfranchisement in relation to client suicide - a synthesis of narrative interpretation, based upon Polkinghorne's (1995) narrative-type narrative inquiry, Nuttgens' (1997) component story analysis and Polkinghorne's (1995) paradigmatic-type narrative inquiry. By engaging in this process, 'posteriori knowledge' (White & Hede 2008:26) was acquired through the generation of both *specific* knowledge (through the use of narrative-type narrative analysis and component story analysis) and more *generalist* knowledge (through the use of paradigmatic-type narrative inquiry)(White & Hede 2008).

The following four chapters (Chapters 6 to 9) examine the data and what can be learnt from therapists' stories of disenfranchisement in relation to client suicide. In the first of these chapters, through the provision of their in-depth component stories, two of the therapists who contributed to this study will be introduced. The first account offered, that of Jude, was the least disenfranchised story heard during the course of the study. The second, Murray's, provides a clear illustration of a deeply disenfranchising experience.

Whilst, ideally, I would like to have presented every therapist's in-depth component story within this chapter, the constraints of the word limit did not permit this to occur. However, in order to maintain the integrity of their accounts, and to ensure that these stories were not re-disenfranchised by being excluded from the study, they have been presented as appendices (see Appendices E to L). I would encourage the reader to linger with each of these stories before proceeding to the next chapter as they have as

much to tell us about disenfranchisement in relation to client suicide as the narratives which have been selected for inclusion in the main body of text.

The next three chapters (Chapter 7 to 9), borne out of the paradigmatic-type narrative inquiry undertaken in Phase Three of the data analysis, examine the three major themes that were identified across the therapists' stories.

In concluding this chapter, I remain mindful of Frank's (2002:13) observation that 'since stories are not waiting for social scientists to endow them with sense, narrative analysis needs all possible humility when asking what it can bring to stories.' My hope therefore is that I have approached these therapists' stories with sufficient humility to permit their inherent 'sense' to shine through.

Chapter 6

Differing Degrees of Disenfranchisement:

Storying Therapists' Experiences of Client Suicide

In this chapter, two of the study's in-depth component stories are presented. These stories were selected as they illustrate the polarities of the spectrum in terms of therapist disenfranchisement after client suicide. As stated in Chapter 1, disenfranchisement refers to loss experiences, such as client suicide, that are not openly acknowledged, socially sanctioned or publicly shared (Doka 1989, Martin & Doka 2000). The first story, that of Jude, highlights the *least* disenfranchised narrative heard; the second, that of Murray, the *most*. Whilst initially tempted to provide some form of interpretation of these stories within this chapter (in order to highlight the reasons why these stories represented the most and least disenfranchised), this option was subsequently relinquished, as it would have flown in the face of both Polkinghorne's (1995) and Nuttgen's (1997) guidelines for undertaking narrative-type narrative inquiry. As these guidelines strive to produce explanatory, emplotted stories about the thoughts, feelings and actions embedded with participants' stories in as deep and unedited a way as possible, both Jude and Murray's stories are presented, therefore, with minimal interruption or interpretation.

Since, as discussed in the previous chapter, a qualitative research approach cannot help but impact upon the researcher, I have included some personal reflections, drawn primarily from my journal entries, at the conclusion of each of the therapist's component stories analysis. These reflections relate predominantly to the impact that both the therapist and their narrative had upon me rather than to any interpretation of

their accounts. An analysis of the core themes and storylines that emerged within, and across, both these stories and those of the other eight therapists, are presented in subsequent chapters.

In the following body of text, italics are used to identify when the therapist's own words are being used. In instances where a therapist had responded to my request to provide a title for their story, this title has been included under the therapist's pseudonym.

As stated previously, adherence to the word limit prevented the inclusion of all ten in-depth component stories within this chapter. In order to gain some broad brushstroke insights into the experiences of the therapists who have contributed to this research, readers are therefore encouraged to read the eight remaining stories contained within appendices E to L before proceeding to Chapter 7.

Before presenting the individual stories of Jude and Murray, I have chosen to include my reflections on the interview process engaged in throughout the study, as I believe they highlight the appropriateness of using a narrative approach in relation to the topic under investigation.

Reflections on the Interview Process

What struck me most as I listened to these therapists' stories and later read and re-read their transcriptions, was how much their interviews resembled initial sessions I've had with clients who've presented for counselling with previously unspoken (or unspeakable) issues. Like these clients, once a sense of safety, trust and acceptance had been established within the research relationship, the therapists seemed to open the floodgates on their previously untold stories. More often than not, once the story-telling process had begun, the therapists' words seemed to just tumble out; little was

censored and no time existed for silence or quiet reflection. A sense of urgency often accompanied their recognition of this opportunity to get their story out, and I was aware that an implicit message to just create a space and listen without interruption was invariably being given.

Whilst, in my first few interviews, I agonised over my lack of probing questions (for isn't that what researchers do?), it soon became apparent that to try and interject whilst the participants were in full storytelling flight was to run the risk of doing the very thing I had set out to explore in this study, that is, the ways in which therapists' stories about client suicide get shut down and disenfranchised. Once I recognised the potential for engaging in this parallel process, and chose instead to meet the therapists', often implicit, need to feel truly heard, I was able to abandon my agenda of being seen as the researcher in order to make the therapists' stories more visible.

Paradoxically, once the therapists were given permission to speak in as uncensored a way as they liked, for as long as they wished to, the need to probe all but vanished as they tended to address my unanswered questions in the natural course of their storytelling. This is not to say that no questions were forthcoming on my part. To the contrary, many of the therapists' stories required clarification and deeper penetration if I was to uncover the implicit plotlines they contained (White 2000). However, as is the case with first time counselling sessions, these questions could only be asked once the therapists had reached a point in their storytelling where they felt satisfied that they had shared enough of their experiences for me to grasp the essence of their story. I therefore had to be acutely aware of not only listening to *what* was being said (the content of their stories) but also to the often subtle changes in *how* this was occurring (the process of their storytelling). Since 'attention to the way of telling and the quality

of the voice is a reminder of how the rhythm of the voice, the poetic and musical aspects of telling, draws people together in a way that words alone can never do' (McLeod 1997: 95-96), it was only when I began to hear the pace slowing, the pauses and silences emerging and the opportunity for quiet reflection arising, that it felt appropriate to ask questions about aspects of their story that seemed unclear or, as yet, unspoken.

The Interviews' Discourse: The 'Public' Professional Story versus the 'Private' Personal Story

Whilst the content of each of the therapist's stories about their experience of client suicide was unique, the discourse they engaged in was not. Typically, in the first half of their interviews, therapists provided a temporal frame (Riessman 2000b) of before, during and after their client's death that included a case history of their client, their therapeutic relationship with the client, and the way in which their client had committed suicide. Although this temporal framework was adopted by therapists with minimal input or direction from me, a recursive method of interviewing (Burgess-Limerick & Burgess-Limerick 1998; Silverstein et al 2006) was nonetheless employed to seek clarification and greater specificity about the story being told, and to use previously gained information to inform and frame subsequent interview questions.

It was interesting to note that during the first half of the interview, when the therapist's conversation was centred around his or her professional role and storyline in relation to their client's suicide (that is, the client's case history, the therapeutic relationship, the client's suicide and their 'professional' response to it), this conversation unfolded with little input or prompting from me. However, this was not

the case in the latter half of the interview when an exploration of the therapists' personal responses to the suicide was undertaken.

In the majority of interviews, a clearly defined transition point in the conversational process occurred once therapists had exhausted their line of thought in relation to their professional discourse. This transition point was usually signalled through a slowing down of the conversational pace and/or a pause and expectant look towards me about what else I wanted them to talk about. It was only after therapists had provided me with an indication that they had reached this transitional point that I found myself becoming more actively engaged in the interview process in order for their personal storyline to emerge. Direct questions such as that posed to Elspeth, "*In the aftermath of that suicide, what was happening or happened for you?*" were often required to help orientate therapists towards their personal discourse.

In relation to this latter part of the interview, I found it necessary to prompt much more frequently in order to promote continuation of the personal story and to enable any 'unanticipated' information to emerge (Dunn & Morrish-Vidners 1987/88). This was achieved by employing the recursive techniques described previously, though it did not result in the production of as cohesive a story as that which had been told in relation to their professional role.

Not 'Therapy' but 'Therapeutic' Nonetheless

According to McLeod (1997:105), for many individuals, 'the mere opportunity to tell their story, and to have their story valued and received, is an immensely affirming experience.' Busier and associates (1997:165) support McLeod's (1997) observation by noting that 'the process of "being in relation" is a vital experience which moves us into learning and understanding more about others, ourselves and the world.' This was

certainly the case for the therapists involved in this study. Without exception, therapists described feelings of relief and satisfaction at having been able to talk about their client's suicide. Holly, for example, stated at the conclusion of her interview that, "*Just the process of being able to talk about it was kinda cleansing*", whilst a compliment slip attached to forms returned by Catherine, post-interview, read, "*I really enjoyed being part of your research. It was like a free therapy session!*" Comments such as these illustrate the fact that, far from being a purely academic endeavour, the process of sharing their story with me had been a deeply felt, cathartic experience for these therapists. As Haynes (2006:204) notes, 'there are potential therapeutic effects of undertaking and participating in research', so much so, in fact, that Gale (2002:1) argues 'research interviews can actually be more therapeutic than therapy interviews.'

My findings reflect those of Dunn and Morrish-Vidners (1987/88) who, through the use of detailed interviews to investigate the stories of individuals who had experienced the suicide of a loved one, observed that, 'the interviews functioned partially as therapy sessions, allowing respondents to ventilate their feelings and ruminate on their experiences' (p. 180).

The fact that the interviews did evoke deeply emotional responses from the therapists meant that my training as a psychologist was frequently called upon during the interview process. Active listening, gentle probing, open questions, immediacy, basic and advanced empathy and sitting in silence during therapists' reflective moments and tears were skills with which I was familiar and comfortable and which were used in an effort to deepen the story by making the implicit explicit and the unspeakable spoken. As White (2000:41) has noted, it is through connecting with the absent but implicit

that conversations become double- or multi-storied, and in doing so, provide 'space for people to find new opportunity to speak of the effects of whatever they have found troublesome – whether this be disqualification, subjugation or trauma.' A follow-up note from Elspeth in which she wrote, "*I was impressed by your insightful questions, how you encouraged me to be more explicit and to review my actions, thinking and feeling in certain circumstances*" would suggest that this aim was achieved. Attributes of theoretical and social sensitivity and cultural and cross-cultural understanding, which are necessary if the research tasks are to be managed adequately, were also felt to be present due to my prior affiliation with the professional arena under investigation (Holliday 2002).

Having now reflected upon the interview process, the remainder of the chapter is devoted to the presentation of two of the study's in-depth component stories, those of Jude and Murray, the least and most disenfranchised narratives heard in relation to client suicide.

JUDE

Introducing Jude's Story

Jude had originally approached me to participate in this study after hearing me speak at a conference about the topic I was planning to investigate. Seeking me out at the first available opportunity after my presentation, he asked if I was looking for participants and promptly volunteered his services. While I had wondered at the time whether his eagerness to participate was due to a prior lack of opportunity to talk about his experiences, when I later asked him what his 'yes' had been about, he replied that it was less about the topic area itself and more about being collegial:

I think being collegial is, it's one of the things I think is nice about being part of this whole system and I try really hard to be as collegial as I can.

As I was to discover, Jude's efforts to be *collegial* and *part of the whole system* in relation to my research reflected his deeper desires for belonging and connectedness, desires which, as his story illustrates, permeated both his professional and personal lives.

Jude's Story of Rose

Whilst it was Rose who had come *immediately to mind* when I had invited Jude to tell me about his experience of having had a client suicide, he nonetheless struggled to adequately define her death, initially referring to it as *a para-suicide* but later describing it as *a strange suicide because it took such a long time*.

Having spent over twenty-five years working with marginalised people between the ages of fourteen and twenty-five, Jude was no stranger to "at-risk" clients like Rose. In fact, as the Director and Senior Counsellor in his organization, he had had a long

history of working not only with suicidal clients but also with clients for whom death was almost inevitable:

Working in the environment in which I work, and having worked in that place for a very long period of time, the theme of death is a very significant, very well worn theme. I've seen lots of it, been involved in lots of it. And not just suicide, not even principally suicide, but some para-suicide stuff and some direct suicidal stuff, and just death, period, where people die, HIV-related stuff. So the theme of death has been very strong and I was thinking a lot about it this morning, when I was having a shower actually, just about the images that flood into your head.

It was, in fact, the *sheer pervasiveness of death* within Jude's workplace that had led him to regard death as being *a fairly black experience* and to conclude that it was *the unpredictability of human nature and the fragility of human stability that exists in people's lives that can drive them to do things at one moment that at other moments they wouldn't dare do.*

Jude first began working with Rose in the mid-nineties. Suffering from deep depression, Rose got her HIV-positive boyfriend Tony *pissed and stoned* one day, withdrew a vial of blood from him, and injected it into her arm in an effort to kill herself. As a result of her actions, Rose became infected with the HIV virus that subsequently claimed Tony's life and eventually her own.

Jude's Story of His Therapeutic Relationship with Rose

Jude's relationship with Rose was both long and tumultuous:

I worked with her over a long period of time after that event [injecting herself with Tony's contaminated blood]. You know, through all the phase of her grief, the guilt, the anger, you name it, she went through it. And then finally through the death process with her and then the funeral...the whole thing was incredibly dramatic over a very long period of time.

Throughout his relationship with Rose, Jude saw himself as being much more than just her therapist. In fact his beliefs about therapy, the way it should be conducted and his role within it, meant that his connection with Rose remained constantly fluid, flexible and multi-dimensional, extending way beyond the walls of his therapeutic practice:

Within the therapeutic context, you're holding a whole stack of different things. So even though I acted as a therapist for Rose, when it got to the point where she was very sick and homebound, I would visit her. I often think about Winnicott when I think of Rose because there are stories about Winnicott going and helping a client clean up his house and paying the rent for somebody, and it's a bit like that for me. My model of working means that you don't stay in the model for the sake of staying within the model...it's a transformative model so it shifts to where the client shifts. So my therapeutic work with Rose became palliative care at one point where I use to pick up her medications because there was nobody else around and it seemed stupid to me to be talking about death, dying, family or whatever, even funerals, when there was a chemist two

kilometres away and she couldn't get the medication brought to her, so well, that's what I did.

As had been the case with many of his previous clients, Jude's relationship with Rose involved a series of ongoing traumas, stark recollections and conflicts with others involved in her case, particularly around the time of her dying, which left him with *a constant sense of being caught in the middle:*

She was going in and out of hospital, out of the hospice because she was very unwell and still used drugs and she had this crazy boyfriend. She'd broken it off with him and kicked him out of the house and then one night she got quite ill and she rang the ambulance and she went to the hospice. They took her back to emergency, she went to the hospice, they took her across to emergency...and the next morning she was dead.

The central place that Jude had come to occupy in Rose's life was underscored by the fact that, unbeknownst to him, she had put him down as her next of kin when she was admitted to hospital on the night she died. This decision, and the fact that when the hospital contacted him *he had slept through the pager and by the time I got up the next morning she was dead*, were to cause Jude a great deal of anguish after her death.

Jude's Story of the Impact of Rose's Suicide Upon Him

Jude's recollection of his responses at the time of Rose's death was that they were *very, very clear and very circumstantial:*

Ironically, it wasn't her death that was stressful for me, it was the fact that she'd paged and I hadn't responded and she was conscious when she asked

them [the hospital] to call me. So it was the very next day, I was beside myself with grief.

Given that Jude's relationship with Rose had been so multi-faceted and multi-dimensional, his grief response to her death was a similarly *global* experience:

The sense of grief I think is a bit more global in the sense that because you're involved in so many areas there's a lot more to try and wrap up and fold away. A bit like folding away a tent after the camping has finished.

This process of *wrapping things up and folding them away* was particularly challenging in Rose's case since, even after her funeral, which Jude's organization paid for, Jude's sense of responsibility towards Rose continued:

I was dealing with her death and dealing with the fact that I couldn't find her parents and organising a funeral and feeling guilty, so once the funeral was finished I just wanted to disappear... You know, I still have her ashes in my office because her parents didn't come and claim them...it's very graphic for me having Rose's ashes holding up a stack of books on my shelf, you know, like I think about her often, as I do about a lot of them who have died.

Physiologically, Jude described having had *very strong somatic reactions* after Rose's death. These reactions, which had also happened when other people he had known had died, were *not alarming or abnormal in any way* but merely reflected *a very physical manifestation of something that was very powerful*.

It was the acute sense of feeling *tragically guilty*, however, a feeling that *waxed and waned, up and down, over a twelve month period* which was to feature most prominently in Jude's response to Rose's death and to cause him the greatest concern:

The guilt part is very clear, it's got specificity to it. It was about my failure to be there at that particular moment she most wanted me, that's more distressing, even in recall, than any sense of grief...so it took a long time to process that and get over it.

While Jude associated his inability to be available to Rose in her dying with strong feelings of guilt, he was quick to point out that there was no guilt, whatsoever, attached to the fact that Rose had committed suicide:

I don't feel guilt about any client of mine that's suicided. I don't feel any guilt about, or sense of complicity...Nobody would hold me responsible because it was beyond anyone's responsibility. I do have a strong sense of, "Oh I wish I could have done more" but I also have a strong sense of annoyance, anger, frustration, even rage at times about "Why the fuck would they do such a thing?" You know, "How dare you put other people through it" and "What a gutless act that can be" as well as having an appreciation for, "Fuck, what drove them to that point?"

Though needing to constantly juggle these *complex, conflicting, legitimate thoughts* was hard for Jude, he managed to do so by recognising that they *both deserved air*:

I don't have a problem in myself of being erratic in my thoughts, in the sense of one moment I can be feeling sad about an experience but the next moment be thinking, "I'm so fucking pissed off with what they did!" And I've only got to say to myself when I get a twinge of guilt about thinking those thoughts, "Nah, hang on. How much time and effort did I put in?" And then I think, "Yeah, I'm really pissed off (laughs) because that was really unfair to put me and other people who tried really hard, through such an awful experience."

For the most part, however, Jude stated that he had felt an *enormous sense of relief* once Rose had died, firstly because it meant that it was *finally over*, and secondly, and more importantly, because he could now engage, as he did with all his clients who had died, in a *process of recalling* in which he *gathered all the bits and pieces of her life and tried to make sense of it all* so that he could view both Rose and his relationship with her in a more positive light:

I often say to people that the best thing about a person dying is that they can no longer shit you, they can no longer make any more mistakes...they can no longer fuck up anymore...that from thereon in the relationship with them only gets better. One of the things that sustains me in a fairly lengthy process with people who are really hard to work with is the fact that there is something in there that you can attach to and like about them, and in spite of all the shitty things you have to deal with, when it finally gets to the point where all the shitty things stop, then that's wonderful. And I finally find myself no longer remembering the bad things. That happens for me and it's not a deliberate cognitive process, it's part of my makeup, a coping mechanism I guess. I start to re-form my relationship with that person in a very different way. It's got some intensity about it very early on in the piece but while the intensity lessens over time, the process in me doesn't stop. You know, you often hear people say, "What a waste of time" and I guess part of me says, you know, I don't want that experience. So perhaps it's a defensive reaction on my part (laughs) to work really hard and to try and make sense of the person, to recast or reframe the whole experience of being with this person, particularly when it's been over a long period of time.

It was during this process of talking about how his relationships with his clients improved after their death that Jude began describing his relationship with his father

whom he had nursed for the last six years of his life whilst he struggled with Alzheimers. From all accounts, this relationship had been an emotionally distant one until, suffering from diminished short-term memory and enhanced long-term recall, Jude's father could finally talk with him about some of the horrific World War Two memories that he had kept hidden for most of his life. Whilst Jude acknowledged that this had been a *reparative experience*, this relationship, like many of those Jude had maintained with his clients, had nonetheless been fraught with tension and conflict for much of his father's dying. As had been the case with his clients, Jude stated that *even though it had been incredibly sad when dad died, it was over and there was such a strong sense of relief in me that nothing else could go wrong.*

It was only when Jude began reflecting upon how he *had tried to make sense of how the different pieces fitted together when Rose had died* that he recognised the strong similarities between this process and the one he had engaged in in relation to his father's death. *Jeez, that's exactly the same thing I found myself doing with dad as well!*

Whilst acknowledging that part of the *recalling process to try to make sense of it all* required an opportunity for him to be able to *crawl off into a corner and be a bit more contemplative on my own for a while, to walk and to be with my own thoughts*, it was also facilitated by *the talking space and matrix of support provided by a fantastic team and good supervision:*

I've had a lot of experience with crises and have a reasonably strong sense of what I need and what people around me need as well... I'm a very strong believer in having things structured and unstructured, supportive, formal, informal structures around you... I think getting the support for me is my

responsibility and I've worked really hard carving out a structure for myself that I know works for me. I think it's the wrong time to think about support in the middle of a crisis, it needs to be practised. I definitely don't like to leave it to chance.

When invited to describe more explicitly what shape or form this support structure had taken, Jude stated that it certainly hadn't included the hospital staff involved with Rose since *their contact had ceased abruptly* as soon as she had died, leaving him to follow through, single-handedly, with the post-death arrangements:

One of the ironic things about the health system is that once a person is dead, it immediately changes. They wrap up the body, send it off to another department and close the file instantly. They don't really want to talk about it anymore and I'm the one who follows the body to the parents. You know, she's no longer causing difficulty and they don't seem to care anymore. And that's got its own tiredness and sadness about it.

This *matrix of support* did, however, include a range of individuals drawn from his professional arena. Rose's treating physician, for example, was *incredibly supportive* as she instigated *the most useful exercise* by inviting Jude to meet her at the hospital shortly after he had rung to let her know what had happened. *We went to the hospital and she took me into the morgue and left me there which was really nice because I got to sit with Rose for about half an hour.* She and Jude also engaged in a reciprocal debriefing process, *one day it was her turn to be upset and the next day it was mine. You know, stuff like that over a meal and red wine.*

Jude's team within the organization in which he worked was also an important part of his support matrix:

They had a very strong sense of how significant this was and their response was to pop their heads in occasionally and to say, “Let’s look in your diary, what can we get out of the way?” and “Who can we ring for you?” That’s always really good.

The *good supervision* that Jude had also found vital after Rose’s death involved a number of critical elements. First and foremost, the clinical psychologist who provided his organization with, *not exactly supervision but a third eye*, by sitting in on their team meetings every week, was able to offer Jude *a very strong sense of being loved and cared about* which made an enormous difference:

It meant that I was able to talk with him about how tragically guilty I felt about not being available and I wasn’t shy of crying if I needed to. So that was helpful in the sense of knowing that somebody else knew about it. I got lots of support from him and feel very lucky to have him. I don’t need hand holding. I just need occasionally to hear a voice that says, “It’s okay, you’ll get through this.”

The more formal supervision that Jude regularly engaged in on a fortnightly basis with a second supervisor was also helpful as it provided him with the opportunity for *a lot of reflection on stuff*:

We prepare for that so there’s writing, typing and reflections and it’s usually a combination of transcripts of sessions, reflections and thoughts, my impressions and reactions, my observations and my sense of what the internal experience is for me.

These opportunities for transparency and for fostering a sense of congruence between his internal and external worlds were clearly very important to Jude:

I need to be transparent within my place of work and I try really hard to do that wherever I go. I fought really hard over a long period of time in my teens, twenties and probably into my thirties to really discover who I am and I just don't want to pretend that things aren't me. So not denying things is really important. If I feel that, then that's me.

When asked if he also sought support outside the work context Jude said that he didn't:

I don't tend to talk a lot about work outside of work. I don't have a great need to do that. In fact, I say to myself when I come across other people doing it, "Why the hell are they doing that? Is there a deficit somewhere else in their support structure?" Because the attitude I take with my staff is to say that, "If you've had an experience that's negative do not leave the Centre unless we talk about it". And it may only be two minutes or it may be longer. And it's not about being rigidly split between work and home but [it's about recognising that] there are other parts to my life. I've got family and friends, a good diversity in my social life, and things that I've got to do.

Whilst Jude acknowledged that he *could go on talking for hours*, he also stated that he'd *probably covered most of the things that he could say*. The interview concluded therefore after an hour and a half. In closing, I asked Jude what sustained him, given the ongoing tragedy that surrounded him at work. His reply? That *life is full of tragedies...but I've survived*.

Personal Reflections and Lasting Impressions

Despite the deeply emotional account that Jude provided in relation to his client's suicide, I was aware that during the entire interview the only time his eyes filled with

tears was when he recalled how he had had to *fight really hard over a long period of time to really discover who he was* and that, because of this, he was no longer prepared to *pretend that things weren't him* or to *deny things that were really important to him*. His voice was filled with such passion when he spoke these words, that I was left wondering whether his personal history had somehow predisposed him to seek connection and belonging within his professional arena and if his need to be *collegial and part of a team* had, in fact, been amplified by his own life story.

In retrospect, what struck me most about the interview, per se, was how thoughtfully he had approached it. Highly articulate and deeply reflective, he often paused to mull over the questions posed to him before answering them. It seemed as though he wanted to ensure that he was providing me with the richest information possible. Even after our interview had ended he was still keen to assist, asking if he could share some of the research tips that he had picked up over the years.

Epilogue

Several months after interviewing Jude I shared my research-findings-to-date at a conference at which he was present. As part of my presentation, excerpts from the transcripts, including Jude's, were presented to highlight the core themes that had begun emerging from the data. Of particular interest to me was the heated discussion that arose amongst audience members about the inappropriateness of Jude's actions in keeping his client's ashes in his office and his breach of professional boundaries in doing so.

That evening I received an email from Jude in which he shared his responses to my presentation. With Jude's permission, I have chosen to include several excerpts from this email as they highlight not only the ethical dilemmas that can arise when

participants and their conversations meet each other in a conference context but also the powerful impact that a client's suicide can continue to have upon a therapist many years after the event.

...I realise that no one in the room knew who 'Jude' is but I have to say that I felt quite exposed [during your presentation] and on a couple of occasions wanted to flee. I now realise that in the future it will be important for me not to be in the room during your presentations...

...I could hardly contain my sense of distress when people were making comments about boundary issues in respect of the ashes...their judgements being made of and on me with limited information and hence out of context...

...Though Rose came to the Centre and sought help from us, there was always a "me" in the equation, a person first and foremost who takes on a role, but a person with all that that implies... while we all process grief and somehow move through to some form of resolution over time, death is never completely resolved and the pain remains. I gave a significant part of my life to this young woman and was present when others had fled.

...There is a sacred quality to the experience that needs to be respected. I didn't do so by allowing myself to be present at your presentation today.

Having presented Jude's story, the least disenfranchised account heard during the study, that of Murray is now offered. As will become quickly apparent, Murray's account highlights the deeply disenfranchising experience that the death of a client by suicide can be for a therapist.

MURRAY

“Murray of the Quivering Bottom Lip”

Introducing Murray’s Story

Like Jude, Murray had approached me without prior solicitation after hearing about my research from a mutual acquaintance. As a fellow psychologist practising in the region in which I live, and having moved in similar professional circles for over a decade, I was well aware of his reputation for being a highly skilled clinician.

My interview with Murray took place in his private counselling room at the end of the day. Perhaps foreshadowing the fact that it would be an emotionally draining experience, Murray had specifically requested that the interview be scheduled at the conclusion of his final session so that he could have some space afterwards without the need to resume his professional role.

Whilst we had originally planned to meet for an hour and a half, it was evident to us both as this initial interview drew to a close that we had only just begun to scratch the surface of his experience in relation to his client’s suicide. A follow-up interview was therefore arranged. This took place several weeks later and lasted for approximately one and a half hours. Murray’s story, based on these two encounters, is presented below.

Murray’s Story of Simon

Though Murray had experienced the suicidal deaths of several clients over the years, it was the most recent suicide, that of Simon, that he chose to talk about in depth because it had *impacted more deeply than the other ones as I had seen him a number*

of times and had put a lot of myself, a lot of my professional self into the sessions with him.

It was the *loss of hope in his life*, Murray believed, that had brought Simon, a man in his sixties, to counselling. Whilst Simon had always worked hard to portray the *outward image of having been a very successful businessman*, over the past few years, the deterioration in his relationships with both his wife and children had left him feeling *excluded* to the point where he *didn't see any way of becoming a father or husband again*. Living separately from his family, and having also withdrawn from his family of origin, colleagues and other male friends, Simon had *become an isolate* and *had shut down quite a long way* by the time he contacted Murray for assistance. *He had avoided his emotions quite a lot until the last year or so of his life and then had gotten so in touch with them that I think it was overwhelming*. This, coupled with the fact that Simon had been an *incredibly private man* meant that coming for counselling and *allowing other people into his experiences* had been a *very big step for him to take*.

Murray's Story of His Therapeutic Relationship with Simon

By the time he presented for counselling, life for Simon had become *hopeless and meaningless* and he was *in a very urgent place in his depression...needing to have an answer to those dark foreboding questions about himself, about his past, about his future*.

Until his suicide in 2006, Simon met on-and-off with Murray for a period of approximately eighteen months. Whilst initially Murray had been one of the few professionals involved in the case, as Simon's depression deepened, Murray intentionally widened the network of support:

One of the things that always matters to me is that I'm not the only professional working with someone who's depressed. It matters that other people are making their contribution to try to, to turn the experience in a, a more hopeful direction.

Whilst contributing to a more positive outcome for his client was Murray's primary reason for involving other professionals in his casework, he readily acknowledged that this was not his only motivation:

Part of it, I'm sure, is also a kind of self-protective device on my side, because I don't trust, altogether, my capacity to be the right person at that particular time or maybe I might miss something...To have others in the loop is also a statement about my, my vulnerability or my uncertainty about my effectiveness. Despite the fact that I've had a lot of years in practice and I think, generally speaking, I work well with people, if I think there's a significant threat to a person's life I do look for some security in having other people involved in the situation and sharing the responsibility.

In Simon's case, these professionals included both his general practitioner and a psychiatrist who had been *brought into the loop* when Simon had admitted himself to hospital during a particularly vulnerable period. Simon had, in fact, been commuting between the hospital and Murray's practice in the weeks leading up to his suicide. Murray described the following haunting image of Simon during their final session together:

I remember standing at the window and watching him arrive. I remember him being very hunched over as he walked along the street and very depressed in his demeanour. So all these things I was very aware of and increasingly, I suppose too, I was also aware of our sessions not making any progress in the sense that

between sessions he could take anything that had been helpful in the session itself and use it between sessions... I noticed that and was troubled by that. So the experience was one of also wondering what could be done, if anything or how could I be with him differently?

It was approximately a week after this session that Simon had *discharged himself from hospital, gone to an isolated place, rung the police, and after a lengthy period of time, during which the police had tried to talk him out of what he was intending to do, killed himself*. Murray heard about Simon's death, almost by accident, the following day:

One of my colleagues told me and I don't think realised that in, in the moment of sharing, just I suppose, the depth of interaction or relationship I'd had with him. So that's when I was brought into the loop of information.

Murray's Story of the Impact of Simon's Suicide Upon Him

Murray described Simon's suicide as having had *a really big impact* upon him. Whilst never doubting Simon's potential to take his own life, Murray had been *truly shocked that he'd done what he did* because *despite questions of safety coming up, he hadn't actually talked about, you know, actual methods of suicide or anything...there was no moment where I felt that there was something about to happen*. For Murray, the period of time between his final session with Simon and Simon's suicide now felt like:

...a missing part of the narrative of the last week or so of his life, and how our conversations prior to that last week related to what happened, if at all, during those last few days...I actually don't know how he was construing his life and his experiences at that point. It's like my story, my involvement came to an

abrupt end and then there was another chapter that I wasn't part of...I was outside the loop at that time, everybody else was. Nobody knew. It was beyond talking [for Simon] by then.

The experience of being *outside the loop* and of *not knowing* was one that left Murray going back in my mind, over and over again, as I have probably done since from time to time, less as time goes on, and wondering about the experience he had endured at the end. Furthermore, whilst Murray had believed that he and Simon had had a good [therapeutic] relationship, a good connection because Simon had trusted the relationship to hold the emotions and kinds of despairing experiences that he was describing, after Simon's death he nonetheless questioned whether Simon had really experienced it like that or not, and whether he had actually ever really known him.

Given these comments, Murray's statement later in our interview that *missing part of the story* and being *outside the loop* at the time of Simon's death *didn't matter that much as I didn't have a need to know* about Simon's final days sounded somewhat contradictory. When I invited Murray to expand upon his belief that he *didn't need to know*, he stated that it was because:

...by that stage Simon had positioned himself beyond human relationships altogether, he'd crossed a line and in that place he'd got to, nobody could accompany him...Relationships didn't make a difference for him anymore... So I don't need to know because I need to allow him to do that, to actually position himself beyond human relationships, and if he does that, I don't need to chase him or pursue him.

Whilst, in hindsight, Murray felt that *he had done as well as he could do [with Simon]* and that that *was satisfying no matter what the outcome*, he also acknowledged that he

would have responded completely differently had he been *in the loop* when Simon had actively been contemplating suicide:

I would have alerted all the people who [would have] needed to be alerted to take action that would have reduced his opportunities to do that.... like alerting the psychiatrist and having him scheduled. But by that stage in his life, Simon had taken, in a sense, control of his destiny himself and was no longer letting anybody into the loop.

On reflection, Murray also recognised that *being in the loop* may ultimately have made little difference to the outcome since, having had other experiences of client suicide, he had come to realise that *no matter what safety measures you put in place, if someone decides, either on the spur of the moment or through long and despairing reflection, that they're going to do it, well they'll do it.*

In light of the fact that *being in the loop* may not prevent the inevitability of suicide for clients who chose to *cross the line*, I asked Murray what he then felt the purpose or value of therapy was:

That therapy doesn't do anything that can save them leaves me with a profound sense of helplessness and [an awareness of] the limitations of human relationships at certain points, including the therapeutic one, and the limits of humanness or the capacity of humans to be everything that another person needs. So why therapy? I suppose the only comment I can say is that it was worth a shot. It was the person's best opportunity.

As he reflected upon what Simon might have said if he'd been asked why he had come to therapy, Murray believed that his answer would have been that *it was what he*

thought he needed and that he would have been grateful for the opportunity of talking in ways he couldn't talk anywhere else. Furthermore, Murray believed that Simon would also have said that it wasn't the therapist's fault or the therapy process [that he'd committed suicide], it was something that he took upon himself, that took him outside that, that the decision existed outside of therapy.

Whilst it was *shock, disbelief and numbness* that Murray had initially experienced when he heard about Simon's suicide, these feelings gave way to *something that goes a lot deeper, a kind of dismay, an enormous depth of sorrow, it's like being assaulted...an assault on the sense of the being, you know, that somehow life, existence, being, has been dealt a traumatic blow. That something has been incredibly diminished in that moment of loss...a ripping and tearing experience, that something's just been ripped away, the loss of opportunity for any other outcome...so final and so brutal to himself.*

After Simon's death, Murray found few avenues available to him through which he could express the parts of himself that had had to be *kept in the wings in [his] role as a psychologist including the echoes of his own depression and sense of meaninglessness in myself that would not have been helpful to Simon.*

Whilst he had hoped that the post-suicide session with Simon's wife several weeks later might afford him the opportunity to *abandon the masks of, the roles or styles of professionalism and simply embrace the transcending, the transcended nature of humanness that's shared*, this was not to be the case. For whilst Murray was looking for *a way that would have enabled both of us to deepen our humanness...to have shared the emotion in some appropriate way...the tears, confusion, overwhelming sorrow, whatever*, she was looking for *an intellectual understanding of what had*

happened...to fill in a storyline that would enable her to move on or to recognise that it wasn't her fault. Ultimately then, rather than providing him with the catharsis of sharing [his] story, this post-suicide session became an exercise in intellectual rationalisation where he felt required to respond in kind:

She had a cognitive approach, very cerebral, very rational. I longed for her to ask me about what my experience of Simon had been and what my experience of his death had meant to me...I had no sense that he insulted us or disrespected us or anything like that, just a sense of hurt... If she had come and cried, and if we'd cried together even, that would have been a less painful experience because it would have conveyed something about the value of him.

It was only after Simon's wife had left the session that Murray cried:

I think my tears were about him but also about her and what had gone missing in their relationship. They were of connecting with his despairing of the relationship, of hostility that I don't think she could see that, and of what it might have been like for him to feel so excluded...

When asked if he too had felt excluded during the post-suicide session Murray responded affirmatively:

Yes. She had wanted to come see me as a psychologist who'd been involved with him. She wanted a professional opinion, a professional bit of information, as if I somehow were not part of being a professional. That somehow my humanity wasn't involved in my professional relationship with him, that somehow I could be clinical and detached as a human being from the person I was working with.

Not only did Murray feel that his humanity had been excluded by the clear delineation being made by Simon's wife between his professional role and his personal response but also his grief:

Because her grief seemed so contained there was no opportunity for me to be other than contained with her and to contain my grief which was much more accessible to me in that moment than it was to her or hers was to her.

When I hypothesised about what sort of impact the sharing of a therapist's grief within a post-suicide session might have upon both the therapeutic relationship and the client's sense of them as the therapist, Murray felt that it would lead to *a deepening, a deepening of the connections, so that the therapeutic process that ensues has more credibility, more validity, becoming a platform for making the therapeutic relationship more effective.*

Whilst Simon's wife's expectation that he remain in his professional role and not involve his humanity or express his grief was one that Murray had encountered on other occasions within his professional arenas, it had also been present *from time to time* within his personal contexts as well:

People don't expect me to react the way that other people react and to have the same sets of emotions. That somehow I'm suppose to be beyond that, that somehow I'm suppose to be self-contained, or to somehow remove myself to a self-transcending sort of space and to always be wise or comforting them and not be in distress myself. And if I do express myself, I have to recover quickly because if I don't people won't know what to do and maybe, in their eyes, I've lost credibility. I don't believe that that's the case, but sometimes other people's reactions suggest that.

You know, "You're the psychologist. You're the therapist. You deal with this all the time. Why are you upset? We can be upset but you shouldn't be upset because that makes us feel less secure. You're supposed to be the solid one. We expect you to be there for us, we don't know how to be there for you. You embarrass us. You leave us feeling uncomfortable and insecure because if you're upset, we're upset, then who is there?" So it's that sort of expectation to somehow be more like God than a creature.

The cost to Murray of such expectations was that it left him *feeling lonely and isolated.*

Whilst he chose to attend Simon's funeral, as *it was important for me to honour the relationship I had with him*, here too he felt a sense of alienation from the other mourners, remembering that he had *stood apart afterwards looking at all the family and just wondering what their experience was.* For Murray then, *keeping the actual funeral service sheet in my files from where, occasionally, I'd see it* became the means by which he could *acknowledge the grief he was experiencing* in relation to Simon's death.

Having been unable to express his grief openly during both the funeral and the post-suicide session with Simon's wife, Murray also found himself avoiding its expression through avenues he had *turned to in the past when faced with intense emotions*, avenues such as *journaling, poetry writing and prose.* This avoidance, he stated, was because *it was just too hard. Because it was a felt experience, a weight, the weight of deprivation, of trauma, of assault, of life, existence having been bruised and battered, there were no words, so I think it got shelved.*

When asked if anyone else around him was aware at that time of the depth of his response and of his sense of being *battered, traumatised and bruised*, Murray said no:

I think it was largely something that I shelved or kept within myself and thought that at some later stage I would be able to talk about and perhaps get some clarity about my sense of it, some way of going over the experience, some way of connecting with it and what I knew of him.

This opportunity to talk *at some later stage* did not, however, arise. As we explored the reasons for Murray's reticence about sharing his experience with others, it became clear that for Murray, *the pain and heaviness and devastating impact* evoked by Simon's death required a *particular situation* for him to be *willing to approach it again*:

There are not many people I would entrust that amount of personal experience to. I too am a very private person [like Simon was] and I need to be really confident that a person would meet me on my terms, on my turf, and work with me sensitively enough for me to benefit from it...a lot of people couldn't do that. My intuition says that to follow where that pain was, would take me into other pains once more, and I would need a very wide ambit for this experience to then flow into an exploration of its meanings or its connection to other losses in my life.

Whilst admitting that this *particular situation* could potentially have included supervision, Murray felt that this would not have been helpful or appropriate for him since *supervision's often more limited in its definitions because it's safer and it relates to things that are easily managed in a supervision hour*:

Besides, it wasn't so much at a professional level that I wanted to talk or wanted to explore its meanings. It was more the sort of thing I would explore in a therapeutic context, in exploring my own life as distinct from what I did or

how I responded in my professional work and so on. There are not many things that I had as questions or doubts about the sessions themselves. [So] it would have to be a very particular, special sort of supervisor who I would entrust my personal experiences to [and] a relationship that had already been built up over a period of time where the threads of the relationship were multiple threads, where the personal aspects or being personal in professional work was seen as legitimate so the connections between personal and professional could be explored. I think that professional work and a sense of the personal are sometimes at least intertwined. It's this question in my mind between therapy and supervision, the interface between the two. Or between supervision, therapy and spiritual direction.

Furthermore, because previous encounters in his professional life had left him *with reasons to be suspicious of people's capacities to offer the degree of confidentiality and understanding and support and willingness to enquire because they really want to understand*, Murray believed that visiting *[Simon's death] conversationally would have been easier to do in other contexts...sharing my writing with someone, talking to a friend, talking with my spiritual advisor...somebody who I had given permission to come into the sacred places in my life*. Again though, whilst these other contexts had been available to him, Murray had chosen not to utilise them to any great degree. *I might have put some words around it to one or two, but no, it was something that I largely shelved and kept to myself.*

As our second interview drew to a close, I invited Murray to reflect upon what it had been like for him to speak about Simon's death for the first time:

It's been good. I've reconnected with the emotions of it and inevitably it will reverberate around and connect with other losses, other missings in my life. Because they are so powerful for me, I think that's one reason I've avoided spending too much time thinking about this until now.

Personal Reflections and Lasting Impressions

My interviews with Murray struck me quite profoundly for two different reasons. Firstly, as he began to talk, I became acutely aware of the incredible courage it must have taken for him to risk sharing his experience of Simon's suicide with me. Both interviews, in fact, were regularly punctuated by long pauses, silences, deep sighs and moments of weeping as he gradually peeled back the layers of his story and connected with the pain that had been *just too hard* to put into words until then.

The second aspect of my interviews with Murray that stood out for me was his strong personal identification with many elements of Simon's story – his deep privacy, his past experience of depression and its accompanying sense of hopelessness and his lack of access to individuals who could offer him the safety and support necessary for him to express the deep emotional pain he had kept contained over the years. The fact that Simon had been of a similar age to Murray *was also significant* to him. However, as this disclosure was made shortly after the conclusion of our second interview, I was unable to pursue it further.

Murray's interviews were powerfully raw and courageous. In choosing to share his story, Murray had permitted me *to enter the sacred places in his life* and for that I feel truly honoured.

Epilogue

Several days after our second interview I ran into Murray during my lunchbreak. Whilst I could easily have assumed that his enquiry about the okay-ness of his interviews was related to their relevance to my research topic, my intuition told me that his question actually arose out of his need for assurance about his own okay-ness. The hour-long conversation that followed confirmed this and highlighted Murray's fear not only of being seen as *crazy* because of the intensity of his grief in relation to his client's suicide but also of the negative professional implications that would ensue if he were to be regarded as *the crazy psychologist*. Whilst I felt that I was able to adequately reassure Murray about the normality of his responses by recounting similarities I had heard between his experiences and those of other therapists I had interviewed, I was nonetheless deeply moved by his willingness to share this admission with me.

During this conversation, Murray also revealed that he had reflected upon his father's death in light of our interviews and had begun to wonder *just how far you could stretch the definition of suicide and whether someone could commit suicide simply by choosing not to participate in life any more* – as he believed his father had done. As he grappled with this question, he spoke briefly about the death of another of his clients *in a single vehicle accident on a stretch of road that he'd driven a hundred times before*. Whilst Murray had had little doubt that this client had actually committed suicide, *the fact that the [client's] family didn't believe it was anything other than a tragic accident* meant that it had had to be acknowledged as such. As my interviews with other therapists were to reveal, Murray was not alone in his struggle to decipher what the term “suicide” actually encompassed.

Summary

Through the use of narrative-type narrative enquiry within a four-part, in-depth component story framework, two of the ten therapists' stories have been presented in this chapter. The first account offered, that of Jude, was the least disenfranchised story heard during the course of the research. Murray's, by contrast, offers valuable insight into a deeply disenfranchising experience of client suicide. As stated at the outset of this chapter, due to restrictions on word limit, the remaining eight in-depth component stories have been included as Appendices E to L. Readers are therefore urged to acquaint themselves with these remaining stories as they provide powerful, uniquely individual, insights into the experiences of the eight other therapists.

Having now had the opportunity to immerse yourself in the two stories profiled, plus those contained in the appendices, the following three chapters draw your attention to the core themes and storylines (using paradigmatic-type narrative inquiry) that emerged within and across these accounts. As stated previously, the strength of paradigmatic procedures is that they provide an opportunity to construct and explore the meta-stories that 'transcend and yet bind together individual stories' (Gilbert 2002:228) and in doing so, permit the development of 'general knowledge about a collection of stories' (Polkinghorne 1995:15).

In conceptualising these chapters, the greatest challenge faced was finding the most visible means of presenting the core themes and storylines relating to how disenfranchisement arose within, reverberated through and impacted upon therapists' personal and professional lives. The solution emerged when I literally returned to the source – the definition of disenfranchised grief, as it provided a framework within which to situate both the collective plotlines and the threads out of which each was

woven. Since, according to Doka (1989 cited in Martin and Doka 2000:13), disenfranchised grief refers to loss experiences where:

- a) The loss experience is not openly acknowledged.
- b) The loss experience is not socially sanctioned.
- c) The loss experience is not publicly shared.

the collective plotlines identified during the data analysis have been organised to broadly reflect these three characteristics of disenfranchisement. Thus, plotline one (Chapter 7) examines the ways in which the death of a client by suicide becomes an 'invisible loss' for therapists; plotline two (Chapter 8) explores therapists' experiences of being in an 'invisible relationship' with the deceased (both before and after their death); and plotline three (Chapter 9) explains how therapists become 'invisible mourners' in instances of client suicide.

Chapter 7

Plotline One: Invisible Losses

This chapter, through the use of paradigmatic-type narrative inquiry, explores the first core theme to emerge from within and across the participants' accounts, namely, the ways in which the death of a client by suicide becomes an 'invisible loss' for therapists. As stated in Chapter 6, this core theme broadly reflects the first characteristic of disenfranchisement identified by Doka (1989 quoted in Martin and Doka 2000:13), that 'the loss experience is *not openly acknowledged*.' Using excerpts from the therapists' stories, this chapter highlights the lack of acknowledgement that therapists encountered within both their professional and personal spheres, in relation to their client's death.

As stated in Chapter 3, it is an indisputable fact that ending one's life through suicide is still regarded within Western culture as being immoral and therefore taboo (Thompson 2002). Donaghy (2005:5), for example, refers to suicide as being 'shocking, frightening and unspeakable' and claims that death by this means creates a 'suffocating stigma' for those left in its wake. In the face of such overwhelming negativity, it is hardly surprising then that, prior to this study, the majority of therapists interviewed had been afforded very few opportunities to openly acknowledge the impact of their client's suicide upon them and that this had been one of the driving forces behind their decision to take part in my research.

Holly, for example, stated that it was the very fact that she *had not spent much time thinking about or reflecting [on the suicidal deaths of two of her clients]*, that had led her to hope that the research might be *a nice experience to see what was there*.

Elsbeth too had acknowledged that *[not only had] volunteering to be part of [my] research been another way of debriefing [but that] it was also an opportunity to reflect and do bit more assimilation in relation to [her] feelings at the time and [her] feelings now, a couple of years later.*

For yet another of the study's participants, Murray, taking part in this research had provided him with his very *first* opportunity to share his experience of client suicide. The fact that, at the completion of our initial one-and-a-half hour interview, he had eagerly suggested that we schedule a follow-up conversation, underscored his overwhelming desire to finally be able to share his story. Even Jude, whose story was the least disenfranchised heard during the study, acknowledged *that he could have gone on talking for hours*. Holly's question, "*Do you want to limit your time because I could talk for a while?*" further emphasises the unmet need of therapists to be given repeated opportunities to talk about their experiences of client suicide in un-censored, unlimited ways.

The following observations by Matt, Susan and Catherine also highlight the awareness that therapists had of needing to be given opportunities to talk openly about their client's suicide as part of an ongoing process of healing and meaning-making:

Matt: [Being able to tell one's story] is, I believe, integral in one's emotional healing, so I thank you for allowing me to vent whatever residual emotions were still embedded in my being... I still get goose pimples and the tears well up but I recognise the need to talk and talk and talk it out of my system, not in a meaningless way but in a constructive way.

Susan: Part of the disjointedness [in my storytelling] was about the internal struggle to make sense of a precious life lost and to come to terms with it. That takes time and although I have talked about it in the past, the depth of reflection with you was very helpful. I was left with the recognition of how important it is to tell these stories.

Catherine: Even though it's research, I did think it would be beneficial because it's so personal and I think the fact that I can still get upset about it today shows that it's still the process happening.

Comments such as these about the need to have *ongoing opportunities to make sense or make meaning* of the suicide reflect contemporary constructivism and narrative conceptualisations of mourning as a process of meaning reconstruction in which the loss is worked and re-worked over time (Neimeyer 1997, 2001a, 2001b, 2001d, 2006; Neimeyer & Keesee 1998; Neimeyer & Anderson 2002). As proponents of this viewpoint have noted, for meaning-making to occur, it must encapsulate both the *context* in which the loss has occurred and the *narrative processes* through which the bereaved individual engages in their search for meaning and significance (Neimeyer & Anderson 2002). However, as will subsequently be discussed, for the majority of therapists interviewed, both the contexts in which their loss occurred and the narrative processes they were permitted to engage in, were far from conducive for meaning-making to take place.

Despite their awareness of the need to talk out their experiences, the fact that many of these therapists had previously been denied either an initial invitation or ongoing opportunities to discuss the impact that their client's suicide had had upon them meant that they had approached their interviews with some degree of trepidation. Faith, for

example, began her interview by acknowledging that talking about her client's suicide had felt like a *really big question to answer*, whilst Matt stated that because he *still felt emotionally involved*, (even though the suicide had happened over thirty years ago), he had *had some apprehension* about the interview. As he explains:

[I chose] not to focus too much on trying to recall it [prior to our interview]...

[I] hadn't wanted to re-live the suicide and be pre-occupied with it, "Oh my God, what is it, when was it, how did it happen?"..."Will I have any aftermath?"

For therapists who had worked particularly hard in the past to conceal their story, the interview process was extremely anxiety provoking. Dirk, for example, acknowledged that it had been a matter of *just wanting to get the interview over and done with* because of the emotional turmoil he had been experiencing in the two-week lead up, including *flashbacks and bizarre nightmares [about the two suicides]*.

Despite their initial trepidation, every therapist concluded their interview by stating that they had found it to be a very positive experience. Faith, for example, acknowledged that since *the suicide had been a very disempowering experience*, being able to tell her story had permitted her to feel like *she was being with it in a more empowering way, making plans, seeing possibilities*; whilst Aiden, who'd been *absolutely astounded at how the conversation had flowed*, concluded that the experience had been *pretty special*. Even Dirk, who had demonstrated the most angst (including *flashbacks and bizarre nightmares*) before being interviewed observed that being able to talk about his experiences *had been good* and had left him *feeling lighter*.

Other authors have noted the sense of risk, controversy and courageousness felt by survivors of suicide when they choose to openly acknowledge the death (see deKlerk 2007; Lewis 2004; Williams 2001). As Grad et al (2004) points out, the trepidation that accompanies the choice to be open rather than secretive, underscores the ongoing oppression and stigma still associated with death by this means.

Whilst the lack of opportunities afforded therapists prior to this study to talk about their client's death clearly reflects the isolation from mainstream culture that this stigma creates (Chin & Balon 2006), it was not just at the societal level that client suicide became an 'invisible loss' for therapists. Within their professional contexts, the negativity associated with this type of loss also meant that it remained a largely un-talkable experience for therapists who had experienced it. This dynamic, and its consequences, are explored in the following section.

Disenfranchisement through Derision: Censoring the "taboo" within the Profession

Whilst it might seem reasonable to assume that affiliation with a profession such as counselling (which espouses the need for such qualities as unconditional positive regard and non-judgemental acceptance amongst its members) should afford some degree of 'immunity' from the taboo-ness surrounding suicide, the data collected during this study suggests otherwise. In fact, the silencing already being felt at the societal level by the therapists interviewed was found to be further compounded by the messages, both explicit and implicit, being received at the professional level about the need to keep the experience of having had a client commit suicide under wraps.

The following statement by Faith not only illustrates this silencing but demonstrates that, in the face of such censorship, therapists ran the risk of believing that they must

have been the *only* person to ever have had a client suicide and that this indicated their inadequacy as a therapist:

At first [after the suicide] I thought, "I must be really bad because it doesn't happen to other [therapists]." I actually had no idea!

Holly, too, whose immediate response to the suicidal death of her client had been, "*Holy shit! This stuff really does happen!*" had *always been surprised that nobody else talked about [their clients'] suicides*. Whilst readily acknowledging that she *wouldn't have had any problems talking about it* with other therapists, she had felt unable to do so because of the secrecy surrounding this type of loss. As she explains:

Like, not even as therapists do we talk about it. It's taboo. The fact that we don't talk about the fact that we don't talk about it is taboo! I know therapists who've had clients commit suicide but they've never talked to me about it. It's obviously something that you don't talk about. You just don't talk about this stuff with people.

For Holly, the consequence of having experienced this censorship within the professional arena was that she had needed *to be careful not to bring it up* unless it had already been raised by somebody else. As she explains:

So it's almost like I look forward to someone bringing it up in the conversation. I look forward to the opportunity to talk about [Russell's suicide] 'cause it was such a trapped experience for me [in that] there weren't many places to talk about it and just process it a little bit.

The implicit rule identified by Holly of not bringing the suicide up unless it had already been raised by someone else was also strikingly apparent during an interaction

witnessed between Dirk and Susan. Despite having moved in the same professional and social circles for a number of years, both had been totally unaware of each other's experiences of client suicide until a mutual acquaintance had drawn attention to this fact during a social function. Only then were they able to acknowledge, for the first time, that they had both had a client die in this way.

Even in instances where therapists *did* choose to tell their colleagues that their client had committed suicide, these disclosures tended to be brief, perfunctory, one-off events, more resemblant of a psychological autopsy (a process found to be less than satisfactory by some past researchers (see Goldstein & Buongiorno 1984)), than an in-depth conversation about their personal experience of loss. In the aftermath of her client's suicide, Catherine, for example, had found herself *retracing what she had done [in relation to Barney] at a very superficial level in a sort of debrief* with a drug and alcohol nurse *who was quite objective*, whilst Elspeth *didn't go on and on about [the suicide] over the following weeks* with her work colleagues, since one of their husbands had *let it be known that he didn't want the whole evening spent 'talking shop'* when they met together socially.

Comments such as these illustrate the censoring experienced by therapists with regard to the loss-related narratives they were permitted to engage in. On the rare occasions when therapists were permitted to talk about their client's suicide, these conversations were 'external narratives' only - concrete, overt, sequentially presented accounts that might be expected and tolerated as part of a psychological autopsy, rather than 'internal' and 'reflexive' narratives (Angus, Levitt & Hardke 1999) that would have permitted therapists to describe and express their affective reactions and to reflect upon the suicide in an effort to make some sort of sense of the loss. As a result of this

censoring, the opportunity for meaning reconstruction, which Neimeyer (2001b) contends is central to the grieving process for the majority of mourners, was denied.

It was the very fact that this professional and personal censorship *does* exist that provided Faith with the impetus to speak, in an almost protest-like fashion, at a conference about her own experience of client suicide. As she explains:

I thought, "I'm not going to keep this a secret any longer. Everybody's keeping it a bloody secret!" ...No-one's talking about it but something's going on. What the hell is going on that no-one's talking about it? Only after it happened to me did a few [therapists] admit that something had happened to them. Some people came up to me after [my presentation] and spoke quietly and shared something of their experience [but] it [felt like] it was very secret.

Faith's conversation also reflects the rule identified earlier by Holly that therapists are only permitted to talk about their experience of client suicide if the topic has already been broached by another colleague, although, as Faith observes, the resultant talk must be *spoken quietly* and therefore remain shrouded in secrecy.

Even Faith, however, who had deliberately chosen to 'bite the bullet' and speak openly about her experiences, reached a point where the choice to continue to break the silence became too risky. In Faith's case, this occurred when she was asked to publish her presentation in the conference proceedings, an invitation she declined on the following grounds:

I didn't want to publish in the conference papers. I actually withdrew. It all felt too difficult. I felt I'd gone out and exposed myself in that public place where people could talk to me or respond or react [but] I actually didn't want it in

writing [as in that medium] you're not there to answer people's questions or to challenge their assumptions. You're left open to the whim of whatever they want to make it mean and it's not in your hands.

Furthermore, despite recognising that *it would [have been] a real healing process* to have accepted another therapist's recent invitation to co-author an article about their shared experience of client suicide, Faith acknowledged that her fear of being judged by others had meant that they had *never acted on it*.

The fact that Faith's automatic assumption was that her literary audience's response would be one in which she would have to justify her actions and defend her position clearly underscores the taboo-ness of this subject area and the huge risks that therapists felt they were taking by choosing to break the code of silence surrounding their experience of client suicide. In light of the above, it is hardly surprising that therapists who chose to share (rather than completely censor their stories of client suicide) did so only when they were able to retain a sense of ownership and control over how these stories would be perceived, received and understood by the listener.

But just how has the taboo-ness surrounding the experience of suicide and the invisibility this creates with regard to this type of loss managed to infiltrate the professional realm of therapy and why do its members perpetuate it? A closer look at the accounts of those interviewed goes some way towards answering these questions.

Disenfranchisement through Disapprobation: From Omnipotence to Impotence

Without question, there is a strong emphasis within the counselling profession that therapists be thoroughly educated about, and highly skilled in, suicide risk assessment and intervention. Whilst no training programme would claim to be able to prevent the occurrence of suicide, an assumption exists, nonetheless, that by gaining suicide

assessment and intervention skills, therapists are imbued with the knowledge, power and responsibility to save people's lives. The following comments by Dirk and Holly underscore this widely held belief:

Dirk: It's something that I get very angry about in our profession because we put ourselves up on a pedestal at a higher standard than basic humanity as if we're this all-knowing presence... What bullshit! [When I think about] some of the things that I've observed from my colleagues and myself with regard to our practices I go, "Fuck off. We're not all-knowing, we're human too."

Holly: As a therapist, people place so much responsibility in my lap. Some clients and sometimes even more the community expect that we have so much power and responsibility. [But] for me, in both those circumstances [of client suicide] there was clearly nothing really obvious that I could have done. And it's not my job to save somebody's life. I hope that I can give them reason to live and inspire and encourage them but I can't save people.

That such a glaring mismatch *does* exist between the omnipotence ascribed by others to therapists and the impotence that they were actually experiencing in the aftermath of their client's suicide had lead several therapists to consider ways in which this disparity might be ameliorated:

Faith: Not enough is said about what it's really like [being a therapist]. It's like we're always promoting the "ideal" and that comes out of

trying to be something we're not...The reason I said yes to your research was because it redresses the situation.

Whilst engaging in this study had been Faith's means of attempting to redress the situation, Dirk's efforts to rectify these misperceptions within the counsellor education programme in which he taught had proven less satisfactory. His following comments vividly highlight the negative backlash received whenever he attempted to challenge the gap that existed between the rhetoric of the training curriculum and the reality of practice:

The message that I try to get across to my students at the College is, "Move outside the bullshit scenario. [The curriculum's] what you're told but that's not the reality." [But] I'm often being pulled aside by the Admin. going, "You're not supposed to be saying that kind of thing!" Sometimes I go to the Educators' meetings and I do stir the shit a little bit because I want people to go, "Break down those barriers! Stop being full of hypocritical bullshit! Join the fray!" and I can see some of them chomping at the bit to join me but they're not game to [in case they lose their jobs].

Unfortunately, the cost to therapists of having to operate under the guise of this professional rhetoric was that they felt unable to talk about what was *actually* occurring in their day-to-day practice for fear of being judged as having acted unprofessionally or unethically. According to Dirk, this situation had become so untenable that he was now *not sure where the ethical standard was or what the reality was*. In his words:

I think to myself, “Well, what do I do? Do I take the party political line or do I go “Bullshit”?” And that’s mostly what I do. I live in my own little world and do what I think from an ethical perspective.

In addition to running the risk of shattering *other* people’s myths about therapists’ omnipotence by openly acknowledging their experience of client suicide, these therapists also faced the often painful challenge of having to rescind many of their own previously held convictions about their superiority, power and control. Susan’s assertion that *there’s a kind of arrogance that sometimes goes with our profession* is captured in the following words from Dirk who, prior to his clients’ suicides, had admitted that as a therapist *you do think yourself God-like [and that you’ve] got all this power!* It was only after his clients’ deaths that Dirk had finally had to acknowledge that *he couldn’t be all things to all people* and that he had actually *gotten arrogant [and] full of himself* in thinking that he *could save the world.*

In Faith’s case, the suicide of her client had *totally cracked open every illusion [she’d previously] had about herself being an efficient, effective counsellor.* As she acknowledges:

It was all a lie. What the death did, it connected [me] not only to the ‘perfectionist’ I alluded to be but also [I] got in touch with the imperfections of my actions. “I’m not always right, I’m wrong.”

The reduction or complete shattering of any previous sense of power or omnipotence held by these therapists in the face of their client’s suicide reflects the findings of previous research (see Berman 1995; Gitlin 1999; Kolodny 1979; Kleespies, Penk & Forsyth 1993; Takahashi 1997; Tanney 1995) and underscores Berman’s (1995:99) observation that once a therapist has experienced the suicidal death of a client, they

are ‘forever reminded of how little control they truly have over the lives and choices of their patients.’ Unfortunately, however, the fact that therapists who have not experienced the suicidal death of client may still be operating out of the narcissism and grandiosity that initially drew them into the profession (McWilliams 2004b) means that they are at risk of condemning the perceived shortcomings of their bereaved colleagues rather than supporting them (Smolin & Guinan 1993).

Disenfranchisement through Disrepute: Liability, Lawsuits and Litigation

Given the high degree of power and responsibility afforded therapists to save clients’ lives, admitting that your client had committed suicide *despite* the use of suicide risk assessments and interventions was to venture into dangerous territory, since not only did it challenge the dominant discourse about the preventative nature of implementing such measures but it also exacerbated therapists’ fears about being punished for having failed to keep their clients alive.

For over half the therapists interviewed, this feared punishment took the form of being sued by their client’s parents or other family members for negligence or incompetence. As Holly notes:

Most therapists don’t talk about their client’s suicide because of the shame and of feeling, “I may have been responsible or negligent in some way, may have missed something or didn’t do something properly.”

Dirk’s fear of being sued arose after a conversation with his client’s parents in which they had *made it pretty clear that in their minds [he] had let Jason down* and that Jason had hanged himself because of this. Not only did this fear escalate Dirk’s existing feelings of self-reproach at having been *one of those therapists who kills their*

clients, but the way in which he had responded to the parents had made the experience feel even more unacceptable and more unspeakable to him. As he explains:

I remember being very ashamed when the mother rang me up [to tell me Jason had committed suicide]. My first thought was, "Oh fuck! She's going to sue me!" And when I played it back in my head, every response to her was purely from the basis of self-protection professionally. [And] it didn't sit particularly well with me. I sort of went, "That's a bit pathetic. Here's a woman who's just buried her son, literally that day, and my only response was to think about me." [My job] is to connect with people on a more human level. I didn't think that was very human. Well, it is human but I thought that I was above that, putting purely my needs on that level.

Dirk's comment that he 'thought he was above all that' also underscores earlier discussions about the disenfranchisement that arises when therapists find themselves placed on *pedestals at a higher standard than basic humanity*.

So strong was the fear of litigation for two other therapists that they found themselves engaging in behaviours contrary to the norm in relation to the storage of their deceased clients' information:

Susan: [Although] I do keep files for interns, I destroyed that one. I didn't read it, I didn't look at it. I just threw it away because I didn't know how her father would take it...[Besides] it's not going to do that family any good to hear how much pain he caused her.

Elsbeth: We have had records subpoenaed [in the past]. I was anxious to protect the organization to the extent that when the Director said,

“Look, until we see the solicitor let’s just protect this woman’s case file and get it off the premises. Are you okay to take it home and file it there?” that I said “Alright.” And I’ve still got it [years after the death] and every now and again I see it and...think I should put it back in the ex-client records at work now where it needs to be.

Interestingly, whilst both Susan and Elspeth had felt justified in their decisions to make their clients’ files inaccessible, neither had openly discussed their actions within their wider collegial network. Given the ferocity of other therapists’ accusations during my conference presentation that Elspeth had breached the Code of Professional Ethics by removing her client’s files from her workplace, her original decision to keep both the loss of her client and her actions in relation to it to herself seems hardly surprising.

Fear that the suicidal death of their client would, in Holly’s words, *reflect badly on them as a therapist or person [and] put a black mark against them* was another significant factor in these therapists’ concerns about others finding out that their clients had killed themselves. Faith’s *worst fear*, for example, was that in light of her client’s suicide, people would conclude that, *“I’m not going to send anybody to her.”* As she explains:

Well, we don’t refer a plumber if they can’t fix things do we? It’s like in our commodities sort of way of thinking, everyone’s got to do the best job or be the best, that sort of stuff. So it doesn’t look like your best foot, you know? It could be a real liability. ...It’s like anyone who loses a client is a failure or something and I thought, “That’s not fair and it’s not real.”

Whilst other studies have drawn attention to the fear that therapists have in relation to being sued or blacklisted for having failed to prevent their client's death (see Berman 1995; Cryan, Kelly & McCaffrey 1995; Grad, Zavasnik & Groleger 1997; Hendin et al 2004; Kleespies, Smith & Becker 1990; Linke, Wojciak & Day 2002; Midence, Gregory & Stanley 1996; Sacks et al 1987; Tanney, 1995; Yousaf, Hawthorne & Sedgwick 2002; Valente 1994)) this study is the first to describe the consequence of this fear in terms of how it shapes therapists' subsequent professional behaviours. Unfortunately, however, as these accounts demonstrate, in an effort to avoid becoming ripe targets for litigation (Jobes & Berman 1993:91) several therapists found themselves becoming ripe targets for professional condemnation – an unenviable position for anyone to be put in.

Unarguably, the taboo nature of suicide in general, and client suicide more specifically, was a significant factor in creating the invisibility surrounding this type of loss for therapists. However, it was by no means the only one. The following section discusses two further factors which contributed to this invisibility - the limited (and limiting) way that suicide is currently conceptualised and defined within Western society; and the denial by others that a suicide had actually occurred.

Disenfranchisement through Definition: What Constitutes a Suicide?

As noted in Chapter 3, with few exceptions (Grad, Zavasnik & Groleger 1997; Reed 1998; Maple 2005; Maple et al 2007) the majority of the literature within the field of thanatology refers to suicide as being both *sudden* and *unexpected* (Ellis, Dickey & Jones 1998; Grad 1996). Whilst unarguably this definition proved accurate for some of the suicides described in this study (those of Josh, Simon, E.J. and Carl) it was, nonetheless, far from absolute. To the contrary, the *majority* of suicides discussed by

therapists did not conform to this widely accepted description about the nature of suicide.

With regard to the notion of suddenness, Jude's experience of Rose's death, which *took place over a very long period of time* after she had intentionally injected herself with her boyfriend's HIV-contaminated blood, was anything but sudden - a fact that left him struggling to adequately conceptualise his experience. Whilst initially referring to Rose's death as a *para-suicide*, Jude later revised his description to one of *suicide*, albeit a *'strange' one because it took so long*.

Murray, too, found himself considering *just how far you could stretch the definition of suicide*. In light of our conversation, and drawing upon his experience of his father's protracted illness, Murray was left wondering *whether someone could commit suicide simply by choosing [over a number of years] not to participate in life anymore*.

Whilst both Jude and Murray's stories challenge the notion of suicide as being a sudden event, it was in relation to the concept of unexpectedness, however, that this study's findings differed most significantly from the dominant discourse. An analysis of the therapists' narratives revealed that far from being unexpected, most of the suicides had been predicated with a sense of inevitability.

Since Holly, for example, believed that *with some people there's almost an inevitability [and] it's just a matter of time before they try and they succeed...it [had] really felt like [suicide] was the only answer, the only conclusion that could have ever happened* for her client. The following comments by Catherine, who had *known that something was building up, something was coming*, further illustrate the fact that, for many therapists, it was not a question of if their client would commit suicide, but when:

Life was really difficult for [Barney]. He was at the point of saying, “What have I achieved in my life? I haven’t achieved anything. My life is useless, futile.” I wouldn’t be surprised if he just gave up at that point. I think it’s highly possible that he thought, “Well, if this is the end then let it be.”

Maple et al’s (2007:132) observation that a discrepancy currently exists between the social discourse around suicide bereavement ‘which does not account for those preparing for the suicide death’ and the actual experience of the mourner (in which the death has been anticipated and expected) is borne out by these therapists’ accounts, further challenging the traditional conceptual framework upon which most bereavement research and literature is based. As these authors note, by continuing to use the traditional ‘unexpected death’ definition in relation to suicide, researchers have inadvertently restricted the spectrum along which suicide bereavement may be appreciated and understood. Their recommendation that ‘more fruitful conclusions are likely to be made by broadening the current comparative framework between suicide and other forms of sudden death to include suicide death that is expected’ (p. 133) is endorsed, wholeheartedly, by the findings of the current study.

Having lived with an ongoing sense of inevitability that their client would commit suicide one day, many therapists also found themselves feeling relieved when it finally did happen. This inevitability-relief dynamic is clearly highlighted in the following extracts:

Dirk: [Jason’s] life was pretty pointless and he had no future whatsoever... [I] had always considered suicide a huge possibility... I thought to myself, “You don’t have a future” so my relief was that it felt like he was released.

Holly: Of course [Russell] did it. That was the only answer for his life, the only possible resolution for him. I couldn't imagine him staying alive or any other outcome. So even to this day it almost feels like a resolution, like, you know what, that's the only option. His life was tragic and the ending must have been an ending to the tragedy for him. So that gave me some peace.

With the exception of a few studies (see Gitlin 1999; Takahashi 1997), little detailed research currently exists in relation to the experience of relief after client suicide. Within the general survivors of suicide literature, however, these findings support those of Maple (2005), whose interviews with parents whose children had committed suicide revealed that it was often met with a sense of relief in instances where the deceased's life had been fraught with chaos and turbulence. What sets the current study's findings apart though are the additional complexities, discussed below, that arise when the inevitability and relief occur within a professional relationship rather than a personal one.

As stated previously, a current assumption exists within professional and lay circles alike, that by undertaking training programmes in suicide risk assessment and intervention, therapists will be able to save people's lives. Little wonder then, that when working with certain suicidal clients, therapists found themselves in an absolute dilemma - caught between the expectations of having to remain professionally optimistic (by continuing to engage in therapeutic measures designed to save clients' lives) whilst actually believing (but being unable to overtly admit) that death was the most likely outcome. In light of this, acknowledging out loud one's sense of inevitability about a client's suicide became an inherently risky and taboo process,

particularly since, as both Rycroft (2005) and Szasz (2006) have noted, the medico-legal assumption that ‘life must be protected at all costs’, makes the act of suicide seem like a ‘quasi-crime’ (Szasz 2006:34).

Whilst admitting to a sense of inevitability about their client’s suicide was challenging enough, when coupled with a feeling of relief, therapists faced even greater difficulties voicing their experiences. Although Rando (1993) has highlighted the fact that a sense of relief following a death is often regarded within Western society as being permissible (or even expected) in instances where the deceased was viewed as a “valueless” individual within society (for example, because they were a sex offender, drug trafficker or murderer), the fact that the deaths discussed in this study not only involved individuals who were far from valueless but also occurred within a therapeutic context, left several of the study’s participants wrestling with the discomfort of how to interpret what their sense of relief might be saying about them as therapists.

For Holly, acknowledging that she had felt both a sense of inevitability and resolution in relation to Russell’s suicide had left her thinking “*Did I rationalise this?*” [and] *feeling icky, like [she’d] got off the hook*. In Dirk’s case, there had been an *inevitable guilt about feeling that way*, since doing so had left him questioning, “*Who the hell [was he] to be thinking that way?*” and that it was *pretty arrogant to think that it’s a relief to be dead*. Both Dirk and Holly’s statements illustrate the internal struggle that arose for therapists when their client’s suicide felt both inevitable and created a sense of relief, since each of these responses fell outside the currently permissible parameters of what it means to be a competent and caring therapist. These findings reflect observations by Elison and McGonigle (2003) within the generalist

bereavement literature that mourners who experience a mixture of sadness and relief are likely to feel quite disorientated by the internal conflict that this creates.

Even when their clients' suicides *did* conform to the dominant discourse, by being sudden and unexpected, therapists' stories remained equally as un-talkable. In these instances, therapists' accounts became silenced by their fear of being judged by others as having been professionally incompetent or negligent for having missed any early warning signs about their client's impending death. Aiden, for example, whilst firmly believing that *there had been no red flags or obvious warning signs* had nonetheless *gone through a stage of guilt after Carl had died, lying in bed at night till one o'clock, two o'clock, thinking, "What did I missed in that lead up time?"* However, because he had feared that *his credibility might be on the line* with the school's staff if he told them that he was *doubting his ability*, he had chosen to *contain [these feelings] whilst he was doing his job*, only allowing himself to become vulnerable once he no longer had to *maintain the professional role at school*.

Matt too had experienced feelings of both guilt and shame in the aftermath of his client's suicide, believing that it had been *his responsibility to look at what the risks involved were* (despite having received no training in suicide risk assessment at his clinic). In Matt's case, it had been his clinic's decision to *dismiss [the suicide] all together [because it] had exposed a raw nerve [about how the clinic] could obviously have done certain things differently* that had lead to the censorship of his feelings of guilt and shame.

In addition to having to hide their feelings of immense guilt about having possibly missed any early warning signs, therapists also had to suppress the turmoil they had experienced over whether or not they could have done something more to prevent the

death, fearing that such admissions might also be misconstrued as an indication of profession incompetence. Susan's statement that whilst, on the one-hand, she had believed that she *was not to blame* for her client's death, on the other-hand, she had still questioned whether or not she *could have done something different that would have saved her [client]* was typical of those heard throughout the study and reflects the real, yet unspeakable, agony that therapists experienced as they oscillated between periods of absolution and recrimination shortly after the suicide's occurrence.

Even Matt, whose deeply held conviction was that his client's death had been due to his clinic's *professional inadequacy*, had been unable to share this belief and its associated feelings because of the clinic's need to suppress the facts surrounding the case. As he explains:

[What the clinic] was trying to hide was like a cancer [with] the guilt eating away at them [about the fact that there had been no in-house training educational sessions...no measures put in place to check how you were going, what you were doing, evaluating what your outcomes were]. [Its decision to adopt] a false bravado [meant that] I had to go numb to survive. That was my defence. You know, feel nothing. I could have been a robot walking into work.

That therapists in this study agonised over being blamed or condemned for having potentially missed something or for not having done enough is to be expected given that both professionals and lay people alike view therapists whose clients have committed suicide as having been responsible for their death through professional negligence (Bailey, Kral & Dunham 1999; Jordan 2001). The feelings of isolation, guilt and fear of recrimination that this viewpoint evokes in therapists and the

'hesitancy to verbalise their grief and bereavement' (Valente & Saunders 2002:8) this creates, is graphically captured in the above accounts.

Despite initially questioning whether or not they had missed vital clues or had responded inappropriately, the overwhelming conclusion reached by the therapists interviewed, was that they had *not* been responsible for their client's choice to ultimately kill themselves. Matt's statement that he *was not his brother's Maker and therefore couldn't be responsible for Josh's life or for monitoring him twenty-four hours a day* reflects this widely held viewpoint, as do the following comments by Aiden and Elspeth:

Aiden: Yeah, I did go through that guilt to start with that was connected with the self-doubt [but] I've now reached a stage in my own understanding where I realise I can do only so much. I can try to look out for all the signs that I'm aware to look out for but in the end I can't be there twenty-four hours a day and I'm okay with that.

Elspeth: It's the realisation of, look, I didn't cause the problem. I didn't do anything wrong. It's not mine to fix. It's not mine to own. I can only be here for them and use whatever skills I have to try and open up some windows for them where they might be able to perceive that there is some hope of change...I can't solve everything. I can't rescue everyone.

This sense of only being able to do so much is also captured in Murray's reflections:

No matter what safety measures you put in place, if someone decides, either on the spur of the moment or through long and despairing reflection that they're going to do it, then they'll do it. [I think Simon would have said] that it wasn't the therapist's fault or the therapy process [that he'd committed suicide], it was something that he took upon himself, that took him outside that, that the decision existed outside of therapy.

The majority of therapists interviewed did, in fact, reiterate Murray's belief that ultimately it was the client who chose whether to live or die and that this choice was separate to the therapeutic process that they had engaged in. Holly, for example, stated that she *respected both of [her] clients' rights to do what they did and felt like it had been no reflection on [her] as a person or as a therapist*, whilst Dirk acknowledged that *people make their own decisions and this [suicide] was what Jason had decided to do*.

In light of the above, it is tempting to be reassured by the previous findings of Trimble, Jackson and Harvey (2000), that by accepting the possibility of suicide as an outcome and believing that they were not responsible for their client's death, therapists were employing two of the most beneficial strategies available to reduce their risk of experiencing high degrees of distress. Such findings, coupled with the argument by Horn (1994) and Hendin et al (2004), that therapists whose schemas place the responsibility for the suicide squarely with the client fair better emotionally than those who engage in self-blame, would certainly suggest that the therapists in this study were able to minimise the emotional impact of the suicide upon them by engaging in such constructive thinking. Unfortunately, however, even when therapists firmly believed that they, *"Couldn't be responsible for [their client's life]"*, *"Could*

only do so much”, “*Couldn’t solve everything [or] rescue everyone*” and “*Couldn’t have done more than [they] did*”, these convictions remained difficult to voice for a number of reasons.

Firstly, despite being able to absolve themselves from feeling responsible for their client’s death, many therapists remained haunted, nonetheless, by the spectre of what others may have thought. The following statement from Holly, *who had never felt like [she] didn’t do good work*, readily captures this widely held fear:

[I] never felt responsible for [Russell’s suicide] but felt that others might think that I was.

Secondly, by admitting their beliefs to others, therapists further exposed and challenged the previously discussed myths about the capacity of suicide training to save people’s lives and therapists’ omnipotence in relation to this.

And thirdly, if, as these therapists believed:

- a) Suicide training cannot prevent suicide from occurring.
- b) Therapists are not omnipotent.
- c) It is the client, not the therapist, who is ultimately responsible for the choice of whether to live or die.

a more fundamental question about therapy per se might emerge, namely, “What was the point of engaging in it?”

The following comments by Murray and Susan not only highlight how, in the aftermath of a client’s suicide, this highly controversial question became pertinent for

therapists, but also the Pandora's box that risked being opened should such a question be raised within their wider professional or personal contexts:

Murray: That therapy doesn't do anything that can save them leaves me with a profound sense of helplessness and [an awareness of] the limitations of human relationships at certain points, including the therapeutic one...[So why therapy?] I suppose the only comment I can say is that it was worth a shot.

Susan: Well, [my client] didn't want to [ring me when she was highly suicidal] and that was her choice. And if it was just too hard or too painful, then I can't be responsible for that. [But it raises] an interesting therapeutic question [for which I have] no answers, "Is everyone saveable in terms of being able to heal themselves?"

Clearly then, whilst a therapist's personal schemas about their inability to save people's lives and their lack of responsibility for their client's death may have been a potentially constructive strategy to employ, the fact that the broader social schemas in which they worked vehemently opposed them, meant that this strategy's effectiveness was markedly reduced.

It is evident from the above that therapists found themselves faced with a number of unacceptable stories in relation to their client's suicide. The first, admitting that you believed that there had been no other option for your client but to kill themselves (and that this had been a relief for you) was certainly taboo. As Elison and McGonigle (2003:127-128) have noted, 'relieved griever are denied the remedy that works best: telling and retelling their stories...To be a relieved griever is to be the keeper of secrets – a lonely place.' Equally as damning, however, was to admit that there might

have been other options had you not missed the potential early warning signs and been more pro-actively involved in instigating preventive measures. Finally, if the bottom line was that your client truly wanted to kill themselves, and there was absolutely nothing that could be done therapeutically to prevent this from occurring, was it enough for therapy to become just '*worth a shot*' in the end?

Disenfranchisement through Denial: But It Really Wasn't a Suicide...

Interestingly though, irrespective of whether their client's suicide was sudden or protracted, unexpected or inevitable, filled with, or devoid of, a sense of relief, therapists' opportunities to openly acknowledge its occurrence were also influenced by how others chose to define the cause of death.

The lack of an official finding of suicide in the case of Barney's death, for example, had meant that Catherine had initially wondered if she was actually eligible to participate in my research. Even though *she* had firmly believed that Barney had chosen to end his life, the fact that no coronial proof existed to back this up, had left her continually questioning the legitimacy of both her experience and her story in relation to it.

It was not just the absence of coronial confirmation, however, that denied therapists the right to openly acknowledge their experience of having had a client commit suicide. The way in which their client's family had conceptualised the death also impacted upon their story-telling abilities. For example, whilst the death of one of Murray's clients in *a single vehicle accident on a stretch of road that he'd driven a hundred times before* had left him in little doubt that this client had committed suicide, *the fact that the family didn't believe it was anything other than a tragic accident*, meant that Murray had felt obliged to also acknowledge it as such.

Similarly for Faith, the need of her client's parents to regard his death as *an accident* (rather than a suicide through an intentional drug overdose) left her questioning her own reality and thinking that she *might be making something up or overdramatising*.

In her words:

They were finding a lot of other reasons for why [the suicide] could have been. I think that being the very religious people that they were, that it was very difficult for them to admit that it was a suicide. [So] I thought, "Maybe I was wrong, maybe it was something else?" ... It created a bit of a ripple for me that the parents never said it was a suicide, never. It was always something else.

Susan too, had found herself struggling to validate in her own mind that her client's death *had* been due to suicide since the client's father was *holding onto the belief that [his daughter] was actually murdered rather than committing suicide*. As Susan acknowledged, whilst she *didn't actually believe this, [her] level of doubt [was] further raised* during the ensuing inquest because the police had already destroyed the evidence *as everyone had just assumed it was a suicide*.

That therapists experienced having the truth of their story about how their client had died denied by their clients' family is hardly surprising given the wealth of literature indicating that family members commonly disguise this type of death in more socially acceptable terms (Mehrabian 2005; Valente & Saunders 2002; van der Wal, 1989; Worden 2001). What is surprising, however, is that even in instances where family members knew that their son, daughter or partner was consulting a therapist and was possibly suicidal, they *still* chose to deny the truth about the cause of the death and, in doing so, denied the opportunity for a shared story to emerge in one of the few arenas where this may actually have been possible.

Reflections on Plotline One: Invisible Losses

It is evident from the above, that the first characteristic of disenfranchised grief, that ‘the loss is *not openly acknowledged*’ (Doka 1989 quoted in Martin & Doka 2000:13) operated on a number of levels within these therapists’ collective stories.

At both the broader societal level and within their professional spheres, therapists’ narratives in relation to client suicide were denied or excluded because of the taboo-ness associated with this type of loss; the unwillingness of others to acknowledge that a suicide had actually occurred; and the narrowness of the current definition of suicide (sudden and unexpected) which fails to accommodate the type of suicide encountered by the majority of therapists interviewed (inevitable and sometimes slow). When ‘inevitable’ suicides were also met with a sense of relief, these stories became even less visible, since they felt outside the norm of acceptable conversations to be having in relation to the deceased.

In instances where their experience did fit within the dominant discourse (that is, when the suicide was sudden and expected), therapists were still unable to talk about their loss for fear of being blamed or sued for having missed something or responding inappropriately. Furthermore, since it is the desire to save people’s lives that entices some individuals into therapeutic practice in the first place, de-bunking this myth by lifting the lid on the *reality* of client suicide became a very risky proposition for those faced with such a loss.

Unfortunately, however, even when therapists’ stories were cast within the broadest and most inclusive framework for conceptualising and contextualising mourning, that of meaning reconstruction, the dominant discourses operating within their personal

and professional lives continued to impact profoundly upon what therapists felt able to share about the loss and the how this storytelling process took place.

In light of the above, the results of this study confirm Sudak, Maxim and Carpenter's (2008) observation that, despite some arenas becoming less stigmatised over time, the stigma attached to having been the therapist of a client who committed suicide, remains as unacceptable and unspeakable as ever – a fact which perpetuates the muffling, if not the complete muting of therapists' loss-related narratives.

Having now explored the ways in which therapists' experiences of client suicide become 'invisible losses', the following chapter examines the second core theme identified in the research, the 'invisible relationship' that exists between therapist and client, both pre- and post- suicide, and the impact that this has upon therapist bereavement.

Chapter 8

Plotline Two: Invisible Relationships

This chapter explores the second of the three core themes therapists used to narrate their experience of disenfranchisement in relation to the suicidal death of their client. This core theme, ‘invisible relationships’, encapsulates the second characteristic of disenfranchisement described by Doka (1989 quoted in Martin and Doka 2000:13), that ‘the loss experience is *not socially sanctioned*.’ As the subsequent discussion will demonstrate, the cost to therapists of having the significance of their therapeutic relationship with the client unacknowledged by others was that avenues of support within both their personal and professional arenas remained limited, if available at all.

As a review of the literature has illustrated, there are many instances of loss where the loss experience becomes disenfranchised because the relationship in which it has occurred is not openly acknowledged and therefore not ‘socially sanctioned’ - for example, homosexual partnerships (Hart 2001; Martin & Doka 2000); extra-marital affairs and remarriage of a former spouse (Doka 1995). Whilst the lack of social sanctioning revealed in this study was *not* due primarily to the relationship being disapproved of, although some would argue that needing to see a therapist remains a taboo subject in many quarters (Roufeil & Lipzker 2007; McGovern & Hodgins 2007), a lack of acknowledgement was present nonetheless. This was fuelled by both the rules and regulations operating within the *context* in which the loss had occurred and the *type* of loss experienced (that is, death by suicide). These two factors, and the unacknowledged (and un-acknowledgeable) relationship they created between client and therapist, are explored in greater detail below.

Disenfranchisement through Delineation: Codes, Confidentiality and Concealment

Without question, the relationship between therapist and client is an inherently invisible one due to the strict codes of ethics relating to confidentiality and boundaries that surround it (Hodelet & Hughson 2001; McWilliams 2004b; Zur 2005). Dirk's assertion that *if you build a therapeutic relationship with somebody in your room then that's the therapeutic relationship and when you take it outside of that it changes the dynamics...[and creates] ethical problems*, underscores the clear proximal and relational delineations that these codes demand.

Given that such codes are designed to protect the safety and rights of both the client and therapist by stipulating what constitutes appropriate professional conduct, in the face of their client's death, therapists struggled with how to 'legitimise' the fact that they were having a very personal response to a professionally-related loss. The following dialogue from Catherine is typical of that heard during the study, and illustrates not only the internal struggle that therapists found themselves engaged in as they tried to reconcile the fact that they were being personally impacted by a loss within a professional relationship but also their fear about how this might be perceived by others. As Catherine's notes:

[Because I knew I was] not meant to have anything but a therapeutic relationship with this client... it was about sorting out, "This is not a relationship." However a therapeutic relationship can be a deep relationship, especially if it's a person I care about. My fear was that if I got upset about my client, would people think that I was fond of him? Would they understand that depth? Is one supposed to cry over a client? I mean, they are a client...And what about the confidentiality issues and the questions?

Catherine's conversation highlights one of the central tenets that the codes of professional conduct currently espouse, that to maintain clear, professional client-counsellor boundaries, therapists must remain devoid of any personal connection with, or personal feelings towards, their client and that should any personal connections or feelings arise, these are indicative of a breach of professional ethics (Cleret 2005; Lewis 2004).

The fear of being seen to have breached the profession's codes of ethics by making both the relationship and the impact of its loss a personalised experience was also identified by Holly who, in the following extract, highlights the limits that these codes also placed upon therapists' capacities to discuss their experiences in the broader, non-professional context. As Holly, who had had felt *unable to share* her story explains:

If it had been a personal friend [who had suicided] it would have been very easy to go and talk to everybody about it, to process it easily. [But] because it's part of my professional life, there's not a lot of opportunities to do that. I did mention it to a few key people but I didn't feel like I had the same ability to go into depth with it [as I would have] had it been somebody [other than a client].

Even Susan, who *didn't hold the view that she needed to be really rigid about the boundary between the personal and professional* was not immune from having to try and determine under what circumstances it would be justifiable to be impacted by the loss of a professionally-based, as opposed to a personally-based, relationship. However, as the following extract illustrates, the conditions under which this might be considered appropriate came with stringent caveats attached:

I think that when you lose somebody, well I suppose even with a client, if you were in the middle of work and were expecting to keep seeing them, it's like a void, a gap.

The only therapist not to have any qualms about openly acknowledging the impact that the loss of his client had had upon him was Jude, whose beliefs about therapy and the therapist's role, least resembled the codes of ethics' guidelines. As Jude explains, because his *model of working [with clients] was a transformative model [meaning that] he didn't [have to] stay in the model for the sake of staying in the model*, in the aftermath of Rose's death, he had had absolutely no compunction about sharing his loss experience with others since the model's multi-dimensional and highly visible nature meant that others already had *had a very strong sense of how significant this [loss] was* for him.

Unarguably then, having to operate within the stringent guidelines set out by their codes of ethics meant that therapists' relationships with their clients (and their stories relating to the subsequent loss of these relationships) became "Claytons" relationships – relationships you had when you weren't having a relationship. As both Schank and Skovolt (1997) and McWilliams (2004b) have attested, it is the 'greyness' in the current codes of professional conduct that leave therapists having to second guess about the ethics and appropriateness of their behaviour. The fear of guessing incorrectly, and being seen to have breached these codes and boundaries, cannot help, therefore, but leave therapists reticent to discuss their experiences.

In addition to, or perhaps as a result of, their inability to openly acknowledge the existence of these relationships, therapists also found themselves having to battle the invisibility that arose from the complete lack of acknowledgement by others of these

relationships (and the significance of their loss for the therapists involved). This dynamic, and its ramifications for therapists, is examined below.

Disenfranchisement through Delay: Hearing About the Death

Whilst Doka (1995) contends that there *are* instances where the significance of the relationship between professionals and their clients is acknowledged, with the exception of Jude, there was little evidence of such acknowledgement in this study. In fact, the lack of legitimisation afforded to the therapeutic relationship by others became strikingly apparent for many of this study's participants immediately after their client's suicide when they found themselves left off the family's list of people to notify about the death. Because of this omission, many therapists learnt about their client's suicide almost surreptitiously, accidentally stumbling across the information in the course of their daily life.

Elspeth, for example, whose client's family *didn't make contact or anything like that*, had only found out about the suicide when she had *looked in the local newspaper and there was her death notice*. The fact that when she had later rung the psychiatric nurse (who had also been involved in the case) to tell him what had happened, he had responded, *"Yes, I already know"*, left Elspeth feeling even more discounted and disenfranchised. Catherine too received her first information about her client's death, not from a family member, but because she happened to have been *listening to the local news, [had] heard that there'd been a death from a fire in a flat and [had] just sort of thought, "Ooh, I wonder if it could have been him?"*

Due to their lack of inclusion in the family's list of people to notify, it was only through engaging in their own detective work that these therapists were able to piece together at least some of the facts surrounding their clients' deaths. In Catherine's

case, having heard the news bulletin about the death of a man in a fire, she had taken it upon herself to ring the police who had then *confirmed that it was [Barney]*. As Catherine acknowledged, whilst she had *virtually worked out that it was him [she had]* still needed some sort of confirmation that it had happened.

Even after having had their clients' deaths confirmed by an outside source, therapists needed to remain firmly within their instigator role if they wished to receive further information. It was only through sheer persistence, by *keeping in touch with the woman and the police*, that Catherine, for example, had *found out that they were doing an autopsy, when the funeral was and that the relatives would be out from overseas* for it.

Furthermore, had they not taken the initiative to pursue further details about their clients' suicides, this anonymity would, they believed, have proven costly, post-death, in terms of their grieving processes. As Catherine explains:

Keeping in touch [with others who had information about the death] was about some sense of working towards a closure because [in the absence of this information] it didn't feel like things were closed.

That an inordinate amount of time, effort and detective work was often required on the therapist's part if they wished to receive information about the suicide has not previously been acknowledged in the literature. The results of the current study provide new insights, therefore, into previously unexplored ways in which the anonymity required within the therapeutic relationship may impact upon therapists in the immediate aftermath of their client's suicide.

Even therapists who *had* been informed by a family member about the death often experienced a time lag between the actual event and their notification of it. Whilst for some therapists, like Dirk, this period had “only” been a *couple of days*, for others, the period of not knowing had stretched over several months. As Susan recalls:

And I didn't even know [about his death] until his wife rang me [months later]. She came and had one session with me. She was just wanting to kind of join with me in recognising how damaged he was.

In Elspeth's case, it was to be *six months* before she received the news of her first client's suicide. Prior to this, Elspeth had had to live with the uncertainty of whether the story she had heard a month after her client's final session, (*that there'd been this suicide, this guy had put a nail gun through his head*), had related to him. Whilst admitting that she had *wondered if it [had been] this man, no names [had been] mentioned*, so she had had no way of really knowing. Like Susan, however, news of the death had eventually been provided to her, not because she had been his therapist (and was therefore someone who needed to be notified) but because his wife had decided to come *back for grief counselling* and had disclosed the suicide as part of *her* therapy.

The experience of being left in a state of not knowing after their client's suicide is also vividly highlighted in the following extract from Murray's story, who, like Susan and Elspeth, had only been contacted by a family member because they had required his professional services in relation to their own grief responses. In the following dialogue, Murray describes how, prior to the follow-up session with his client's wife, he had been left wondering about the period of time between his final session with his client and his client's death:

[There's] a missing part of the narrative of the last week or so of his life, and how our conversations prior to that last week related to what happened, if at all, during those last few days...I actually don't know how he was construing his life and his experiences at that point. It's like my story, my involvement came to an abrupt end and then there was another chapter that I wasn't part of...I was outside the loop at that time.

For Murray, being *outside the loop* and in a state of not knowing had left him *going back in [his] mind, over and over again...wondering about the experience [his client] had endured at the end*, a dynamic, as will subsequently be discussed, that therapists who remained within the loop were largely able to avoid.

For therapists like Elspeth, Murray and Susan, having been left *outside the loop* for weeks or even months after the death, meant that in instances when other clients had failed to keep their appointments, they were left wondering if they too had committed suicide (and that no-one had thought to inform them). Elspeth, for example, had had a number of *very suicidal clients who had just disappeared [leaving her to wonder] "Did they go and do it?"* The powerlessness and sense of not knowing that this had created for her is captured in the following disclosure:

I saw [a woman] once or twice after her [suicidal] incident and then nothing. So I don't know what happened to her. I tried ringing her home a number of times but there was no answer and eventually it was cut off. So there was really nothing I could do to find out.

Accounts such as these contain many of the attributes associated with the experience of 'ambiguous loss' (Boss 1999). For these therapists, like others facing such situations, the ongoing psychological presence (but physical absence) of the 'unfound'

individual, (in this case, their client), oft times resulted in ruminations and information seeking about, what might have happened (Beder 2002). Whilst the literature acknowledges that such losses can prolong, complicate, impede and disenfranchise the grieving process due to the lack of meaning-making opportunities that they afford (Betz & Thorngren 2006); the lack of language available to discuss them (Betz & Thorngren 2006); and the lack of existence of potential support networks and rituals for mourning (Rycroft & Perlesz 2001); to date, the focus has been solely upon the experiences of families of missing persons. The results of this study necessitate the broadening of the parameters of the missing person experience to include therapists struggling with the ambiguous loss of their client. Recommendations for assisting therapists negotiate these unacknowledged and under-researched experiences are contained in Chapter 10.

Whilst learning about their client's death via a family member proved to be a disenfranchising experience, those who received the news within their professional contexts (where presumably their professional roles and obligations and the need to maintain confidentiality were less compromised) fared little better, with many expressing dissatisfaction with both the way in which this news had been imparted and the degree of detail given.

The news of Matt's client's death, for example, was broken to him impersonally through a clinical report circulated to all staff members the morning after the death whilst information regarding Simon's suicide was offered to Murray as little more than a by-line during a conversation with a colleague:

One of my colleagues told me and I don't think realised in the moment of sharing, the depth of interaction or relationship that I'd had with him. So that's when I was brought into the loop of information.

Unfortunately, few references have been made within the literature with regard to the negative ways in which therapists might receive the news of their client's death. With the exception of Knox et al (2006), who state that supervisors who choose to leave messages on their supervisees' answering machines must be considered to be callous and non-empathic, this study is one of the first to explore this disenfranchising element of the experience of client suicide.

It is apparent from the above accounts that the lack of recognition afforded to the therapeutic relationship by others meant that, in the event of their client's suicide, therapists found themselves either being left *out of the loop of information* completely; included in it only if a family member wished to procure their services in relation to their own grief responses; or being given minimal clinical details that were pertinent to the case by their colleagues. Given that such responses only served to perpetuate the current expectation that therapists be devoid of any personal attachment or feelings towards their clients, it is hardly surprising that their stories about the significance of these invisible relationships (and the impact of their loss upon them) also remained invisible.

However, whilst both lay and professional people alike may have assumed that therapists were neither personally invested in, nor affected by, their therapeutic relationships (and therefore didn't warrant inclusion *within the loop* in the event of their client's death), this was far from being the case. As the following extracts illustrate, when describing their relationships with their clients, therapists consistently

used key words such as *connection, attachment, investment, care and sharing* to underscore their importance:

Faith: I had felt such a sense of connection with this person...

Holly: I think a lot of [my sense of connection and attachment to my client] had to do with the relationship and how invested I felt [in it]...I didn't necessarily enjoy working with Russell but I worked really hard. I felt it was really important and I felt for him.

Susan: I had a lot of compassion for E.J....really cared about her...[we'd] built quite a strong relationship [over the period of time we'd been working together].

The following extract from Catherine also illustrates the reciprocal nature of this relationship:

Catherine: [My grieving was about] the loss of the depth of the trust and understanding and the sharing of personal things [with him], the little bits and pieces of my life.

The immense loss felt by therapists about not having had the significance of their therapeutic relationships with the deceased acknowledged is perhaps most poignantly captured in the following dialogue, also from Catherine's story. Here she acknowledges how, at her client's funeral, being unable to talk openly about their relationship had felt like a missed opportunity – not only for her (with regard to having others validate the uniqueness and legitimacy of their relationship) but also for those present (in terms of how she could have helped them get to know him better):

And I felt as his therapist I knew some of his really deep, inner sort of...excuse me getting teary...so I felt quite unique at that service in terms of knowing him.

It is clear from the above, that the lack of acknowledgement afforded to the therapeutic relationship meant that therapists struggled to have the significance of its loss recognised and legitimised by others. Having been omitted from being personally notified about the death, funeral arrangements and the like, therapists also struggled to find suitable networks of support within their professional and personal arenas in which their grief could be shared. The sense of isolation this created for therapists, and the need for them to be exceptionally pro-active if they wished to receive support, is explored in greater detail below.

Disenfranchisement through Disregard: Who Cares About the Carer?

As numerous authors (see Ashby 2005; Charles-Edwards 2000; Miller 1998; Wolfelt, 2005) have noted, the organization in which a therapist is employed may impact significantly upon the ways in which their grief may be expressed. This was certainly the case for Matt, Catherine and Jude, employed within the health system where attitudes such as “*Only the strong survive*”, “*Crying is a sign of weakness*” and “*Blokes talking about their feelings [are] poofter bastards [who need to] just get on with it*” were rampant.

Matt’s *underlying fear*, for example, was that if he *dropped the false bravado* and revealed how vulnerable he was actually feeling that his work colleagues *would think he was a bloody sissy, a weak person*. The following extract reflects the internal battle he found himself engaging in because of the *defences and pretences [and] dismissive attitudes* his workmates adopted after the suicide of his client:

You know, [I ended up thinking] “Why can’t I maintain the façade like the other fellas, like my mates seem to have? Why can’t I be dismissive? Is there something wrong with me?” So they made me think, “Wow! Are you supposed to be so insensitive that you can’t even feel?”

Whilst Matt had put his work colleagues’ attitudes and responses down to the fact that his client’s suicide had occurred over three decades ago (when we *didn’t have in-house debriefing sessions, clinical support or supervision like we have these days*), an examination of the other therapists’ more recent experiences of client suicide revealed very little has changed with regard to workplace attitudes towards grief and mourning.

Catherine, for example, described how she had *tried to pull herself up from getting upset over the death of a client* because in her *tough work context there had been no-one really to talk about it with as there was a lack of understanding [and an] inability to empathise at her level*. As she explains:

In the last couple of weeks we’ve had a couple of deaths of clients and I’m actually part of the Root Cause Analysis meetings...you know, do little boxes and flow charts of the procedures that were in place and could be better assessed. And I had to talk to the caseworker, “How do you feel about it?” Totally emotionless. And here I am, my experience of having a client who’s died...and I think, “How can she be so callous and so unfeeling?” And she made a joke about the dead person in public, in a meeting about the relatives...So I feel really justified in not having shared the stuff about my client with these people because a lot of them are narcissists and they’re so cold. And it does make me feel like a bit of a loner...

[And] it raises the question, “Who can a psychologist go and talk with about something that is not going to impact on work, not going to make me look like a weak person because I’m upset? And what about the confidentiality issues?”
[So in the end I decided], if I’m going to have a cry, I’ll have to cry alone.

The accounts of these therapists underscore Walter’s (1999) notion of ‘policing grief’ and Doka’s (1995) ‘grieving rules’ which are imposed by the broader social context to regulate a mourner’s grief to levels deemed acceptable and permissible. As previously noted by Iacovini (1993:66), however, the ‘unconscious conspiracy of silence about feelings’ that exists within many organizations because of such rules, often leads to the experience of ‘stifled grief’ (Ashby 2005) – a dynamic graphically illustrated by these therapists’ stories. As a result, not only were therapists left struggling to decipher just which grief reactions, if any, were deemed appropriate within their work contexts, but they were often forced to mourn, unsupported and invisibly, whilst continuing to engage in their work-related roles.

In addition to experiencing negative attitudes towards their expression of grief, therapists also encountered a deadline for grieving mentality within their workplaces that further inhibited their access to ongoing support and understanding. As Matt notes:

The health system has got a lot to answer for. It espouses care and concern but it never practices it with its own people. Nobody comes around in a caring way to find out and say, “How are you going?” or “Is there something else we need to do?” Nothing happens and it’s one my many disillusionments with the system. We talk about care but do we practice care? [It’s like case closed] move on guys, there’s more work to be done so just get on with it.

The fact that Matt's organization adopted a case closed, move on attitude meant that he was also not given the opportunity to meet with his client's family so that he could say, "*Hey, I'm sorry, give us a hug. How do you feel?*" For Matt, not only *would that have been of benefit for their healing process but for [his] too [as it would have helped him] come to terms with the fact that [he] could still help the living who were a part of his life.*

Even Jude, who had worked exceptionally hard to establish and maintain support networks in which his grief could be witnessed and validated, was not completely immune from external pressure to just get on with it. When referring to the hospital staff who had also been involved with his client, Jude noted that *their contact had ceased abruptly [after her death]* leading him to observe that:

One of the ironic things about the health system is that once a person is dead, it immediately changes. They wrap up the body, send it off to another department and close the file instantly. They don't really want to talk about it anymore and I'm the one who follows the body to the parents. You know, she's no longer causing difficulty and they don't seem to care anymore. And that's got its own tiredness and sadness about it.

The lack of organisational sensitivity (Eyetsemitan 1998) and use of 'tokenistic gestures' (Ashby 2005) described in the literature is glaringly apparent in these therapists' stories. Through the prioritisation of litigation-resistant file maintenance, medicolegal investigations and client caseloads over the provision of opportunities for the expression of grief, it is clear that the organizations in which these therapists worked amplified the disenfranchisement already being experienced within their wider social contexts.

Whilst it might be assumed that freedom from organisationally imposed stereotypes and expectations such as the above would afford therapists in independent practice greater scope for the expression of their grief in a supportive environment, this was not found to be the case.

Murray, for example, who had worked as a therapist in private practice for several decades, stated that it was the very fact that previous encounters in his professional life had left him *with reasons to be suspicious of people's capacities to offer the degree of... support and willingness to enquire because they really want to understand* that he had chosen to *largely shelve [Simon's suicide] and kept it to [himself]*.

The sense of being shunned rather than supported in instances of suicide has been well documented within the literature (see Courtney & Stephens 2001; Smolin & Guinan 1993; Ping Tsao, Tummal & Weiss Roberts 2008), particularly in instances where the mourner's relationship with the deceased has been a hidden one (Sudak, Maxim & Carpenter 2008). The feelings of professional, personal and emotional isolation described by participants in this study mirror those reported in earlier studies by Hendin et al (2000), Kozłowska et al (1997) and Pilkinton and Etkin (2003), where therapists also failed to receive the post-suicide care they required.

The 'get over and get on with it' attitude espoused within these therapists' work environments clearly reflects the phases/stages and tasks models of grieving which view breaking the attachment with the deceased as 'healthy' to the grief resolution process. Unfortunately, however, because the imposition of this framework endorses grief-related narratives of separateness, those which reflect a desire to continue to grieve for and renegotiate the loss of their relationship with the deceased run the risk

of being viewed as 'pathological'. Thus, comments such as Catherine's, about having continuing *little memories or thoughts* about her client, and Jude's, that he *starts to re-form [his] relationship with that person [post-suicide] in a very different way [through a] process [within him that] doesn't stop*, are likely to remain unspeakable and unendorsed in workplaces which have failed to embrace more phenomenological and flexible continuing bonds frameworks (Klass, Silverman & Nickman 1996; Stroebe, Schut & Stroebe 1998) in which 'permission for the bereaved to find a place for their dead' (Walter 1999:106) has not been given.

In order to minimise their experience of 'social helplessness' (Grad et al 2004) and disenfranchisement, therapists in this study needed to be prepared to invest a great deal of their own time and energy if they wished to create a support network that actually met their needs. Jude, for example, having been informed by *a lot of experience with crises and a reasonably strong sense of what he needed*, had executed a high degree of intentionality in crafting his *matrix of support* over the years. As he explains:

I'm a very strong believer in having things structured and unstructured, supportive, formal, informal structures around you... I think getting the support for me is my responsibility and I've worked really hard carving out a structure for myself that I know works for me. I think it's the wrong time to think about support in the middle of a crisis, it needs to be practised. I definitely don't leave it to chance.

In Matt's case, having gotten to the point of recognising that *[the drinking, drug taking and false bravado] was not getting [his colleagues or him] anywhere [and that] there must be healthier ways of dealing with [the suicide]*, he had taken it upon

himself to speak with the psychiatrist-in-charge about the need to implement more formal support mechanisms within the workplace. The group sessions which were subsequently arranged, however, whilst initially designed to help staff members *work on the personal stuff so that [they'd] be comfortable with [themselves] and not blame themselves*, only served to highlight the diametrically opposing responses that already existed in relation to the suicide. With regard to receiving individual support, Matt again found the onus of responsibility placed squarely upon his shoulders to approach his supervisor. However, given his unsupportive work context, he had felt the need to *quietly go away* to do this.

Therapists who *did* receive support within their workplace tended to gain it from colleagues who worked alongside them and who were able to provide gentle, ongoing encouragement, not only in relation to the suicide itself but also with regard to their professional competence and capabilities. Matt, for example, *looked towards two workmates for support and strength*:

[Not only because] they were not overly trying to prove a point [about needing to be macho] but also because when they ran groups, one or the other would be there to give the support and to give a nudge if you were full on in your thoughts and looking very distant. You know, "come back here", that kind of stuff, which was good.

Faith too found her *closest confidante all the way through* to be a colleague who was *absolutely wonderful*:

She's my co-worker and I needed to keep that relationship free of her being my supervisor. So I didn't get any supervision from her as such but we walked through it together. She just allowed me to be who, whatever I was, over and

over again. She listened and she comforted me. She kept reminding me of my qualities because in that black space I couldn't see anything good. She kept coaching me when we did teaching together, saying, "That was a brilliant lesson you gave." It was everyday, on the spot, moment by moment whenever we worked together.

In Jude's case, his staff's response, which was *always really good*, had been to just *pop their heads in occasionally and say, "Let's look in your diary, what can we get out of the way?" and "Who can we ring for you?"* Jude had also engaged in a reciprocal de-briefing process with his client's doctor, *one day it was her turn to be upset and the next day it was [his], stuff like that over a meal and red wine*, which had also proven to be highly beneficial.

That therapists turn to colleagues for support in the face of their client's suicide has been observed by numerous previous researchers (see Alexander 1991; Alexander et al 2000; Berman 1995; Brown 1987; Chemtob et al 1988; Goldstein & Buongiorno 1984; Grad, Zavasnik & Groleger 1997; Henlin et al 2000; Knox et al 2006; Linke, Wojciak & Day 2006; Trimble, Jackson & Harvey 2000). What have been less well investigated, however, are the *specific* elements of this support that make the difference for therapists. The accounts of this study's participants draw greater attention to these specifics, and in doing so, reflect the findings of previous generalist bereavement research by Lund (1989), that it is the qualitative aspects of the mourner's support network (that is, perceived closeness, sense of mutuality and depth of self-expression permitted) rather than the quantitative factors associated with it (for example, its size or frequency of contact) that determines its effectiveness and influence upon bereavement.

Disenfranchisement through Dissonance: Clinical Supervision – Panacea or Pretence?

As a review of the literature has illustrated, clinical supervision is regarded by most professional counselling bodies as a pre-requisite for registration, membership and membership upgrade (Australian Psychological Society 2007; Australian Counselling Association 2004). The Australian Psychological Society (APS) (2007) argues that supervision is also an integral part of professional development since it aims ‘to ensure that therapists deliver the highest quality services to the client and the community’ (p. 1). To achieve this end, monitoring client safety and development, enhancing client wellbeing, ensuring legal and ethical practice and encouraging adhesion to agencies codes, policies and procedures are all part of its mandate (Barletta 2007:122-124). The role of the supervisor has therefore been described as a combination of teacher, evaluator, consultant, facilitator, mentor (Barletta 2007:125) gatekeeper, objective observer and protector of the public (Australian Counselling Association 2004; Barletta 2007). Over the past ten years, supervision has become a mandatory requirement of most professional organizations, with therapists in private practice expected to arrange access to it through organizations such as the Australian Counselling Association (ACA).

Given its mandate to provide evaluation and quality assurance, it seems logical that therapists in this study who were most likely to express satisfaction in relation to supervision were those who had been looking for pragmatic, directive support pertaining to their professional roles and responsibilities, post-suicide. Aiden’s positive experience of supervision, for example, was due to the fact that, as an inexperienced therapist struggling with such questions as, “*Hang on, what do I do here? What services are available?*” and “*What responsibility do I have?*”, his

supervisor had been able to *work alongside [him] and [was] very good in terms of being quite directive in her style, “You need to do this, this and this” which was quite helpful.* As Aiden explains:

I think a lot was weighing on me, resting on me, in terms of making sure we were doing the right thing. People were asking me, “What should we do here? What should I look for here?”...[It felt like I] was supposed to have all the answers...I felt able to be open with her about what I was struggling with.

Faith too had found the advice she had received from her supervisor about how to carry out her professional role when meeting with her client’s parents extremely beneficial as it had permitted her *to clear anything of [her] fears and reservations so that [she] went feeling very open and positive.* In Elspeth’s case, engaging in supervision had proven useful because it *had allowed her to sort of step back [from Rachel’s suicide] and look at it intellectually.*

For other, usually more experienced therapists, however, it wasn’t pragmatic professional guidance that they were wanting, but rather an opportunity to explore the personal impact of this event with an empathic other. Catherine, for example, had longed for a supervisory experience in which *she just didn’t have to go it alone [where] there would be someone who could empathise, that could understand.* Whilst such an experience had eluded her, Jude had been more fortunate, having found someone who had been able to provide him with a *very strong sense of being loved and cared about.* As the following dialogue will illustrate, however, Jude was quick to point out that this individual did *not* provide him with supervision per se but with something he regarded as having been much more richly layered and personal:

[It was] not exactly supervision but a third eye...It meant that I was able to talk with him about how tragically guilty I felt about not being available and I wasn't shy of crying if I needed to. So that was helpful in the sense of knowing that somebody else knew about it. I got lots of support from him and feel very lucky to have him. I don't need hand holding. I just occasionally need to hear a voice that says, "It's okay, you'll get through this."

Like Catherine and Jude, Murray too had wanted an opportunity to explore the personal meanings of his client's suicide. However, given his pre-existing belief that supervision was incapable of providing him with anything but a professional focus, he had deliberately avoided engaging in it. As he explains:

It wasn't so much at a professional level that I wanted to talk or wanted to explore its meanings. It was more the sort of thing I would explore in a therapeutic context, in exploring my own life as distinct from what I did or how I responded in my professional work and so on. [So, in order for supervision to be beneficial] it would have to be a very particular, special sort of relationship that had already been built up over a period of time, where the threads of the relationship were multiple threads, where the personal aspect or being personal in professional work was seen as legitimate, so the connections between the personal and professional could be explored.

Murray's sentiments are reiterated by Holly who, having not had access to supervision at the time of her client's suicide, had fantasised about having a supervisor who could have provided her with *the opportunity to look a bit deeper, in terms of how that particular event [the suicide] impacted her as a person and a therapist.*

For the majority of therapists interviewed, the fact that supervision needed to have been able to encompass both their professional *and* personal stories to have been of benefit left them struggling with the gap between what they had desired and what they had felt had been on offer. Comments like Susan's, a supervisor, that *[whilst] there are times when it is really appropriate to work with supervisee's personal lives, if it's clear that it's a big issue for them...they must make a commitment to go and get counselling*, underscore the dilemma for therapists in determining the appropriateness of bringing *big issues* like their client's suicide into the supervisory arena.

The most damning inditement of current supervisory paradigms and practices, however, was made by Dirk who, like Murray, had deliberately chosen not to talk about his client's suicide in supervision, believing that it was unable to offer him the genuine, honest exchange between colleagues that he had desired. As he explains:

Supervision's bullshit! It's something we've created to give us the pretence of professionalism... I think there's an element of, "We take the cases to supervision that are going to make us look our best."...We don't want to put ourselves on display so therefore we take to supervision the neat ones... And certainly the feedback I've had from a lot of other people is that I'm not the only person who doesn't take the tough cases to supervision...I could go off and joke about [getting quite horny about an attractive client] with this mate overseas, but you're not supposed to admit that. You're supposed to go, "No, I put myself above all that." ...[So] I couldn't take that sort of stuff to supervision because I thought someone who was my supervisor would go, "You sleaze bag. You prick. What did you do?" Whereas there was no judgement from [my mate] besides, "Okay, you fucked up, so you're human." ... I think it would make us a far more

real profession [if we could challenge all those artificial rules]. I hear so many things come out from people that are just clichéd bullshit.

For Dirk then, what had been missing from supervision was a supervisor who was willing to break through the professional façade about therapist omnipotence by being upfront and challenging in relation to his experiences. In Dirk's words:

Maybe I just wanted somebody to turn around and say, "You got arrogant. You got full of yourself. You thought you could save the world. You fucked up" because that have been more real for me, more real in terms of being honest...So I don't have a supervisor now but what I do have are people who have nothing to do with this profession whatsoever...who are honest enough to go, "You're being a dickhead"...[So] I feel I can be far more honest and get more out of it from the so-called non-professionals.

The notion of supervision being beneficial only if it could *cut through the bullshit* and *break down the facades* was also captured in Matt's story. Matt, who had considered his supervisor to be his 'guru' his mentor, like a father figure, had deeply appreciated the fact that *at times [his supervisor] had been really challenging, [saying], "Maybe you are the culprit?"*, an approach he had found *very challenging [because] you had to really deal with it*. As he explains:

He was very good at that. [He'd] leave you to think about it and sweat on it. It grounded us a bit more...He was being the Devil's advocate, the provocateur...a real champion of taking down facades.

These findings reflect previous observations by Wosket (2000), that as therapists acquire more skills, experience and seniority, their personal and professional selves

become less easy to separate. The increased personal authenticity and increasingly personalised approaches to counselling that this maturation brings means that, for these therapists, ‘their life issues become their supervision issues’ (Wosket, 2000:60). Thus, unlike neophyte therapists who bring to supervision questions about ethics, interventions or procedural strategies (Barletta 2007; Goodyear & Bernard 1998; Pearson 2004), more experienced practitioners bring, ‘those parts of the self that are touched and affected by their client’ (Wosket, 2000:61). As a result, supervision and the supervisory role must be highly malleable if it is to successfully meet these vastly different needs (Pearson 2004).

Interestingly, for many of the therapists interviewed, in addition to needing supervision to be more than an exercise in quality assurance and professional development, the best supervisory experiences had occurred not within the four walls of their supervisor’s office during a formal supervisory session, but in informal settings in which more informal roles and more flexible timeframes could be adopted. In Matt’s case, for example, supervision had *usually happened [during lunch with his supervisor] after a beer or two when [Matt] was far more relaxed and not consciously holding back the defences and pretences*. Winstanley and White (2003) report similar findings by noting that the level of rapport between supervisor and supervisee is higher when sessions are held away from the supervisee’s place of employment. Goodyear and Bernard (1998:10) concur by arguing that, ‘it seems intuitive that the context of supervision would affect its nature and processes.’

Like respondents in Winstanley and White’s (2003) study, the need for supervision to be more than a perfunctory, one-off, event was also cited by several of the therapists interviewed. Holly, for example, spoke in terms of having wanted someone that she

knew she had *unlimited amounts of time to spend talking about [the suicide]* with, whilst Murray acknowledged that one of the reasons he had avoided it was because *supervision's often more limited in its definitions because it's safer and it relates to things that are easily managed in a supervisory hour*. In Faith's case, it was the very fact that *what was lacking [in supervision] was that [she] didn't take it and build on it [that had meant that] the old pattern came back and took over again*.

It is evident from the above that, for the majority of therapists interviewed, supervision was felt to be neither a satisfactory nor a safe experience. Codes of professional conduct, operating within both the wider professional context and during the supervisory hour, left many participants struggling to decipher just which of their experiences, if shared, might be construed as being either breaches of their professional roles and responsibilities or indicators of their incompetence, personal weakness and failure as a therapist. Little wonder then, that the majority of therapists chose either to boycott supervision completely or to tailor the stories told during it to comply with the current discourses about what constitutes acceptable therapeutic practice. Out of necessity, rather than choice, stories relating to their experiences of client suicide remained silent or were shared with audiences in their personal arenas only, safe environments in which being in relationship, encountering the personal within the professional, and telling one's story at a pace and within a timeframe chosen by the participant, not the audience, were the norm.

Therapists' Personal Support Networks

As a result of the negative attitudes they had encountered towards the expression of grief within their workplaces, the majority of therapists interviewed did not look towards their work environments for support. In terms of looking elsewhere, however,

therapists held strongly opposing viewpoints about the appropriateness of involving non-work-related individuals in their experience of client suicide. Jude and Matt, for example, made conscious and deliberate choices *not* to discuss their clients' suicides outside the work arena, preferring instead to keep their professional and personal worlds very separate.

For Jude, choosing not to *talk a lot about work outside of work was not about being rigidly split between work and home but [about recognising that] there [were] other parts to his life, family and friends and things that [he] had got to do*, and that he did not want to contaminate these arenas with work-related issues. Matt's decision *not to pull other people into his work issues, most certainly not his family*, was due to his belief that *work was bad and sad enough [so] he didn't want to bring it home because it could become an obsession and upset the balance of his life*. As he notes:

[Talking about the suicide] was done at work, that's where it was relevant.

Anything outside of that didn't matter.

Whilst this delineation proved effective for Jude, due to the existence of a strong support matrix within his workplace, for Matt, the outcome was less positive. As Matt conceded, the fact that his relationship with his partner *went cold at that time and then finished [may have been] partly due to not dealing with the suicide in an overt and conscious way [with her]*.

In instances where therapists did seek support from their personal networks, these networks were chosen because they were able to offer the core elements of support that had been desired, but missing, from their professional arenas. As the following extracts will demonstrate, these elements included relational longevity; deep levels of intimacy and trust; non-intrusive invitations to talk, on a repeated basis, in informal

settings; a willingness by the other to wait for the story to unfold gradually, at the therapist's pace, over a period of time; and the capacity to challenge and break down facades.

Aiden, for example, sought out his *really, really close friends, not role peers or anything, just adult friends, [who he] felt comfortable having a beer or enjoying a meal with to talk in a more detached way about what had been happening.* As Aiden describes:

It was a really close relationship in terms of just being able to sit and not even say anything. Just to be together is a really regenerating thing. So that was really helpful.

In Dirk's case, having intentionally chosen to avoid supervision, it was a *very close mate*, with whom he had built an *enormous amount of trust* over the years, from whom he sought the support he had felt unable to obtain within his professional spheres. In his words:

It's an unusual relationship in that I would genuinely describe it as an intimate relationship...He knew there was a whole heap of stuff going on but we'd not talked about it and he was comfortable enough to give me space...We sat down and had a beer and talked about it...Superficial stuff to start with...Just little bits of it, not any great outpourings...He was able tell me what I wanted somebody to tell me, "So basically you think you fucked up. You think you're responsible for two blokes killing themselves."

For Susan, because she *practiced what she preached [to her supervisees and students]* about the need to get support, she *had talked with her friends and her partner* about

her experiences, *checking in that there was nothing that [she] could do differently [as well as] just having a place where [she] could honour [her] own grief and talk over [her] own sadness.*

Ultimately though, the best support, be it formal or informal, was that which provided therapists with the opportunity to *abandon the masks, roles or styles of professionalism and simply embrace the transcended nature of humanness* (Extract from Murray's story).

Reflections on Plotline Two: Invisible Relationships

As the above discussion has illustrated, the 'invisible relationship' that exists between therapist and client encapsulates the second characteristic of disenfranchisement discussed by Doka (quoted in Martin and Doka 2000:13), that 'the loss experience is *not socially sanctioned.*'

Within therapists' professional and personal arenas, the death of a client by suicide was regarded as being a non-significant event as it was not based upon socially-sanctioned kinship ties, but rather, upon a professional working alliance. The failure by others to take into account the tenacity of the client-therapist relationship and its associated feelings (Bonanno & Kaltmann 1999; Moss & Moss 2003) meant that therapists' right to grieve was discounted or disallowed by those around them, including instances in which the grief related to an ambiguous loss. Furthermore, the case closed, move on mentality that existed within therapists' workplaces and social contexts meant that the strong grief-related responses that they were experiencing went largely unnoticed and unsupported.

In addition to the disenfranchisement created by the lack of social sanctioning, the visibility of the client-therapist relationship was further compromised by the codes of

professional conduct and ethics under which these therapists worked. The stringency of the mandates pertaining to roles, boundaries and confidentiality meant that therapists had to remain extremely vigilant about what they shared and with whom, whilst simultaneously providing support and counsel to others. As a result, and despite the fact that social support has been identified as being the most critical factor in assisting mourners during their bereavement (Kneiper 1999), avenues of support within therapists' personal and professional arenas remained extremely limited, if available at all.

In terms of the support that therapists would have liked, qualitative rather than quantitative elements were those most desired. Thus, an empathic ear from someone with whom the therapist had built a close, trusting relationship over a long period of time was of paramount importance, as was the choice to attend to either the personal or professional impact that the suicide had had upon them.

Unfortunately, with regard to supervision, the very things that supervision purports *not* to be and not to offer were the very things that therapists were seeking in light of their client's death. Thus, guidelines laid down by both the ACA (2004) and the APS (2007) that stipulate that supervision is not a dual relationship and that it does not provide psychological services or a forum for the sharing personal matters, became roadblocks for conversation in relation to client suicide. Therapists were therefore left with one of four options:

- a) To find a supervisor who also 'broke the rules' and could therefore provide satisfying supervision.
- b) To 'play by the rules' and engage in unsatisfactory supervision.
- c) To avoid supervision altogether and seek support outside the profession.

d) To remain silent.

From these therapists' perspective it was not enough for supervision to be merely a clinical autopsy of the case or for it to focus solely on the professional impact that the suicide had had upon them. In light of this, it appears that the counselling profession may have to accept that in instances of client suicide, some therapists will be unwilling to take their cases to supervision unless the current framework of supervision is overhauled to make it more user friendly. This issue will be discussed in greater detail in Chapter 10.

Having now explored the ways in which therapists' relationships with their clients become invisible, the following chapter examines the third, and final, core theme identified during the study, the role of 'invisible mourner' that therapists occupy, post-suicide, and the negative impact that this has upon their bereavement process.

Chapter 9

Plotline Three: Invisible Mourners

This chapter, 'Invisible Mourners' explores the third plotline identified in this study, a plotline corresponding with Doka's (1989 quoted in Martin and Doka 2000:13) third characteristic of disenfranchisement, that 'the loss experience is *not publicly shared*.' As has been the case in the previous two result chapters, excerpts from the transcripts will be used to underscore the ways in which therapists in this study found themselves being cast in the role of 'invisible mourner', a role that denied them the right to express their grief and to have it acknowledged and legitimised.

To date, the majority of literature exploring why 'the loss experience is not publicly shared' has focused upon such factors as the taboo-ness associated with the loss itself; the type of relationship in which it occurred; and the role that the mourner has occupied in the deceased person's life. Having examined the first two factors in the previous chapters, this chapter begins by turning its attention to the third factor identified within the literature - the mourner's role in relation to the deceased and the ways in which it can inhibit the visibility of the grieving process. In the latter half of the chapter, two further factors identified during this study (stereotypical assumptions and peripheral rituals), which are referred to sparingly in the current literature, are explored since these, too, contributed significantly to therapists' experiences of becoming 'invisible mourners'.

Disenfranchisement through Duality: Personal and Professional Convergence

As Doka (1995) has noted, the fact that therapists are often expected to remain within their professional role, supporting and comforting family members after a death,

means that they are not permitted to mourn their loss as fully or as publicly as they would like. This was certainly true for this study's therapists since, without exception, the need to remain professionally available to the client's family, whilst simultaneously being personally impacted by the suicide, automatically afforded some degree of invisibility in relation to their own experiences of grief.

Murray, for example, who had hoped that his post-suicide session with Simon's wife would permit him *to share the emotion in some appropriate way*, found instead that he had been left feeling as if:

Somehow [his] humanity wasn't involved in [his] professional relationship, that somehow [he] could be clinical and detached as a human being from the person [he'd] been working with

because Simon's wife:

Had wanted to come and see [him] as a psychologist who'd been involved with [Simon], wanted a professional opinion, a professional bit of information.

In Holly's case, needing to remain professionally available to her client's wife after receiving her voicemail about the suicide, had meant forgoing her own grief-related needs in order *to regroup [and] pull [herself] together again enough to get on the phone and call [the client's wife back]*. Furthermore, because this woman had also been receiving counselling from her at that time, Holly, like Murray, had found herself having to deal with competing agendas - her *personal* desire to know more in relation to the death and her *professional* requirement to put the needs of her client first. She recounts this experience, in detail, below:

I still worked with his wife and she came back in after it happened, so I knew to be careful not just talking about it to anybody in general because I needed to respect her and his privacy and confidentiality. I always wished that I could have asked her about the details of the suicide – but that was my curiosity. I felt like it would have been voyeuristic and self-centred of me to ask... [So] I was curious to hear what people had heard, just kinda asking questions about, “Well, what did you hear?” without saying, “Well, you know he used to be my client.”

The fact that, in order not to reveal her role in relation to the deceased, Holly had had to assume the position of observer to the grief of others, rather than participant in her own grief-related responses, meant that she was automatically relegated to the category of invisible mourner.

As had been the case for Holly, Catherine too reported feeling as if she had had to remain in her professional role, *standing apart from [her] emotions* and just *looking at the procedural things* in the aftermath of her client’s suicide. The following description of her encounter with her client’s brother at the funeral clearly highlights the personal – professional split she experienced at that time:

I felt I was doing my job as a worker, as a professional, that, “This is my job therefore I’m going to have to convey to you that your brother was doing well, support you and say nice things about the dead” and to treat him as I would any other family member of a client. And he was obviously quite upset so I thought, “Keep it brief otherwise we’ll both end up sobbing.”

This experience of being caught between one’s personal needs and agenda and one’s professional requirements is also captured in the following comments by Faith who,

two and a half years after her client's death, *still* experienced a tug-of-war between her personal need to *ring up [her client's mother] to find out how she was doing now* and her professional concern about whether this *was what [Ryan's mum] would need or if it was just her need or curiosity*.

Even therapists who had initially felt comfortable about abandoning their professional role in the presence of their client's family found this comfort short-lived. As Aiden, who was *brought into the circle* by his client's parents acknowledged, whilst he had initially felt that *it was okay to be there, to sit there, not in the role as a counsellor but as someone sharing the story with them, [he had nonetheless] remembered feeling a bit guilty later on, [believing] that he had probably been expected by Carl's parents to maintain the professional role*.

In addition to having to remain within their therapist role in order to support the remaining family members, several participants found themselves having to occupy a *multitude* of additional roles shortly after the death – roles that further diminished their opportunities to openly and publicly mourn their client's suicide.

Jude, for example, having already *held a stack of different things within the therapeutic context* with Rose, experienced a *constant sense of being caught in the middle* particularly around the time of her dying, *dealing [single-handedly] with the death, dealing with the fact that [he] couldn't find her parents and organising [her] funeral*. Because of these multiple roles and responsibilities, it was only *once the funeral was over* that Jude felt able to attend to his own needs.

The need to have to subjugate one's personal needs and responses for one's professional obligations is further illustrated by Aiden's story since his work context, a school, also required him to adopt a multitude of roles post-suicide. As Aiden

explains, *despite [the fact that] the grief of it all was all just sort of hitting home for him, he nonetheless knew what he needed to do at that stage and just went into autopilot... kicking into his professional roles [which] then allowed him to keep going:*

I'd had my cry, let a bit of pressure off, so was ready to keep functioning. There was still that unreality of it all but you still had that mental checklist of what you needed to do to set up things for the next day... I think I really hadn't begun to attend to myself at all. I was still in the conscious awareness of, "I need to keep functioning. I need to keep doing what I need to do." My professional role was still there. I was functioning okay, probably pretty tired but running on adrenaline at that point. I guess I was probably running around just checking up and trying to monitor the whole situation.

Like Jude, it wasn't until the funeral service was over that Aiden was finally able to *begin to attend to himself and to engage in the sort of personal reflection that had had to be shelved whilst he'd held together the professional stuff.*

As well as having their personal responses disenfranchised by the needs of their client's family, some therapists found themselves having to give precedence to the needs of their employers and colleagues. In Aiden's case, simultaneously having to meet the needs of both his employer and fellow staff members had meant that *even though these [workplace] relationships were relatively close [he was] still seen as the counsellor by them [and therefore] had to remain in his professional role.* His following recollections highlight the dilemma faced by many of the therapists interviewed – that is, to respond to the death in personally appropriate ways meant risking being seen as having acted professionally inappropriately:

I remember going through a stage of being pretty angry with God, “Why the hell would you allow this to happen?” I certainly had to keep that contained because I remember feeling quite anxious that if I touched that with the staff then I probably would have said some professionally inappropriate things...my fear was that if I allowed these things to come out [with the staff] that they’d probably have kept coming out, and in terms of my role...

Susan too had had little choice but to remain professionally associated with the death of her client since not only had she had to participate in the initial inquest but later follow up questions in relation to her client’s posthumous registration as a psychologist. As she explains:

[And] it goes on [six months after the suicide]. I’ve just had a letter from the Director of the college asking me about E.J.’s confidence and what competencies she had passed...I’ve since had all my reports sent from the Board because they needed to get my signature to release all that to her father.

For Susan, needing to deal with these ongoing administrative requirements had left her with little choice but to remain in role, posthumously, in relation to her client.

In Elspeth’s case, because her organization’s fear of litigation became its primary agenda post-death, her *first* response after hearing the news of her client’s suicide was to *ring the Director from work, see a solicitor and get an opinion from him* rather than deal with her own grief-related needs. Whilst what Elspeth *had wanted to do more than anything was to:*

Contact the family [as that] could have brought some closure for me, the Director of the service and the lawyer had said that whatever I did, don't do that.

The cost to Elspeth of being unable to talk with her client's husband was that it had left her *with a lot of questions still in her mind, ...so many questions that [she'd] been trying to find answers to*, not only about the details of the suicide but also about its impact on him. As she recalls:

So, I used to think about him, worry about him, and I thought, you know, I don't know what happened to him. And that's the comparison between the two cases because [my first client's] wife did come back and we had a long period of time working together through all sorts of things. And that has enabled to bring some closure for me.

It is evident from the above, that needing to remain in role in order to support their clients' families and friends or to meet their organisation's or colleagues' needs was inherently disenfranchising for therapists. Murray referred to this experience as having to keep his personal responses *in the wings* whilst Catherine described it *as doing the professional thing between the tears*. Aiden's comments that his *Me-ness* couldn't *come to the surface* because of his need to remain professionally engaged are echoed by the following extract from Jude's story which further highlights the significant personal cost that this role-related disenfranchisement created for therapists:

Although Rose came to the centre and sought help from us, there was always a "me" in the equation, a person first and foremost who takes on a role, but a

person with all that implies...I gave a significant part of my life to this young woman and was present when others had fled.

This is not to say, however, that having to remain in role was an exclusively negative experience. For some of the study's participants, the opportunity to meet with their client's family, post-suicide, permitted them to process their grief-related responses in ways that might not otherwise have been possible. As Holly notes, being able to *work therapeutically with Russell's wife afterwards* was the most useful aspect of the whole process because it had allowed her to *see how [Russell's wife] made the decisions she made [to be able to get some resolution]*, a fact that had assisted Holly with her own resolution and the *whole set of closure that happened within that*.

Elsbeth too had found that in *being able to be there [for her client's wife] as she worked through her guilt and self-blame, [not only was she able] to hear in great detail what had happened and why it had happened [but also] to tell Ian's wife that she had been fearful for him from the very first session [and that this] had really brought closure*.

Disenfranchisement through Discounting: Therapists' "Non-existent" Grief

Whilst therapists risked becoming "invisible mourners" because of their need to remain in role, this was not the only reason for its occurrence. Mourner invisibility also arose because of the misperceptions of others about therapists' capacity, need and right to grieve.

Whilst evidence exists regarding the 'stereotypical assumptions' (Neimeyer 2000b) that are made in relation to the capacity of children, the elderly and the disabled to grieve, this study provides some insight into the stereotypical assumptions that therapists encountered with regard to their 'grieving capacity'. As the following

accounts illustrate, within both their professional and personal arenas, therapists were seen as being somehow immune from needing to mourn the death of their client. As Murray explains:

People don't expect me to react the way that other people react and to have the same sets of emotions. Somehow I'm supposed to be beyond that, somehow I'm supposed to be self-contained or to somehow remove myself to a self-transcending space and to always be wise or comforting them and not to be in distress myself...You know, "You're the psychologist, you're the therapist. You deal with this all the time."

Catherine too found herself caught between her personal need to mourn and the expectations that she felt others had about her in relation to this:

I thought they'd expect me to be quite contained [at Barney's funeral]. I'm the psychologist so I should be composed. I'm not one of the friends or family. So therefore perhaps I shouldn't show emotions publicly. It was that juggle between, "Do I allow myself to be human and feel what I'm feeling or do I put on a show because I should?" So I'm thinking, "I've got to be composed, I'm not going to wail."...I mean at the funeral I was also looking at potential clients. I'm there crying in the funeral thinking, "God! They're going to think, 'Oh! I'm not going to go and see her!'"

In instances where therapists failed to conform to these stereotypical assumptions by becoming emotionally demonstrative, they were quickly pulled back into line by those around them in order to minimise the discomfort that these feelings evoked. Corr (quoted in Elison & McGonigle 2003:123) refers to this dynamic as 'oppressive toleration' in which the mourner is expected to stifle their grief-related responses 'in

order not to trouble or disturb others by bringing it out in the open, or expressing it in certain ways.’ As Murray observes:

If I do express myself, I have to recover quickly because if I don't people won't know what to do... "We can be upset [but] you shouldn't be upset because that makes us feel less secure. You're supposed to be the secure one. We expect you to be there for us [but] we don't know how to be there for you. You embarrass us, you leave us feeling uncomfortable and insecure because if you're upset we're upset, then who is there." So it's that sort of expectation to somehow be more like God than a creature. ...And maybe in their eyes I've lost credibility. I don't believe that that's the case but sometimes other people's reactions suggest that.

Faith too, had felt pressure from both her husband and friends to remain emotionally ‘intact’ in the aftermath of her client’s suicide. As she explains:

[My friends] are so used to seeing me ‘together’ and being in charge of my life that they didn't like the fact that I wasn't.... Some of my friends wanted me to (claps hands), “Come on, hurry up, just get on with it and come back to us when you are.” I thought that they might dismiss my feelings so I didn't talk to them about it. It was quite stressful to actually feel that alone at times... My husband also felt like I should have been over it, that I was making it mean something [and] that I was failing to get my mind around it, get on top of it mentally... My emotions were very messy for [him]. He needed me to be ‘cool’.

Even when they chose not to be pulled back into line, therapists still agonised about the legitimacy of their emotional expressiveness. In Catherine’s case, her initial conviction that *sobbing openly and noisily [at Barney’s funeral] was a natural*

emotion [and that] it was okay to feel, quickly gave way to the need to have to justify, in non-grief-related terms, why she had lost control of herself at the funeral. As she explains:

I think it was a bit of a combination of having had a big night out of drinking alcohol the night before [the funeral] and not a lot of sleep. I think that really took away a lot of my control [so that] I couldn't control the tears. I think that if I'd gone to bed early and hadn't had anything to drink the night before that I would have controlled myself.

The fact that such a sharp contrast existed between Catherine's fears about how others might interpret her personal grief responses and her apparent lack of concern about being seen as the psychologist who got very drunk the night before her client's funeral underscores the taboo-ness she experienced in relation to the expression of her grief.

Because assumptions about the non-existent grief of therapists prevailed, several therapists found themselves having to grieve, quite literally, behind closed doors. Catherine, for example, having made the decision to *keep an emotional check on [her reactions to the suicide], [to not] let it hit her [in the workplace] and to deal with it when she went home* described having:

Sporadically had some crying sessions [after the funeral], about three sessions, usually over a couple of glasses of wine, more sort of late at night, in my bedroom, in privacy, over personal just sort of 'lost' stuff.

Aiden too recalled that after becoming aware of *needing to try and connect with [himself] again after all of that "I need to keep functioning" stuff, [he'd] come home, sat and had a couple of beers [alone] and crawled back into bed at 2am.*

For Murray, the fact that his client's wife had used their post-suicide session *to look for an intellectual understanding* of what had happened, and had expected him to remain firmly within his professional role whilst she had done this, had meant that he had only felt permitted to cry once she had left the therapy room. As he explains:

Because her grief seemed so contained, there was no opportunity for me to be other than contained with her and to contain my grief, which was much more accessible to me in that moment than it was to her or hers was to her.

This notion of *contained-ness* is also reflected in the following comments by both Holly and Faith, and relates, as it had in Murray's case, to post-suicide conversations held with their clients' families. In the following dialogue, Holly describes how, as a result of her conversation with her client's wife, she had found herself having to move from her initial emotionally uncontained response to a more analytically contained one:

When I called [Russell's wife], she was more matter-a-fact than I was which sort of brought me back around. She was very contained where I felt very uncontained, just like everything sorta spilt out of me. So I was like, "God, are you okay?" and she was like, "Yeah, I'm fine." And I think what happened after that was I got fairly analytical about it.

In fact, for Holly, the external pressure she had felt to react in a particular way was *part of the reason why [she] didn't talk about it because [she] didn't think [she] was having the correct reaction* to the suicide of a client. As she explains:

[When I have disclosed to lay people about the suicide] their reaction is like, "Oh my God! How terrible!" And it's like, "Mmm...Terrible for me? Terrible

for the person?” So that’s where the guilt comes in too. “Was it terrible for me?” It was shocking but I don’t ever remember feeling like it was terrible for me.

In Faith’s case, the contained-ness she had been met with from her client’s mother during their initial post-suicide phone call, had left her feeling *like an idiot* because whilst the mother had been *so calm and cool* during it, she’d been in tears and *lost it*.

As she explains:

I just felt the pain in my heart and I could just not stop weeping and she was very contained. I had absolutely no control, where she was absolutely in control. So we were like opposites, total opposites.

For Faith, speaking again with her client’s mother during the funeral proved equally disenfranchising, for although Faith *just could not stop sobbing*, she found herself having to fight for the right to express these emotions in an uncensored way. In Faith’s words:

[Ryan’s mum] said, “It’ll pass” and I thought, “I don’t want any of your platitudes. This is just my raw emotional response and I think it’s okay.” So I really couldn’t speak to the mum all that well.

It was only during a meeting with this mother several months later, when *they were able to cry together* that Faith’s grief finally felt legitimised:

That felt good. It felt more normal in a way, more real. She felt more real. I’d felt quite distant, not really connected with her at the time of the funeral but later, after that meeting, [that changed].

This dynamic, of having to simultaneously oscillate between the containment of their grief and its expression, Doka (2006) argues, increases the risk to mourners of either becoming completely engulfed by their responses to the loss or completely cut off from them because of the taboo-ness surrounding their expression. So strongly felt was this taboo-ness, in fact, that several of the study's participants felt compelled either during or shortly after the completion of their interviews with me to enquire about the appropriateness of their emotionality during their story-telling process.

Catherine, for example, checked that I *wouldn't mind [that she] was getting teary* and apologised when she did (*excuse me for getting teary*), whilst Murray had strongly feared that if others had been privy to his account, not only would they have regarded him as being *crazy* for having had such a strong grief response but that as the *crazy psychologist*, they would no longer make referrals to him. Faith too, despite her training in Emotional Release Counselling and her firm belief that *raw emotional responses were okay*, still asked me, "*Did anyone else cry when you were talking to them?*" Each of these comments vividly highlight the taboo-ness that these therapists' felt in relation to the expression of their grief and the pressure this created for them to appear un-affected by their client's suicide.

These findings reflect observations by Lewis (2004) that the counselling profession's failure to acknowledge and investigate the issue of personal vulnerability amongst its practitioners (for fear that it might harm the profession's public credibility), perpetuates the message that therapists must be immune from woundedness if they are to be regarded as being professionally competent enough to practice. Clearly then, needing to separate their personal responses from their professional roles and settings meant that assumptions about therapists' non-existent grief were reinforced. As a

result, accounts like the following, which provide a clear snapshot into the strong physical and emotional reactions that therapists experienced in relation to their clients' deaths, remained largely invisible and untold:

Holly: [It was] a real shock...I just felt like the blood drained out of me as I heard [about the suicide], trying to catch my breath and all I could go was, "Oh God! Oh my God!" just that kind of repeating over and over, kinda trying to get a grip and just feeling like I was in the twilight zone, like my head was not in the same place as my body...just walking around, not feeling connected. Just that sorta white, like the blood's gone from me somewhere.

Murray: [I felt] truly shocked...disbelief...numbness...a kind of dismay...an enormous depth of sorrow...tears... confusion.

Jude: I have a strong sense of annoyance, anger, even rage at times about, "Why the fuck would they do such a thing?" You know, "How dare you put other people through it", "What a gutless act that can be" [and] "I'm so fucking pissed off with what they did!"

Matt: [I had] a profound sense of shame and guilt.

Susan: "How do I make sense of this?"...

These results support those of previous researchers (see Anderson 1999; Chemtob et al 1997; Hendlin et al 2000, 2004; McAdams & Foster 2000; Yousaf, Hawthorne & Sedgwick 2002) who found that shock, guilt, numbness, anger, confusion, crying and a search for meaning in relation to the death were typical therapist responses in the aftermath of their client's suicide. However, given the invisible mourner role that they

occupied, many of this study's therapists found themselves struggling to find avenues through which these responses could be adequately expressed. The following section explores this experience and highlights the risks that therapists exposed themselves to when, having found themselves marginalised within community-based rituals, they chose to engage in more personalised forms of ritualisation as a means of signifying their changed relationship with the deceased.

Disenfranchisement through Distancing: Peripheral Rituals

Traditionally, rituals and memorials provide a vehicle through which mourners can openly acknowledge the deceased's transition from life to death as well as their changed relationship with them. As Kollar (1989) has noted, the benefits of ritual for the mourner are that they meet the physical, social, psychological and spiritual goals required for grief resolution and are therefore critical to the healing process (Bolton & Camp 1987; Glasscock 2001; Romanoff & Terenzio 1998).

Whilst an analysis of the transcripts revealed that therapists were aware of the importance of using ritual when working with individuals who, like them, had been impacted by their client's death, there was little evidence to suggest that their own needs with regard to engaging in a ritualising process were either recognised, or met, by others. In fact, for the majority of therapists interviewed, having already battled to receive information about the death itself, participation in publicly held rituals arising from it was, *at best*, a marginalising experience.

With the exception of Dirk, who was prohibited by his client's parents from attending their son's funeral, the marginalisation experienced by the majority of therapists interviewed was due not to having been banned from participating in the rituals per se (although it could be argued that had they not pro-actively sought information about

the funeral arrangements, a number of therapists would have been excluded by default), but because of the discrepancy they had experienced between their personal needs and their professional roles and obligations in relation to such events.

Aiden, for example, readily acknowledged that because his decision to accompany his client's father to view the body was a professionally-based one (as *he knew he had to go because that's what Carl's father wanted [despite] his own fear of "What will I see?"*), the only way he had been able to *hold together the professional stuff [so that he could care for Carl's father]* was to engage in *detachedness from [himself], detachedness from [his] gut*. For Aiden then, the fact that he was *running on autopilot* throughout this process meant that he was unable to use this ritual (and those subsequently associated with the funeral) as a vehicle through which to express his own grief. As he notes:

[It was only] once the funeral service was over that [the grief] then actually started to catch up with me.

For Jude, like Aiden, having to remain in his professional role in order to facilitate his client's funeral meant that it was not the most beneficial form of ritualising he was to experience. Instead, *the most useful exercise* was instigated by his client's doctor who *took him into the morgue and left [him] there [with his client's body] which was really nice because [he] got to sit with Rose for about half an hour*, not in his role as Rose's therapist, but as an individual mourner deeply affected by her death.

Even therapists who did not have a designated part to play during the funeral proceedings found themselves feeling marginalised, nonetheless, by their professional role. The following account by Catherine captures the agony that this role created for

therapists as they tried to decide whether or not to engage in publicly shared rituals such as their client's funeral. In her words:

I kept going through this, "Will I or won't I go to the funeral? Should I or shouldn't I go? Is it correct in terms of my workplace? Who's going to benefit? There might be some of my other clients there. If I go to one funeral, should I go to every funeral of every client? What do I do with the information about [Barney] in terms of the family? How does this fit in with confidentiality and ethical issues? Should I be supporting his relatives? As the service provider, should I be making some sort of statement to them?" So I was looking at the personal as well as the professional sorts of issues but also the need for closure for me and even up to the last minute I tossed and turned about that.

Having made the decision to attend their client's funeral, therapists still found themselves unable to participate as fully as other mourners. Murray, for example, who had chosen to attend Simon's funeral as *it was important for [him] to honour the relationship [he] had had with him*, remembered the acute sense of alienation he had felt whilst he *had stood apart after [the funeral] looking at all the family and wondering what their experience was*.

Whilst Murray spoke of the physical distancing he had experienced, other therapists recounted their sense of having to remain emotionally distant during the service as the reason why their participation had felt compromised. As Faith, who chose to take a back seat during the proceedings, explains:

Anyone who wanted to speak at the funeral could. I didn't. I was going to speak but I couldn't trust my emotions. I knew I would crack up and no-one would

have been able to hear me anyway. I just could not stop sobbing when I talked about it, the pain in my heart was so intense.

Whilst a fear of becoming highly emotional was also Catherine's primary reason for choosing not to speak at the funeral, her decision was also tempered by her need to maintain confidentiality with regard to her relationship with Barney. As she recalls:

I went through that, "Will I or won't I?" [speak at the funeral] because Barney had such lovely qualities. And I thought, "No I shouldn't because I shouldn't divulge confidentiality" and "Maybe this is for the family and I haven't even met the family." So I jostled with that as well.

That therapists avoid attending their client's funeral has been well documented by past researchers with reasons for non-attendance being given as either the fear of being blamed by angry family members for the death's occurrence (Alexander et al 2000; Cryan, Kelly & McCaffrey 1995; Kleespies, Smith & Becker 1990; Pilkinton & Elkin 2003; Yousaf, Hawthorne & Sedgwick 2002) or the fear of legal proceedings being instigated (Cryan, Kelly & McCaffrey 1995). The results of this study provide insight into a further reason for therapists' hesitancy to be present at the funeral – the challenge that having to remain in role presents and the 'role uncertainty' (Grad 1996) this creates. As the above accounts illustrate, the discrepancy therapists experienced between their personal need to grieve and their professional requirement to remain contained, confidential and comforting to others lead to compromised participation and compromised mourning. For therapists in this study, having to occupy this 'delicate role' (LoboPrabhu 2008:134), in which the needs of others took precedence over their own, made the full and open expression of their grief near impossible.

Despite these drawbacks, several therapists spoke of their satisfaction at having chosen to attend the funeral, a result reflected in the literature (see Berman 1995; Campbell & Fahy 2002; Hendin et al 2000; Kleespies, Smith & Becker 1990). Faith, for example, acknowledged that *it had been very helpful to go to the funeral* since only through listening to stories about her client that had *sounded as if he'd been saying goodbye*, had she been given proof of Ryan's suicidal ideation, proof *and a big picture to sit something in*.

For Catherine, having engaged in the most agonising of decision-making processes about whether or not to attend the funeral and how best to portray herself there, choosing to go had ultimately made her *glad* because:

I think if I hadn't gone I don't think I'd have gotten so much in touch with my feelings about him and his death.

However, the fact that therapists *did* find themselves either excluded from or hovering on the periphery of publicly shared rituals in relation to their client's death, left them with little choice but to find their own personally designed (and privately executed) ways of ritualising their loss. Susan's ritualistic process, for example, had involved firstly *sending an email to all the supervisors [when] she'd gotten the news [about E.J.'s death] both as a way of honouring E.J. and to ritualise her grief, and secondly using the visualisation she'd created in the last few years [in which she] imagined this beautiful room with stained glass windows where [she's] standing at the door just watching [her] clients pass into the light*. For Susan, the significance of, and need for, engaging in this ritualisation process was that:

[It's] kind of got a spiritual element to it, that once you're gone, you're in peace. It's like the pain and suffering's gone [and] the only way I can reconcile

[E.J.'s death], so that I don't stay too angry and too wounded myself, is to focus on the letting go.

For the majority of therapists, however, honouring their client's death ritualistically occurred not through actively engaging in processes such as visualisation but through the attainment of a linking object with the deceased. As Rosenblatt (1999) has noted, linking objects, which are items that once belonged to or are associated with the deceased, serve as reminders of the relationship and provide solace for the bereaved. They are, therefore, a critical part of the mourning process since they meet the mourner's need to find familiar and continuing connections in a life story disrupted by loss (Hall 2001; Neimeyer 2000b).

For Murray, *keeping the actual funeral service sheet in [his] files, from where, occasionally, [he'd] see it*, became his means of *acknowledging the grief he was experiencing* in relation to Simon's suicide. For Jude, *having Rose's ashes holding up a stack of books on [his] shelf [was] very graphic [since he] thought about her often*; whilst for Aiden, the *cappuccino machine* that he had received shortly after his client's suicide provided an ongoing connection with him. In Catherine's case, holding on to the plant she had bought during her therapeutic work with Barney helped ritualise his death. As she acknowledges:

The plant's a nice memory of him. [I took it out of my office] and I've got it at home now. It's lasted and it's been part of the process for me and that's been helpful.

The poignant question raised by Catherine at the conclusion of her dialogue, *'What if the plant dies?'* clearly illustrates the significance that this linking object had for her.

It is evident from the above, that due to their lack of involvement in the wider, more visible arenas of their clients' lives and deaths, therapists often had to be very enterprising in terms of procuring a linking object. However, because these linking objects were associated with a socially unsanctioned loss that had occurred within a professional relationship, therapists who chose to keep them risked being judged harshly by others for having done so.

As previously mentioned, this dynamic was graphically illustrated by the heated discussion that arose during a presentation of my research-findings-to-date in which therapists and other health care professionals unanimously announced how appalled they had been at Jude's breach of professional boundaries by keeping his client's ashes in his office. For Jude, who had been privy to the discussion, listening to the condemnation of others had proven to be an extremely harrowing experience. As he was to share later with me:

I realise that no-one in the room knew who 'Jude' is but I have to say that I felt quite exposed [during your presentation] and on a couple of occasions wanted to flee...I could hardly contain my sense of distress when people were making comments about boundary issues in respect of the ashes...their judgements being made of and about me with limited information and hence out of context.

The need for therapists to engage in some form of personalised ritual in the aftermath of their client's death supports contentions by both DeSpelder and Strickland (2002) and Hunter (2007/2008) that for reconstruction of meaning within grief to occur, private rituals and 'rituals of remembrance and new meaning' (Hunter 2007/2008:153) are absolutely essential. This need appears to be particularly strong in instances such as those described above, where individuals have been excluded from

the 'common rituals and shared norms of consolation' (McWilliams 2004b:276) by the confidential nature of their relationship with the deceased, the stigmatisation attached to the loss and/or the lack of awareness of others about their need to grieve.

In light of the above, the findings of this study dispute the value of adopting a phase/stage/task framework to loss, grief and mourning in instances of client suicide since getting over and letting go of their relationship with the deceased was not the desire of these therapists. To the contrary, through the use of linking objects, therapists, already challenged by the limitations placed upon them by others to move on from the death, worked exceptionally hard to find a vehicle through which to maintain and re-narrate their ongoing relationship with the deceased. The fact that therapists were so emphatic about not wanting to let go of this relationship supports McGee's (1995:18) belief that 'holding on to grief might be the most growth-producing and liberating experience' for the mourner. Furthermore, it underscores the necessity for the counselling profession to adopt more flexible models of grief that acknowledge, support and celebrate the ongoing nature of the therapist-client relationship, post-suicide.

Reflections on Plotline Three: Invisible Mourners

It is clear from the above, that therapists' capacity to mourn as deeply and openly as they would have liked was compromised by a myriad of factors, leading to the third characteristic of disenfranchisement identified by Doka (1989 quoted in Martin and Doka 2000:13), that 'the loss experience is *not publicly shared*.' These factors included the implicit and explicit assumptions within therapists' professional, social and personal contexts that very clear cut lines of demarcation be maintained between their professional and private lives (Lewis 2004); the imposition of stringent

boundaries between therapists and clients; and the need to remain professionally objective in the workplace. As a result, therapists were left floundering to decipher which, if any, of their grief-related responses could be expressed.

Unfortunately, however, whilst the personal role of mourner was considered unprofessional and inappropriate, it was difficult and undesirable to uphold. Despite the fact that dual roles and relationships are unavoidable at times (Zur 2005) and that there is no such thing as a discrete professional self as the current codes of professional conduct would suggest, therapists found themselves having to put their grief-related needs on hold in order to avoid the occurrence of any boundary violations.

The profession's emphasis on self-control, containment and detachment meant that participation by therapists within socially sanctioned rituals such as funerals was also discouraged. As a result, therapists were left with little option but to grieve, quite literally, behind closed doors and to use linking objects to create their own private rituals of remembrance as a way of acknowledging the loss and engaging in a process of meaning reconstruction. Once again, however, this practice was disparaged within the profession. As a result, Neimeyer's (2000b:12) contention that, in the absence of ritual and community support, mourners often have little choice but to assume that 'their continued distress is a sign of personal failure' was certainly true for many of this study's participants.

Summary

As the past three chapters have illustrated, at its very worst, the counselling profession can be seen as one that 'eats its young' with regard to the exceptionally high, and at times, completely unrealistic expectations it places upon those who choose to enter it.

Stringent codes of professional practice which frown upon the 'contamination' of the therapeutic relationship by the personhood of the therapist; suicide training programmes that turn a blind eye to the reality of client death in order to perpetuate the dominant discourse about prevention and the saving of lives; and frameworks of clinical supervision and professional support that emphasise accountability over compassion cannot help but amplify the disenfranchisement experienced by therapists in relation to client suicide. It is clear, therefore, that the 'suffocating stigma' that Donaghy (2000:5) argues is already attached to deaths by this means is being aided and abetted by the very profession calling for its abolition. In the following, and final chapter of the study, the risks posed to therapists, both personally and professionally, of this disenfranchisement are examined, together with ways in which the counselling profession and the field of thanatology need to change if the current situation is to be adequately addressed.

Chapter 10

Risks in the Current Situation and Recommendations for Change

'We in this work are missing an outer layer of skin

and must take care to renew ourselves.'

(Saunders 1997 quoted in Renzenbrink 2005:16)

In this, the final chapter, attention is paid to the risks posed to therapists, not only of having had a client commit suicide, but also of having this experience disenfranchised. In light of these risks, and by way of closure, this thesis ends by offering a series of recommendations for future practice and research in the hope that they may go some way to ameliorating the current situation.

Stress, Vicarious Trauma and Burnout

That client suicide can have a profound effect upon therapists, both personally and professionally, has become increasingly documented within the literature. The use of words and phrases such as 'crisis' (McAdams & Foster 2000), 'monumental anguish' (McWilliams 2004b) and 'an extraordinarily painful process' (Knox et al 2006) bears testimony to the language used by the participants in this study. Elspeth, for example, described her client's suicide as a *very confronting experience* whilst Susan admitted that, for her, *suicide is just always big*. Jude also acknowledged the profoundness of the experience upon him by stating that *the whole thing [had been] incredibly dramatic over a long period of time*.

Several therapists also expressed genuine surprise at just how deeply they had been affected by the death, both at the time of the suicide and for the ensuing years.

Catherine, for example, acknowledged that she hadn't expected that *it would be that painful* whilst Matt conceded that the suicide had *impacted on [him] a lot more than [he] had given it credit for at the time* and that it had *made a mark on his life that he would never get over because he could still recall it, see it, feel it, to some extent [thirty years after the death]*.

The ongoing impact was also reflected in Dirk's observation *that it just niggles away at you a little bit, erodes you away a little bit at a time [making it] all just a bit too hard* and by Aiden's comment that he was *absolutely astounded at how the memories had [still] flowed*, many years after the death. Given that the therapists themselves were unprepared for the intensity or duration of the effect that their client's suicide had upon them, Dirk's additional comment that *[no-one else] realised just how much of an impact it had had on his life* seems highly justified.

Whilst these excerpts contain words and phrases that reflect a deeply felt, deeply painful process, others contained language descriptive of trauma, supporting McWilliam's (2004b) contention that the suicide of a client can be a 'traumatic event'. Matt, for example, referred to his client's suicide *as that early trauma* whilst Murray described the effect that his client's suicide had had upon him in the following way:

It's like being battered, traumatised and bruised...an assault on the sense of the being, that some how life, existence, being, has been dealt a traumatic blow...a ripping, tearing experience, that something's just been ripped away...a weight of deprivation, of trauma, of assault.

So profound was the trauma associated with the experience, that several therapists provided descriptors of symptoms concomitant within the classification for Post

Traumatic Stress Disorder (PTSD)(see Ireland 2007:255-256). Aiden, for example, described how he still had very powerful and vivid memories in relation to having viewed his client's body, including *the smell there [at the hospital chapel]* and the fact that his *sense [had been] in overdrive*. For both Jude and Dirk, acknowledging that the images and memories associated with the suicide still came *flooding back* for them was a powerful indicator of their ongoing impact.

Interestingly, however, despite acknowledging that their clients' suicides had been traumatic, and that they had experienced reactions akin to post-traumatic stress, no therapist assessed themselves as having ever suffered from, or to be currently suffering from, this disorder. At best, therapists conceded that their client's suicide had been either a highly stressful or traumatic experience and that the professional realm in which they worked inherently made them susceptible to stress, vicarious trauma and burnout. In the words of two therapists:

Matt: It's a very risky game we're in. We need to be able to put things in perspective or they can consume you, eat you up...[I needed to avoid] succumbing to the shock and horror and sea of negative emotions of the initial realisation of suicide.

Holly: When I think about the pain it causes me sometimes to care about people there are times when I don't want to do it anymore. My backup plan would be to just go and do something that had no impact on anybody's life [because], you know, I think it does take its toll.

Unfortunately, though, given the high level of stigma that these therapists had been met with in relation to their clients' suicides, and the shroud of secrecy that had fallen

over their stories in relation to them, the concern voiced by Thompson (2005:9) that the risk of experiencing stress, vicarious trauma and/or burnout ‘is not taken sufficiently seriously’ within the fields of loss and grief was confirmed by this study’s participants. The ‘haemorrhaging of the self’ (Tan 2005:82) that several of the therapists experienced as a result, is discussed in greater detail below.

Diminished or Maladaptive Coping Strategies

In light of the risks posed to therapists of experiencing stress, vicarious trauma and burnout, both within their wider work contexts and with regard to client death by suicide, several participants acknowledged the need to engage in self-care strategies if they wished to maintain a sense of wellbeing in their personal and professional lives. Susan sums this awareness up in the following dialogue, though she notes the challenge that this can create for therapists:

You know, we as therapists are more exposed to pain than most and we have to learn to find a way to find that balance of letting it in enough to be present to our clients and remain empathic and compassionate, and keeping it out enough so we don’t carry it and it doesn’t wound us. And I think it’s quite difficult.

Unfortunately, however, in instances of client suicide, the majority of therapists interviewed appeared to struggle in their attempts to engage in effective coping strategies.

For some, it was the lack of available avenues within their professional and personal arenas to openly express their grief that led them to engage in potentially destructive behaviours in an effort to cope with their reactions to their client’s death. As Matt describes:

How did we cope? We drank too much, we took drugs, we became sexual deviants...got into fights...obsessed about one thing or another. At lunchtime we used to go and have a beer, some people would drink to excess. That's how we coped.

In Catherine's case, having agonised, in private, about whether or not to attend her client's funeral, 'coping' had involved *going out for a night on the town [the night before Barney's funeral] and having quite a lot to drink because [she had been] feeling a bit lost, sort of unresolved, not ready to go home and go to sleep.* In the absence of avenues within his professional and personal life to openly express his grief, Dirk too had turned to alcohol as a means of coping with his client's death. As he readily admitted, however, his decision to go *overseas and drink tequila [which he'd] recommend to anybody [to do]* was really about *self-abuse.*

Whilst, for these three therapists, the use of maladaptive coping strategies had been determined, at least in part, by unsupportive cultures within their workplaces and/or private lives, for others, the use of ineffective coping strategies was predominantly driven by the therapist's decision to draw upon methods of coping they had used in the past when faced with stress, grief or trauma. Elspeth, for example, openly acknowledged that she had a tendency *to switch out of her emotions into her head too much*, which meant that she *had been able to detach herself from an emotional reaction to the suicide.*

In Holly's case, her *capacity to just kinda wrap everything up* and to engage in *lots of rationalisations and cognitive build-up* in relation to the suicide had, she acknowledged, *had something to do with [her] as a person and [that she] as a person definitely impacted [upon her] as a therapist.* It was only through engaging in this

study, and by deeply sharing her experience of her client's suicide, that she had allowed herself, for the first time, to be brought to tears and *to stop being afraid of her emotions*.

The above accounts reflect assertions by Allen and Hayslip (2001) that, faced with a new loss, mourners tend to draw upon strategies used in the past to cope. Given that the way in which a bereaved individual has responded to a past loss is regarded as being *the* most significant predictor of the length, pattern and intensity that their current mourning will take (Neimeyer 2000b; Martin & Doka 2000), serious implications are raised for therapist bereavement, post-suicide. As Valente and Saunder's (2002:11) caution, if a therapist's grief is not satisfactorily resolved, 'impaired personal and professional relationships, an increased sense of isolation, secrecy, suicidal feelings and use of substances' may arise. In light of this study's findings, cautions such as these should not go unheeded.

For Murray, however, it was neither a lack of available avenues of support nor the employment of previous maladaptive styles of responding that made coping with his client's suicide so difficult. Rather, it was the intensity of emotions he had felt in relation to the loss that had caused him to abandon his usual coping mechanisms. For Murray then, *the pain and heaviness and devastating impact [of the suicide]* had made it all seem *just too hard*, leading to his avoidance of avenues he had *turned to in the past when faced with intense emotions (such as journaling, poetry writing and prose)*.

Murray's experience of self-induced or internalised stigmatisation (Dunn & Morrish-Viners 1987/1988; Kneiper 1999; Van Dongen 1993) reflects the vicious cycle that Seguin, Lesage and Kiely (1995) have described in which the survivor of suicide's

self-imposed isolation initially leads to limited contact with others and subsequently to inaccurate perceptions about the degree of support that is potentially available. In these instances, stories become self-silenced rather than other-silenced.

Clearly then, because the therapists' experiences in relation to their clients' deaths were already being disenfranchised within both their professional and personal arenas, the strategies chosen by them to try and cope with the loss were also largely unseen or overlooked by others. None of the therapists interviewed discussed ever having been asked by their organisations or supervisors about the coping strategies they were using, nor had they been offered counselling by their employer, a finding reflected in the literature (see Rothchild 2004; McWilliams 2005). As a result of this lack of checks and balances, many therapists found themselves engaging, undetected, in less-than-effective strategies in response to their client's death.

Reactivation of Previous Loss Experiences

As the generalist bereavement literature has illustrated, current grief experiences have a habit of 'triggering other sadnesses from the past' (Moloney 2005:26), a situation that can amplify the impact of the present loss on the mourner. Although, with the exception of Kolodny et al (1979) and Pilkinton and Etkin (2003), previous research into the impact of client suicide on therapists has failed to explore this dynamic, its presence has been noted within this study, with over half the participants providing details of past deaths within their current loss narrative. In *every* case, these details were provided without prior prompting from me, triggered instead, by the therapists' recollections of the death of their client.

Holly, for example, found herself making comparisons between her reactions to the news of her client's suicide and those she had experienced in relation to both another

client who had died by that means several years earlier and to her brother's death. As she notes, *my brother got killed just years before that, and the same sort of thing...I can really compare it to when I heard my brother was killed.* For Elspeth, these past loss recollections related to her son's suicide; for Matt it was the suicidal death of his supervisor. In Jude's case, discussing the meaning-making process he had engaged in after his client's death had prompted him to reflect on the process he had engaged in at the time of his father's passing - *Jeez, that's exactly the same thing I found myself doing with dad as well.* Murray, too, found himself reminiscing about the other losses in his life as part of his conversation with me. As he acknowledged, *inevitably [talking about Simon's suicide] will reverberate around and connect with other losses, other missings in my life.* Finally, for Catherine, it was through being at her client's funeral that had *brought up memories of other funerals and other deaths* for her.

Whilst the reactivation of old losses is not a 'risk' for therapists per se, those who support them, would be well-advised to remain mindful of the fact that therapists are likely to be dealing with *concurrent* grief experiences and not merely the grief relating to the recent loss of their clients. The risk to therapists arises when a failure to take these re-activated losses, and their ensuing grief, into account occurs, since the disenfranchisement they may already be experiencing in relation to their client's death may be further compounded by this oversight. In order to reduce this risk, therapists must be provided with sufficient time, space and repeated opportunities to process not only their grief in relation to their client's suicide but also that which has been re-activated in relation to past losses. The following words from Murray capture this requirement eloquently:

My intuition says that to follow where the pain was would take me into other pains once more, and I would need a very wide ambit for this experience to then flow into an exploration of its meanings or its connection to other losses in my life.

Crisis of Confidence in Professional Role

In addition to struggling, at times ineffectively, with symptoms associated with stress or trauma, therapists also found themselves battling with a crisis in confidence, a phenomenon which has been recognised in the literature (see Alexander et al 2000; Anderson 2005; Grad, Zavasnik & Groleger 1997; Linke, Wojciak & Day 2002; Tanney 1996). For some of this study's therapists, this crisis was triggered by their belief that, since they must have missed the warning signs about their client's suicidality, they clearly did not have the skills necessary to remain in their role. For Aiden, a neophyte counsellor, *all his voices of self-doubt were quite disarming*. As he explains:

I'd arrived at this school with only a pastoral care background. So there were questions of, "I'm not worthy of this job. I don't have the background. If there'd been a trained counsellor this may not have happened."

For yet other therapists who had believed that they were adequately trained, experienced and competent with regard to working with suicidal clients, the death of their client by this means left them feeling completely de-skilled. As Faith describes:

[After Ryan's death] something happened to my confidence – "Can I trust my feelings? How can I trust my intuition? Will I pick up what needs to be picked up? Are [clients] safe with me?" ...I started to feel like I wasn't a good trainer [either] so I resigned. [It was like], "Well, how can I teach people about

[suicide awareness and intervention] when I don't even know how to do it myself? I'm a fraud," sort of thing.

In light of the suicidal deaths of two of his clients, Dirk also found himself questioning his competency as a therapist - *What is it about me that I'm doing wrong?* He even stopped answering the phone as he was having a physiological response of fear when it would ring and *changed his focus [by] not doing substance abuse counselling anymore or taking phone calls from the Survivors of Suicide [in case someone else committed suicide]*. So acute became the crisis he was experiencing, that eventually he got to the point where he went, *"Fuck it, I can't do this any more"* and took some extended leave.

For Faith, like Dirk, this crisis of confidence led to a radical modification of her practice in an effort to 'protect' both herself and her clients. As she explains:

I decided not to take on any new clients...to protect myself I think... It's almost like I didn't want anyone depending on me. I started referring my child clients on [too] as I thought they were the most vulnerable with me at that time...I was absolutely ruining my business. I just couldn't answer phone calls. I was just hiding away, climbing into a hole and hibernating...I kept telling [clients] about some other good therapist.

For yet others, more fundamental concerns about their choice of career came to the fore. In Matt's words:

There was like a cloud descending upon you, making you feel, "Am I competent enough?" and "If I am, how come I didn't pick [Josh's suicide] up?" So sitting in the [therapy] group [as the group facilitator] it was very uncomfortable to be

actually involved. I felt incompetent; the wind was taken out of my sail. “Should I even be doing this job? Have I got the right mental to do this job? I should have chosen some other career path.”

Whilst, for Matt, it took *three or four months* for him to *feel at ease with the clientele within the unit again, to feel part of the group* and to have his faith in his professional career path re-affirmed, for others, the journey back to a sense of professional competency was much more convoluted and painful. Faith, for example, experienced deep depression and suicidal ideation requiring treatment with anti-depressant medication. As she acknowledges:

It got to the point where I didn’t want to get out of bed. Clients would cancel and I’d say, “Great!” And it was like it all felt too much and I started to feel there must be a way out of this and I started to think about suicide as well. And in that very deep, dark hole, I couldn’t write, I couldn’t talk about it, I just drew all these spirals down to nothingness, lost in the wilderness, just lost.

In Faith’s case, even after slowly having begun to re-establish her practice after taking nine months leave, the question still remained, *“Do I want to keep operating on survival or do I want to grow or do I want to stop into something else?”*

Posthumous Countertransference

As the literature demonstrates, the degree of countertransference within the therapeutic relationship is a further factor felt to influence therapist bereavement, particularly when there has been strong personal identification by the bereaved with elements of their client’s story (Corn 2001; Reed 2005). This study, however, appears to be one of the first to provide insight into the impact of countertransference, posthumously. As the following discussion will demonstrate, despite the fact that their

client was no longer physically present, several therapists found themselves continuing to experience countertransference reactions, post-suicide. For some, these ghosts in the room were triggered by the type of suicide that their client had experienced, for others, they arose during post-death meetings with their client's family.

With regard to the former, Susan, for example, acknowledged that the one aspect of her client's suicide that she *still struggled with the most was that E.J. had hanged herself*. In the following excerpt, Susan admits that her issue with this mode of dying was *maybe her stuff* - a countertransference response evoked by her own belief that hanging would be an unimaginable way to end one's life. As she explains:

Like to me it's such a violent death...maybe it's my stuff being an asthmatic myself, but to die not being able to breathe...Like you'd think she'd take tablets or something. I don't get it.

In relation to countertransference triggered during encounters with members of their client's family, several therapists found themselves strongly identifying with other individuals who had also been bereaved by the loss. In Catherine's case, it was noting, during the funeral, that her client's sister was *almost like a mirror image of herself – well-dressed, similar body type*, a fact that had made her feel *really comfortable with her*, enough to *have taken a bit of a risk* and share some of her experiences in relation to Barney's death.

For Elspeth, it was a post-suicide therapeutic session with her client's wife that was to trigger a strong countertransference reaction, one which found her acknowledging that she *could really, really relate to what Ian's wife had been through* as her own son had also committed suicide. A post-suicide session was also to be the catalyst for

Murray's experience of countertransference. As his following dialogue will illustrate, because of his need to be regarded as a fellow mourner rather than as a therapist by his client's widow, the fact that she had denied him *the catharsis of sharing his story* (by expecting him to remain in his professional role) had left Murray feeling even more distressed at the session's conclusion. In his words:

I longed for her to ask me about what my experience of Simon had been and what my experience of his death had meant to me...If she had come and cried, and if we'd cried together even, that would have been a less painful experience [for me]...

It is evident from the above, that the presence of posthumous countertransference has potentially serious ramifications for both the therapist and remaining family members. Whilst not denying that, if monitored, countertransference can have a positive influence upon the therapist-client or even the therapist-family member relationship (Gelso & Hayes 2001; Fauth 2006), left unchecked, it has the potential to transform post-suicide interactions with family members (be they during funerals or post-suicide therapy sessions), from being forums in which the family can discuss and process their experiences as survivors of suicide, to arenas therapists use to work through their own loss, grief and mourning in relation to the death. Given the lack of other avenues available to therapists to engage in their own grief work, the fact that they might use (perhaps quite unconsciously) either the funeral or the post-suicide session to facilitate their own process of mourning is not difficult to imagine, however, in doing so, both their own needs for support and those of the remaining family members cannot help but be compromised. Recommendations for addressing this issue, with particular focus upon the role of supervision, are contained in the following section.

Having now examined the potential risks posed to therapists of client suicide and the disenfranchisement this entails, it would be easy to conclude that such experiences are both tragic and traumatic in their entirety. For the majority of therapists interviewed, however, despite the enormity of this event in their lives, it was not without its benefits. These benefits, and the ways in which they informed and shaped therapists' subsequent practice and beliefs about self are discussed in the following section.

Positive Legacies: Stories of Transformation not Tragedy

As numerous researchers (see Grad, Zavasnik & Groleger 1997; Tanney 1995) have noted, whilst the suicide of a client can be one of the most profoundly challenging experiences that a therapist can encounter, it can be transformative and growth producing. As the following discussion will illustrate, the notion of suicide being a positive learning experience was reiterated in a number of the therapists' stories.

An increased sense of confidence in their role

For many therapists, the initial destabilising and, at times, dismantling impact of their client's suicide gave way to an increased sense of assuredness in their abilities in their professional role. Having once regarded the suicide as evidence of their lack of suitability for their vocation or proof of their lack of training or skills, these therapists came to reframe the experience as having been a gift that had allowed them to grow in ways that perhaps would not have been available to them had these circumstances not arisen. An extract from a follow-up email from Matt, sent after he had read the transcript of his interview, clearly captures the positive legacies the experience had provided him with:

Rather than seeing the glass 'half empty' and live immersed in inadequacy, self-doubt and lacking in self-trust in my own capacity for productive work... I

began an accelerated healing process, beginning to see the glass “half full”, using the experience to grow.

Like Matt, Aiden also acknowledged the transformation he had undergone as a result of his client’s death, admitting that the trajectory his life had ended up taking because of this loss would likely have been very different had the suicide not occurred:

There’s a bit of a smile on my face when I think about shifting from the self-doubt to the greater confidence in, “Look, I can do this okay.” I may not have made those shifts in the same way, had the same opportunities for growth [like going to uni and doing a counselling degree] if I hadn’t been through that experience, so that’s a bit of a different twist on it. And [as a result of Carl’s suicide] I made some really good friends around town. It’s amazing, isn’t it, how there can be a glimmer of light amongst situations like that?

More authentic as therapists and more realistic about their capacities

In addition to their new found confidence, several therapists attested to the gift of greater authenticity that their experience of client suicide had given them. It was as if, having had the myth of their own omnipotence and perfection shattered, they were now free to acknowledge their own vulnerabilities and limitations and, in doing so, engage in much more genuine and effective therapy, findings which echo those of numerous other authors (see Gitlin 1999; Rae 1998; Takahashi 1997). As Faith and Matt explain:

Faith: I think I actually did have to go through there [where] everything was shattered. I’m very grounded in my vulnerabilities now. I’m much more real. I think I’m much more authentic as a counsellor and my response is more authentic, so I feel I’m actually a better

counsellor. I suppose they are the fruits and the gifts of it - that I've found myself really.

Matt: It became a turning point in my life, particularly in relation to the business of, "Am I worthy of my position? Have I got the capacity to move on from here within the profession and not run away from it?" [Nowadays] as long as I know I've given every effort I've got no qualms in feeling bad or guilty. That's all I can do...Suicides always happen [and] we can guard against it [but] we can't stop it. At the end of the day [having a client commit suicide] was nothing to be ashamed of or blame yourself for as long as you'd done everything you were supposed to do.

In Dirk's case, the suicides of two of his clients had led him to spend the last few years *working fairly hard on himself personally*. As a result, he had come to a place where he *could now look back at the experiences with the suicides and reckon it was probably the best experience [he] could have had [because] it broke down all the facades for him*. Furthermore, *once he'd gotten past his initial fear of working with suicidal clients again, he'd concluded that he was now far more authentic [because] he wasn't working from a textbook and saying, "Well, this is what you should do."* In his words:

I think I'm more therapeutically aware now [of the] need to watch my steps a little bit in terms of not having that arrogance. So some good's come out of it.

Increased thoroughness, pro-activity and directness when working with suicidal clients

That therapists experience a heightened sense of protectiveness towards their remaining clients as a result of having had a client suicide has been documented in the literature (see Kolodny et al 1979; Knox et al 2006) and is also replicated within the current study. Matt, for example, conceded that his client's death had been *very instrumental* to his professional development since now, when working with suicidal clients he *knew [he'd] done everything possible – documentation, clear communication, case management, goals in terms of the person, being a bit more diligent, more open, more honest, more probing. There's nothing [now] to search in my mind in terms of, "Did I do this? Did I do that?"*

For Elspeth who, prior to her client's suicide, had felt that she *wasn't secure enough in the validity of [her] own opinion* to argue with other health professionals about the need for greater client care and support, the subsequent death had provided her with both an increased sense of confidence and a heightened conviction to be as pro-active as possible in instances of suicidal risk. Elspeth describes this transformation in the follow way:

Have I learnt anything? Yes I have. Now I would ring the GP and put a lot more pressure on him. That's the one thing I could have done and didn't do. I do that at the drop of a hat now...I'd say it's been pretty positive since so many are referring clients to me. With my current client I've been very precise, very outspoken so I haven't had the experience of trying to give [the Mental Health Team] a message and for them to discount it.

Positive transformations, like those discussed above, have been documented by previous researchers and lend weight to previous observations (see Doka 1998; Doka

& Davidson 1995; Neimeyer 2000b; Sommers-Flanagan & Sommers-Flanagan 1995) that a therapists' schemas (core beliefs about self and others) may have a profound influence upon their bereavement process. Thus, therapists like those discussed above, who regard their client's suicide as an opportunity for growth and who are able to re-contextualise the death in ways that do not prohibit new possibilities and attachments, are more likely to also describe higher levels of self-confidence and self-awareness (DeSpelder & Strickland 2002), elements which increase the likelihood of positive bereavement outcomes.

Whilst not wishing to minimise the 'life-changing gift that working in the presence of grief' can be for therapists (Becvar 2003:470), the fact still remains, that having a client commit suicide exposes therapists to a number of risk factors. Furthermore, because of the inherently disenfranchising nature of this type of loss, these risk factors are likely to remain hidden from view, potentially exacerbating their impact. In light of this, and by way of closure, the final pages of this thesis offer a series of recommendations for future practice and research in the hope that they might contribute to the amelioration of this currently unacceptable situation.

Recommendations with Regard to Minimising the Risk of Therapist Disenfranchisement in Relation to Client Suicide

As stated at the outset of the thesis, the aim of this research was to explore how the death of a client by suicide is a disenfranchising experience for therapists. So that a more detailed investigation of this primary question could occur, a series of corollary questions were also formulated, including:

- a) How does this disenfranchisement occur within the therapist's professional life/role?

- b) How does this disenfranchisement occur within the therapist's personal life?
- c) When therapists describe their experiences of disenfranchisement, which 'voice' do they speak from: their professional, their personal or both?
- d) What are the dominant discourses in relation to client suicide that lead therapists to experience disenfranchisement?
- e) What factors increase the risk of disenfranchisement occurring?
- f) What factors reduce it?
- g) What changes need to be made (for example, to training programmes and ways of supervising and supporting therapists) to minimise the risk of disenfranchisement from occurring in instances of client suicide?

Having answered questions (a) to (f) in Chapters 6 through 10, and based on these findings, the following recommendations (pertaining to question g) are made with regard to reducing the risk of therapist disenfranchisement in relation to client suicide.

Recommendations for the field of Thanatology

To date, and with few exceptions, those working within the field of thanatology have regarded suicide as being a predominantly sudden and unexpected event. However, as this study has demonstrated, for the *majority* of participants, this was far from being the case. More often than not, the suicides discussed by these therapists were described as having been inevitable rather than unexpected – a matter of when, not if. Furthermore, Jude and Murray's accounts of their 'suicide-in-slow-motion' experiences challenge the notion that suddenness is also a necessary attribute of death by this means.

In light of these findings, and building upon previous recommendations by de Leo et al (2006), Maple (2005) and Maple et al (2007), there is an urgent need for a new,

consistent definition of suicide to be created. The results of this study would suggest that this definition needs to be based upon the *self-initiated intentionality* (Wright 1996; de Leo et al 2006) of the act (a first person perspective) rather than on the degree of expectedness, inevitability or suddenness experienced by others (a third person account). By locating the definition of suicide within this frame of reference, deaths that are self-inflicted and intentional (and expected by others), self-inflicted and intentional (and unexpected by others), self-inflicted and intentional (and sudden) or self-inflicted and intentional (and slow) could *all* be recognised and legitimised. Certainly, had a definition based upon *self-inflicted intentionality* (with its accompanying corollary) been available to therapists at the time of this study, the confusion felt by participants such as Jude about how to define the suicide (in his case, his client's slow, agonising and expected death from a *self-inflicted intentional* injection of the HIV virus) would have been eliminated. Clearly then, until the currently limited definition of suicide is removed from the vocabulary of thanatology, the limited and limiting stories that arise from it will continue to be told. As de Leo et al (2006:5) note, 'it would be highly desirable that the set of definitions and the associated terminology [with regard to suicide] be explicit and generalizable.'

Recommendations for Training

To date, programmes that focus upon risk assessment and prevention remain the cornerstone of suicide-related training for therapists at both the undergraduate and post-graduate level. Although the availability of such programmes and the comprehensiveness of their curriculum remain contentious issues in some circles (see Laux 2002; Neimeyer 2000c; Knox et al 2006; Tanney 1995; Yousaf, Hawthorne & Sedgwick 2002), therapists are likely, nonetheless, to have access to training in both risk assessment and suicide prevention at some point in their professional lives. As the

findings of this study have demonstrated, however, in instances of *completed* suicide, because of the current dearth of training in this area, therapists are often left struggling to comprehend not only that this experience *does* happen, but that it has happened to *them*.

It is imperative, therefore, that much greater emphasis be placed upon designing and implementing programmes that include training about the experience of *completed* suicide, so that increased general knowledge about, and understanding in relation to, this event can emerge. For such training programmes to be of benefit, however, they must incorporate the following information:

- a) How therapists might respond to the pragmatics and protocols attached to the death, particularly in situations where their employer, supervisor or registration board hold different expectations or requirements to their own.
- b) The impact, both short- and longer-term of the suicide upon therapists' professional and personal lives.
- c) The types of support, both formal and informal, available to therapists, post-suicide (for example, supervision, EAP counselling, personal counselling) including the potential strengths and limitations of each.

As Knox et al (2006) point out, whilst training in relation to completed suicide may not reduce the immediate emotional impact of the death on the therapist, it may go some way towards preparing them for the possibility that such an event may occur within their professional life; help educate and forewarn them about the personal and professional impact; and begin the normalisation process. It will only be when, at the grass roots level of therapist training and development, the *reality* of client suicide and its impact upon therapists is made a more visible and likely aspect of professional

practice, that any real inroads will be made into reducing the current stigma, misconceptions and disenfranchisement that this experience currently evokes.

It is not enough, however, to merely include training about completed suicide within future curriculum. Education about grief and mourning should also be offered as part of all undergraduate and post-graduate counselling programmes so that therapists are better able to recognise, understand and respond to any future situations of loss that they may encounter. As Hadfield (2007:316) notes, 'it is inevitable that the ways in which loss has impacted on personal life will emerge in counsellors' therapeutic work'. As part of this educative process, an increased awareness of the coping strategies therapists' have used in previous instances of loss, together with training in alternative, more resilient coping styles, if applicable, would also be important since, as this study has highlighted, past ways of dealing with loss and grief inform therapists' current responses to bereavement. Furthermore, therapists need to recognise that since an individual's schemas inform their responses to loss, they will only be able to deal effectively with their own grief-related needs if they have thoroughly reviewed and revised their existing belief systems (Walsh-Burke 2006) as part of their professional development and training.

Recommendations for Codes of Ethics

Changes are also required to the Codes of Ethical Conduct that are used by the profession to both train and 'monitor' its members. The restrictive nature of the current codes, whose rules and regulations pertain only to the embodied client-therapist relationship, means that, post- client death, there is a complete absence of information or guidelines regarding the ethical conduct expected from therapists in relation to posthumous client-therapist relationships. Until ethical codes contain a

dedicated section relating to instances of completed suicide, therapists will continue to engage in private, and at times agonising, struggles about what “appropriate” or “ethical” behaviour actually entails in such circumstances.

Changes must also be made to the codes’ stipulations that therapists be provided with external options for counselling should personal issues arise within the supervisory context. Given that the death of a client through suicide *automatically* becomes a personal issue for therapists, existing codes need to be modified to reflect and accommodate this reality. The current expectation that therapists be sent off for personal counselling in instances of client suicide, serves only to reinforce the current pathologising of their grief – further entrenching its taboo-ness. Instead, the profession must be prepared to include therapists’ stories of grief within the supervisory context, for only then, can the mourning experienced by bereaved supervisees be viewed as a normal response to the death of a client and not something required to be dealt with through personal counselling. As Wosket (2000) has noted, in relation to life-changing events such as client suicide, supervision has the capacity to encompass dual roles and relationships without the boundary between supervision and therapy ‘stretching so far that it snaps’ (p. 61).

In a similar vein, changes to the ethical guidelines stipulated by research review committees in relation to bereavement research are also warranted. The fact that current guidelines are informed by medical and psychiatric models of mourning means that guarding against the risk of triggering grief-related psychopathology in participants becomes their major aim (Payne & Field 2004:55). This cannot help but place unnecessary constraints upon bereavement research. Within the context of the current study, for example, the stipulation by the university research ethics committee

that only therapists who were currently engaged in supervision (or had ready access to it) could participate, meant that several therapists, keen to share their stories with me, initially signed consent forms agreeing to this condition but subsequently demonstrated that they had *no* intention of actually abiding by it. That participants were willing to ‘hoop jump’ in order to participate is a provocative finding, reflecting not only the urgency of their need to be heard but also the gap that currently exists between the intentions of research committees’ guidelines and those of the participants. Perhaps, as Payne and Field (2004:55) suggest, by adopting social, rather than medical or psychiatric models, which offer non-pathologising, narrative reconstruction frameworks for understanding bereavement, research ethic committees would be better able to support future research endeavours within the field of thanatology.

It is evident from the above, that many therapists feel silenced by the existing codes of professional conduct whether they abide by them or break them. This no win situation perpetuates the gap identified by therapists between the rhetoric being espoused by regulatory bodies and the reality of the therapists’ lived experiences. Until new rules encompassing the post-death client-therapist relationship take effect, the disenfranchisement that this gap currently creates is unlikely to be reduced.

Recommendations for Supervision and the Supervisory Role

Frameworks of Supervision

That supervision feels like an unsafe or unsatisfactory experience for many therapists, post client suicide, has serious ramifications for the profession. It is evident from participants’ stories, particularly those in which supervision was avoided altogether, that the very thing that therapists required from supervision in the aftermath of their

client's death (that is, a reflexive, experiential forum) is the very thing that supervision currently purports not to be able to offer. As Peake, Nussbaum & Tindell (2002 cited in Barrett & Barber 2005:172) note, between 1990 and 2000, only 15 supervision publications were devoted to trainee maturity and emotional development whilst 125 focussed upon the development of therapeutic skills and interventions. Clearly then, by continuing to stipulate that supervision should focus primarily upon accountability, monitoring, manualisation of treatment, litigation and cost containment (Carroll 2007, 2008; Peake, Nussbaum & Tindell 2002), registration boards, counselling associations and the organizations in which therapists work are severely constricting the attractiveness and viability of this avenue of support for therapists struggling to come to terms with their client's death.

By being too prescriptive and formulaic, the current structure of supervision closes down therapists' stories rather than facilitates their deeper exploration. In Carroll's (2007:26) words, the supervisory experience has lost 'its personhood and soul.' Frameworks of supervision that can accommodate a therapist's subjective reality, as well as the objective truth, are therefore required. The fact that a narrative approach to data collection in this study facilitated the deepest process of story-telling that these therapists had encountered, suggests that this framework may work well within the supervisory context. The idiographic stance that narrative approaches take permits the personal voice of the therapist, and the story it speaks to in relation to the loss, to become visible, known and sanctioned rather than invisible, hidden and lost. Thus narrative frameworks of supervision may be particularly suited in instances of client suicide where therapists' stories are likely to have become disenfranchised during the bereavement process (Betz & Thorngren 2006). According to Sullivan and Agostinelli (2007:86-91), other supervisory frameworks that are likely to be receptive to the

personal voice of the therapist include psychodynamic, systemic, person-centred and developmental approaches (see Barrett & Barber 2005) since ‘they stress the importance of addressing counsellors’ personal development during supervision’ (p. 86). Hawkin and Shoheit’s (2000 quoted in Ashby 2005:5) process model may also be applicable as ‘the personal, psychodynamic dimension is the sensitive core’ (p. 6) of this approach to supervision.

Furthermore, since this study’s findings support those of previous authors (see Wosket 2000), that current losses inherently trigger previous ones, supervision needs to cast a much wider net in relation to its focus, post-suicide, exploring the ripple effects created by the client’s death. New supervisory frameworks would do well, therefore, to include the seven general principles of grief therapy provided by Neimeyer (2001c: 174 – 180) and described in Chapter 2 of this thesis.

In order for this reflexive, repetitive, meaning-making process of storying to occur, however, emphasis within the health care system in relation to supervision must shift from being placed upon brevity and case closure to the provision of open-ended opportunities for ongoing case management, post-death. Whilst this might be a challenging prospect in the current health care climate (Peake, Nussbaum & Tindall 2002) it is a necessary one, nonetheless, if therapists are to avoid having to struggle to negotiate the ‘Canyon of Why’ (Campbell quoted in Myers & Fine 2007:121) which so often occurs in instances of suicide.

Clearly then, conducting supervision as if it were little more than an adjunct to, or alternative form of, psychological autopsy, where the focus is upon scrutinising case management, ethics and liability risks, is not enough. Neither is talking about the suicide as if it were just an isolated, purely professional event in the life of the

therapist. As the results of this study have demonstrated, for supervision to offer the best fit for supervisees in instances of client suicide, its scheduling, location, focus, and timeframe should be determined by the therapist and not by the supervisor or the organization in which the therapist works. Thus, ‘beer garden supervision’ or ‘dinner and drinks supervision’ must be viewed as being equally as valid and effective as supervision that is conducted behind the closed doors of the supervisor’s office. Similarly, sessions in which the focus is on the personal impact of working within a therapeutic context must be given the same credence as those in which the pragmatics of the profession form the basis of the agenda. Only by empowering therapists in this way, and by recognising that the uniqueness of their experience requires a uniquely tailored forum, will supervision become an attractive option for the sharing of stories that have, until now, been intentionally omitted from, or significantly censored within, the supervisory context.

Supervisory Role

Unquestionably, the adoption of more narratively based supervisory frameworks would require that the supervisory role become more flexible and idiographic – one which permits the subjective reality of the therapist to be explored and validated in addition to the objective truths. The results of this study suggest that this would be particularly pertinent in instances of ambiguous loss, since supervision may be the only arena in which the therapist is actively invited to voice their fears about their client’s non-return to therapy and have these concerns validated and explored. Furthermore, since there are no rituals for mourning in relation to ambiguous loss, the supervisor’s role must also include the creation of a forum through which the therapist can be encouraged to engage in a symbolic ritual to signify the absence of their client (Beder 2002; Betz & Thorngren 2006).

That countertransference has been found to exist in the posthumous client-therapist relationship also has critical implications for the supervisory role. If, as a result of supervision, countertransference is identified post- client death, the supervisor may either need to be present during any follow-up sessions with the remaining family members or ensure that a co-therapist is available during such encounters. Whatever course of action is taken, however, it must be done in such a way that the therapist does not feel pathologised, as this is likely to reduce the chance of issues relating to countertransference being brought to supervision in the first place.

Finally, as the conduit between the therapist and their place of employment, supervisors must be willing to adopt the role of spokesperson for organisational change in relation to bereavement leave for therapists. By advocating that greater time and space for processing grief; and adequate leave to attend funerals, memorial services, personal therapy or to engage in other personally significant rituals be provided to therapists *before* they are expected to resume their caseload, supervisors can help to reduce the disenfranchisement that the lack of such provisions currently creates.

Recommendations for Future Research

In light of this study's findings, the following arenas, which fell outside the parameters of the current research, warrant further investigation:

Therapists' experiences of ambiguous loss

That the psychological reactions of therapists to their clients' unexpected failure to return to therapy reflect those noted in individuals responding to the unexpected loss of a loved one (for example, a preoccupation with, and information seeking about, what might actually have happened (Beder 2002)) requires further exploration. Since

research to date has focussed exclusively upon ambiguous loss in the context of personal relationships, questions cannot help but be raised with regard to the similarities and differences that exist between this type of ambiguous loss and that which occurs within relationships in which the missing person is a client rather than a family member.

Therapists who remain ‘silent statistics’

Whilst this study has been able to provide insights into the disenfranchisement experienced by therapists who chose to remain in practice after their client’s suicide, the stories of therapists who chose to cease practice as a result of the death remain hidden. Whilst not denying that it may prove extremely challenging to access this population, particularly if they have also chosen to leave the health and welfare sector all together, the information they would be able to provide about their reasons for having made this choice, could offer valuable insights into these forgotten mourners.

Posthumous countertransference

Whilst information exists about the impact that countertransference can have on the therapeutic relationship, there is little written about its impact beyond the grave (Fauth 2006; Ligiero & Gelso 2002). Having unexpectedly identified its existence in the posthumous therapeutic relationship during the course of this investigation, future researchers are now encouraged to intentionally explore this phenomenon in greater depth. Based on this study’s findings, preliminary suggestions have been made in relation to the possible need for the presence of a supervisor or co-therapist during post-suicide sessions with remaining family members. Future investigations into the fruitfulness of such an intervention would also be of value.

Therapist survivor-of-suicide support groups

Survivors-of-suicide support groups have proven to be an effective means of support for those bereaved by the suicidal death of a significant other (Clark & Goldney 1995; Sudak, Maxim & Carpenter 2008; Ping Tsao, Tummal & Weiss Roberts 2008). That therapists currently appear to choose not to access such groups may be due to a myriad of reasons. Future research into the barriers to therapist attendance may shed some light on ways of making such groups more accessible for this survivors-of-suicide population. A pilot study into the effectiveness of offering support groups targeted specifically at therapists might also be of value. Through such a study, hypotheses about the capacity of such groups to reduce the sense of isolation, stigmatisation and disenfranchisement (and the concomitant risks of stress, vicarious trauma and/or career change) currently experienced by therapists could be tested.

Contributions of this Research to the Field of Thanatology

Suicide bereavement and disenfranchisement

In addition to enriching existing research into the impact of client suicide on therapists, this study has been one of the first to directly examine the experience of disenfranchisement of therapists in relation to death by this means.

Having now made the stories of these therapists more visible and accessible, this research (like that previously undertaken in relation to children, the elderly and the developmentally delayed) has also provided some of the first insights into the ‘stereotypical assumptions’ (Neimeyer 2000b) currently made about this population of forgotten mourners.

Furthermore, whilst my findings support previous research demonstrating that factors such as therapist years of practice, level of seniority, age, gender and theoretical

orientation have no bearing on the risk or frequency of client suicide (see Chemtob et al 1989; Cryan, Kelly & McCaffrey 1995; Coverdale, Louie & Roberts 2005; McAdams & Foster 2000), they also illustrate that these factors have no bearing on, and provide no immunity from, the degree of disenfranchisement that a therapist will experience post-suicide.

Redefining the terminology in relation to what constitutes a 'suicide'

The findings of this study offer support to recent groundbreaking research by Maple (2005) that suicide is not always unexpected. Furthermore, they provide some of the first evidence that suicide is not always the sudden event that existing literature would suggest. In light of this, a definition of suicide, based upon the self-inflicted intentionality of the act, has been suggested.

'Relief' in response to loss

To date, the scarce empirical and theoretical literature that exists in relation to the experience of relief after death has examined loss within the context of personal relationships (Elison & McGonigle 2003). This study, with its focus upon relief after death within the context of a professional relationship, broadens and deepens our understanding of this 'non-traditional loss response' (Elison & McGonigle 2003: xix).

Support for a 'continuing bonds' perspective

It is clear from these participants' accounts that therapists wished to maintain an ongoing relationship with their clients, post-death. Whilst support for a continuing bonds perspective has been growing within the generalist bereavement literature, this study provides concrete evidence that the loss of a *professional* relationship evokes similar needs within the mourner for continued connectedness with the deceased. In light of this, Clark's (2001b:106) recommendation that suicide postvention

interventions include the ‘application of Neimeyer’s (2000) concepts of meaning reconstruction and Klass’s (1996) work on continuing bonds with the deceased’ is endorsed by the findings of this study.

The importance of ‘linking objects’ in professionally related loss

Whilst the significance of linking objects has been well documented within the bereavement literature, much of the discussion has focussed upon the solace that they have provided to mourners who have experienced a loss in their personal lives. Through data collected during this study, the critical importance that the role of such objects plays in the lives of individuals mourning a loss in their professional lives has been uncovered.

Broadening the parameters of those affected by ‘ambiguous loss’

Since *clients* as missing persons are not recognised or referred to in the current literature, this study is one of the first to identify the occurrence of ambiguous loss within profession rather than personal relationships. In doing so, it broadens the parameters of those affected by missing person’s experiences to include therapists as well as family members and friends.

Countertransference in the post-termination phase of therapy

As the literature review has illustrated, to date, the post-termination phase of therapy has received very little attention, leaving Garcia-Lawson, Lane and Koetting (2000:88) to observe that there is still ‘much to learn about this phase and the problems that are likely to emerge during this potentially difficult period.’ By uncovering the existence and impact of countertransference in the post-death relationship, the current study has shed further light on this under-researched aspect of the therapeutic process.

Limitations of the Current Study

Within the majority of qualitative research articles reviewed for this study, mention is made of the limitation of engaging in retrospective data collection because of its propensity to lead to compromised recall of the emotional impact of the event under investigation (see Kleespies, Penk & Forsyth 1993; Valente & Saunders 2002; Yousaf, Hawthorne & Sedgwick 2002). It is my contention, however, that collecting retrospective stories was, in fact, a strength of the research methodology used since not only did it demonstrate the *ongoing* impact that client suicide has upon therapists (sometimes decades after the death) but it also highlighted the continuing bonds that exist between these therapists and their clients.

The use of a small, purposive sample might also attract criticism because of its lack of generalisation to the larger professional community. However, the intention of this research was not to provide information about the broader population but rather to offer a series of description-rich, previously unheard accounts that might resonate with the reader (Hunter & Schofield 2006).

By Way of Conclusion...

In closing, I would like the final 'voice' heard in this thesis to be that of participant rather than researcher since it is *this* voice that has informed all that has been written. I leave you then with the words of Matt, whose following reflection succinctly captures the overall findings of this study:

Experience in the [suicidal death of a client] tells me:

Self-flagellation is unproductive

Validation of the initial emotion is essential

Reconciling what has happened, how we fare and what we need to do in the future is equally as important

Moving on, regaining self-composure and confidence is paramount

Having sustained support in the initial stages is ever so essential

And last, but not least, having the opportunity to tell your story again and again is so much a part of the healing process.

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Appendix A

Information Sheet

PhD Research Project

“The Impact of Client Suicide on Therapists”

Dear Colleague,

I am writing to invite you to participate in a research project I am undertaking towards my PhD in Counselling. Whilst the major aim of this project is to explore the personal and professional impact that client suicide has upon therapists, it is anticipated that recommendations about the future training and supervision needs of therapists who have experienced such an event might also emerge in light of the study's findings.

To be eligible to participate, you must be 18 years of age or older, but need not be currently practising as a therapist or counsellor. You must, however, have had the experience of having a client suicide whilst under your therapeutic care.

If you choose to participate, you will be asked to complete a brief questionnaire and engage in an in-depth interview (of approximately one hour's duration) with the researcher. This interview will be audio-taped (for transcription purposes) and held at a time and place convenient to you. A follow-up interview may also be conducted (if additional details or clarification of information provided in the initial interview is required). Participation in this study is voluntary in nature and you may withdraw your consent at any time without penalty.

To ensure your complete anonymity, pseudonyms will be used throughout the study as well as in any publications or presentations that may arise from this research. At all times, your personal details and information will remain confidential and be accessible only to the researcher and her supervisors. Audio-tapes will be erased following transcription, and transcripts kept securely for a five year period after which time they will be destroyed. The anticipated completion date for the study is 2009.

Because of the potentially sensitive nature of the topic under investigation, it is a requirement of this study that participants either be engaged in regular supervision or have ready access to it. You may also wish to contact another trained counsellor (e.g. at your local Community Health Centre or at Lifeline (13 11 14)) should further support be required.

If you have any questions regarding this research project, you are most welcome to contact me, after hours, on (02) 6772 9339 or 0403 150 973, or via email at janelauraclark@yahoo.com. Alternatively you may contact my Principal Supervisor, Dr Annmaree Wilson on 0413 845 681 or via email at awilson4@metz.une.edu.au.

The project has been approved by the Human Research Ethics Committee of the University of New England (Approval No: HEO4/115). Should you have any

complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services,
University of New England,
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile: (02) 6773 3543.
Email: Ethics@metz.une.edu.au

As I would greatly value your contribution to my study, I hope that you will choose to participate if you meet the eligibility requirements outlined above. Please feel free to contact me either by phone or email (see details above). Looking forward to hearing from you.

Yours sincerely,

Jane L. Clark
Registered Psychologist (PS 0045401). MAPS.
677 Rockvale Road,
Armidale,
NSW 2350.

Appendix B

Participant’s Demographic Details

PhD Research Project:

“The Impact of Client Suicide on Therapists”

Researcher: Jane Clark

Principal Supervisor: Dr Annmaree Wilson

(Counselling Programme: School of Health. University of New England)

Dear

Thank you for agreeing to take part in my PhD research project. I would be grateful if you could complete this brief questionnaire in relation to your demographic details. Once completed, please return it to me in the enclosed, pre-paid, envelope. Shortly after its receipt, I will contact you to organize a time and venue for our in-depth interview.

(1) Sex (please tick the applicable box):

- Male
- Female

(2) Age (please tick the applicable box):

- 18 - 22
- 23 - 26
- 27 - 31
- 32 - 36
- 37 - 41
- 42 - 46
- 47 - 51
- 52 - 56
- 57 - 61
- 62 and over

(3) Professional Title (please tick all applicable boxes):

- Counsellor
- Psychologist
- Psychotherapist
- Other (please specify).....

(4) Qualifications held:

(5) Theoretical orientation (please describe):

.....

.....

.....

(6) Are you currently practising (please tick the applicable box)?

- Yes
- No

If you answered 'No' above:

(a) Date of last year of practice:

(b) Reason for cessation of practice:

.....
.....

(7) Practice details (please tick all applicable boxes, answering retrospectively if required):

(a) Type of practice:

- Self-employed
- Government organization (e.g. DoCS).....
- Non-government organization (e.g. private school).....
- Other (please specify)

(b) Average number of sessions per week:

(c) Postcode in which practice/service located:

(8) Years in Practice (please tick the applicable box):

- 0 – 5 years
- 6 – 10 years
- 11 – 15 years
- 16+ years

(9) Year in which your client committed suicide:

(10) Are you currently engaged in supervision?

- Yes
- No

If you answered “Yes” above, what type of supervision do you engage in and how frequently does it occur?

.....
.....

If you answered ‘No’ above, do you have ready access to supervision if required?

- Yes
- No

Thank you for your participation. Please return your completed questionnaire (in the envelope provided) as soon as possible. I will contact you within one week of receipt of your questionnaire to arrange a time and venue for our in-depth interview.

Yours sincerely,

Jane L. Clark
677 Rockvale Road,
Armidale,
NSW 2350.
Telephone: (02) 6772 9339 or 0403 159 973
E-mail: janelauraclark@yahoo.com

Appendix C

Follow-up Letter

PhD Research Project

“The Impact of Client Suicide on Therapists”

Dear Colleague,

Recently I wrote to you inviting you to participate in a research project I am undertaking towards a PhD in Counselling. If you are eligible to participate (i.e. are over 18 years of age, have had a client suicide whilst under your therapeutic care, and have ready access to supervision), and would like to contribute to my study, you are still most welcome to contact me on my mobile (040 315 0973); my home phone (6772 9339) or by email (janelauraclark@yahoo.com) so that we can arrange a time to meet.

If you are either not eligible to participate (i.e. you do not meet the study's criteria) or are eligible to participate (but have chosen not to do so), I would still be extremely grateful if you could contact me with this feedback, as it will provide invaluable demographic information for my research.

Once again, many thanks for your time and input.

Yours sincerely,

Jane L. Clark
(Registered Psychologist PS0045401)
677 Rockvale Road
Armidale 2350

Appendix D

Participant's Consent Form

PhD Research Project:

“The Impact of Client Suicide on Therapists”

Researcher: Jane Clark
Principal Supervisor: Dr Annmaree Wilson
(Counselling Programme: School of Health. University of New England)

I,(full name of participant), being 18 years of age or older, have read and understood the information contained in the ‘Information Sheet for Participants’ and have had all questions that I have raised answered to my satisfaction.

I am aware that the interview(s) in which I am participating will be audio-taped and that these tapes will be erased once they have been transcribed.

I agree to participate in this activity, realizing that I am free to withdraw, without penalty, at any time.

I agree that the research data gathered for this study may be published, provided that my name is not used.

.....
(Signature of Participant)

.....
(Date)

.....
(Signature of Researcher)

.....
(Date)

Appendix E

ELSPETH

‘Reflections on clients who escaped from their unendurable emotional pain but in their escaping left behind a wider circle of pain in their families and in those who tried to be there for them.’

Introducing Elspeth’s Story

Whilst I had initially met Elspeth approximately ten years ago, I was to lose contact with her until we bumped into each other at a conference seven years later. Having listened to my presentation, she was both fascinated by, and keen to be part of, my study.

The component stories that follow are based upon my two interviews with Elspeth. The first interview occurred at the completion of the conference. The second took place, at Elspeth’s request, at a subsequent conference, and was prompted by the reactions of others to my presentation of extracts from Elspeth’s initial interview’s transcript. (See the Epilogue for further details).

Elspeth’s Story of Ian

Whilst, in her counselling role within a women’s health centre, Elspeth had had a number of *very suicidal clients who had just disappeared* (leaving her to wonder, “*Did they go and do it?*”), she *did know of two clients, Ian and Rachel*, who had killed themselves. It was these two clients that she therefore chose to talk about, Ian first, as *she had less to say about him than Rachel*.

Ian, *a qualified builder and carpenter*, had recently abandoned his career in the building industry, having become *obsessed with the thought that he had to provide a high level of income for his family and that building was never going to do that*. Fixing his sights on *selling investments, a bit like a pyramid scheme*, Ian obtained a

lot of training videos and was adamant that he and his wife *sit down and watch them* – something she had no desire to do as she saw them as *very lame stuff, very unrealistic*.

When they first came to see Elspeth, Ian and his wife were clearly at loggerheads. There was *just no meeting in the communication at all*. Ian's wife was arguing *that all she was asking was for Ian to go back to work while Ian was saying that that was absolutely the wrong thing to do and that she had to believe in this dream or it just wouldn't work*.

Elspeth's Story of Her Therapeutic Relationship With Ian

Despite the conflicts that Ian and his wife were experiencing in their relationship, Elspeth *only saw them together as a couple once*:

Having heard her story and his, and being an accountant, I began really testing his dream, his expectation, which was entirely the wrong thing to do because that immediately classed me as, "Useless, no good, I couldn't help." He was very rejecting of any idea that he might need to shift his aims or ideas or that they should even be questioned or examined.

Whilst Elspeth had suggested during the session that Ian *go and see his doctor and have a check (because he was so totally unrealistic in his dreams and expectations)* she *couldn't persuade him in any way, nothing would reach him*.

In light of this session, Elspeth's case notes concluded with the following statement:

I really fear for him when he is forced to face reality because he is not rational.

It was *maybe about a month later* that Elspeth *heard that there'd been this suicide, a guy had put a nail gun through his head*. Whilst she had *wondered if it was this man*,

no names were mentioned so she had no real way of knowing. It was only when his wife came back for grief counselling six months later that Elspeth heard the full story of what had happened:

He had become angrier and angrier, very violent to the point where the sons, they had three adolescent sons, rang the police. The police had come a couple of times and the second time they made her take out a DVO against him. He then started coming to the house and trying to break in. He was really bad, irrational. It was getting to the point of severe danger. Anyway, the police were called again and carted him off to jail for the night and it was evidently when he got out of jail the next morning that he got one of his tools and put the nail gun through his head.

Elspeth's Story of the Impact of Ian's Suicide Upon Her

When Ian's wife had confirmed that the man who'd committed suicide six months previously had been Ian, Elspeth stated that she *didn't take any blame that she should have done more because she couldn't have done a thing:*

I'd like to have sent him off to Community Health for assessment but I knew that that would have terrified him and that's why I suggested he see his GP, maybe just to find out if there was a physical reason for these feelings he'd been having.

She had, however, felt *really pleased when his wife had come back [for counselling]* as it indicated that *enough of a relationship had been built in that one session that she trusted me enough to come back.*

Having also experienced the suicide of her own son, Elspeth stated that she could *really, really relate to what Ian's wife had been through*. Furthermore, *in being able to be there for her as she worked through her guilt and self-blame not only was Elspeth permitted to hear in great detail what had happened and why it had happened but also to tell Ian's wife that she had been fearful for him from the very first session and that she'd felt powerless to do anything*. For Elspeth, the opportunity, post-suicide, to work therapeutically with Ian's wife *really brought closure, [especially since] his wife had agreed with her*.

It was the *other* suicide, however, that Elspeth wished to focus upon more fully during our remaining time together.

Elspeth's Story of Rachel

Rachel was referred to Elspeth by her general practitioner after the hysterectomy she had had four weeks earlier *had left her feeling really awful*:

She has really intense depression and lethargy and kept telling me, "My brain's not working, I can't think."

Elspeth's Story of Her Therapeutic Relationship with Rachel

From the time she *first started coming in early November, Rachel would tell Elspeth that she was having suicidal thoughts, "There's nothing in life worth living for. I can't think. I'm not myself. I'm not who I was before. I've lost too much."* Whilst they would explore those thoughts and what was driving them during their weekly sessions together, Elspeth was convinced that *it was nothing to do with the loss of Rachel's womb or her reproductive capacity or her image as a woman. It was all about, "My head doesn't work."*

Despite HRT and taking anti-depressant medication, *which made absolutely no difference whatsoever*, and attempts by her employer to get her to come back into work and do [only] simple jobs, Rachel's condition deteriorated to the point where she started saying that when she was driving in the car, all she could think about was driving off a cliff or into a lamp post. And she kept saying, "I just think of killing myself the whole time."

Because Elspeth was going on holidays about the middle of December she began worrying about [not only the fact] that, "This case is really beyond me and I'm going away" [but also] that she was working with someone who was suicidal and [that she] hadn't established ongoing contact for her [in her absence]:

When I first went to Women's Health about eighteen months ago, Community Mental Health and Women's Health really didn't talk to each other. If clients were coming to us, Community Mental Health just wouldn't see them. There seemed almost some sort of jealousy or suspicion between us. But gradually, over time, I worked very hard to establish contact with them and to get to know them.

So I rang one of the senior psych nurses there and said to him, "Look, I've got this lady with me and I'm very worried about her. She's openly suicidal and I'm going away next week and I'm not at all confident that she's going to be safe while I'm away. She needs assessment and she needs hospitalisation and I'd like her hospitalised because I would like lots of tests done. And she's assured me she will go to hospital."

Despite her attempts to establish an alternative support network for Rachel during her absence, Rachel re-contacted Elspeth *right before she was leaving on holidays* to say

that she had met with the psych nurse at Community Mental Health who had told her, “*Look, you are seeing Elspeth, she’s very good, just keep seeing her, it’ll be fine.*” This comment, together with the fact that he had made false assumptions about the aetiology of Rachel’s issues had led her to decide not *to go back and see him again*. For Elspeth, Rachel’s decision presented a new set of dilemmas:

I said, “Look, you do know that I’m away from three weeks?” “Yes.” “Can I have an undertaking from you that you won’t suicide? What will you do if these thoughts keep dominating you all the time?” “I’ll go back to my doctor.” And I said okay as there was just nothing else I could do.

Elspeth was to learn of Rachel’s suicide on the day she returned from her holidays:

I looked in the local newspaper and there was her death notice. I subsequently heard that she had taken her anti-depressants, put a plastic bag over her head, and killed herself.

Elspeth’s Story of The Impact of Rachel’s Suicide Upon Her

Because she had been *studying an Ethics unit [as part of her Counselling degree] at the time, it was the legal implications* surrounding Rachel’s death that Elspeth responded to first:

I rang the Director from work and showed her an American ruling where damages had been awarded against this psychologist who had gone off [and left their suicidal client without support]. And I said, “You know, I really did everything I could to have her covered over that period that I didn’t work.”

However, as they were still both *worried about the Service and that the family might charge them*, Elspeth and the Director went to see a solicitor to get an opinion from him:

We have had records subpoenaed and I think until we'd actually seen the solicitor we didn't know whether the family might try to charge me or the Centre with neglect. We didn't know. I was anxious to protect the organization to the extent that [when] the Director said, "Look, until we see the solicitor let's just protect this woman's case file and get it off the premises. Are you okay to take it home and file it there?" that I said, "Alright." And I've still got it and every now and again I see it and I get a pang and think I should put that back in the ex-client records at work now where it needs to be and then it won't stick its head out of the drawer and look at me!

As it turned out, Elspeth's fears about being sued proved unfounded, *as the family did nothing about it, they didn't make contact or anything like that.*

Shortly after reading the death notice, Elspeth also rang the psych nurse at Community Mental Health to let him know what had happened to which he had responded, *"Yes, I already know."* Unable to control her frustration at the way things had transpired in her absence, Elspeth remembered reminding him of the fact that she *had been so sure Rachel was in danger that she had sent her to him and had told him that.* His response, *"Oh well, I didn't pick that up"* left Elspeth wondering what she needed to say to get Community Health to listen to her:

It was frustrating because I didn't feel heard by the Mental Health Worker. When I contacted him, instead of speaking with me, professional colleague to professional colleague, it felt like the dismissal of someone not as experienced

and hard-nosed as he was. It was also frustrating because my opinion proved to be the correct one, not his, yet he sort of patronised me.

It was the psych nurse's following comment, however, that, "*If people are determined to do it they'll do it and there's nothing we can do about it, it happens to us all the time*", that led a *really frustrated* Elspeth to resolve that she was *not going to be caught like that again*:

If they're not willing to put them in when the client was willing to go in as a voluntary patient, I'll schedule them. So I've always got the forms in my office now and they can't ignore that. I've [come to] realise there's limitations on their service that don't impact on me that I can't, don't fully understand, and I've just got to accept that. You know, there's a lot wrong with the mental health service but it's pointless getting frustrated about it.

In the wake of Rachel's suicide, Elspeth found herself *left with a lot of questions still in her mind*:

I would love to have been able to have a brain scan for her and I just couldn't understand why the medical profession was not picking that up and asking questions themselves. I spent a lot of time talking to my GP about the case, what it could be. There were just so many questions for me that I'd been trying to find answers to.

When I invited Elspeth to explore what had been happening to her on a more emotional level at that time she stated that as her tendency is to *switch out of her emotions into her head too much she had been able to detach herself from an emotional reaction to it*. Instead, she had found herself *getting into intellectual*

problem solving, thinking about “What are the legal ramifications of this? What should we do? What should we find out?” Whilst stating that this might all sound legalistic, Elspeth admitted that it was a driving part [of her decision-making process about] what she needed to do.

She did acknowledge, however, that whilst *rationally she hadn't been blaming herself, feeling-wise she'd had a real sense of failure that she'd let Rachel down because she'd trusted her and she'd kept coming back.* Having said this, she was also adamant that she *didn't own it* because whilst she had *felt that Rachel had been let down, she didn't think that she'd let her down:*

It's the realisation of, look, I didn't cause the problem, I didn't do anything wrong, it's not mine to fix, it's not mine to own. I can only be here for them and use whatever skills I have to try and open some windows for them where they might be able to perceive that there is the hope of change.

The one *emotionally-driven thing Elspeth had wanted to do more than anything was to contact the family* as that was what, she believed, *could have brought some closure for her, to talk to the family, but the Director of the service and the lawyer had said that whatever she did, don't do that.*

When I asked Elspeth what difference talking with Rachel's family would have made she sighed heavily and replied:

Well, I think I would have liked to have been able to tell the husband that I really cared that this had happened and be there for him to answer any questions he might have. So I used to think of him, worry about him, and I thought, you know, I don't know what happened to him. And that's the

comparison between the two cases, because Ian's wife did come back and we had a long period of time working together through all sorts of things. I just knew her more and I had felt her total pain and bewilderment. And that has enabled to bring some closure for me.

Despite not being able to talk with Rachel's husband, Elspeth had drawn upon her Director, who was *so aware and very compassionate, and a network of friends who were all in the services industry* as part of her support network *because they were just able to listen more than anything:*

There wasn't much they could do but I felt comfortable using them to debrief. Initially over the phone briefly, then my friends and I met for dinner the next Friday night and I did discuss it with them. From memory, I did tell them of my unresolved questions, my urge to see the husband, asking their opinion of the scenario but, as usual, it was more in the form of wrestling with it as an intellectual problem and asking if there was something I'd missed or not seen clearly. I'm sure that my colleagues would have picked up that I was emotionally disturbed by the suicide [but] I didn't go on and on about it over the following weeks. For one reason, sometimes my friend's husband joined us and he let it be known that he didn't want the whole evening spent 'talking shop.'

Interestingly though, Rachel hadn't *mentioned Ian's death to her friends because the relationship with him hadn't built all that deeply.*

With regard to supervisory support, Elspeth stated that talking with *her very good supervisor, whom she saw on a regular monthly basis, had allowed her to sort of step back [from Rachel's suicide] and look at it intellectually:*

For instance, I'd go to my supervisor and say, "I think, intellectually, when I walk out the door of our centre I leave everything behind but I know that I [actually] don't when I wake up at night and have been dreaming about it!" So she'd get into with me, "Well, you know, what's this about you having to own it [and fix it]?"

In light of these suicides, Elspeth acknowledged that she had become much more directive and pro-active in her practice:

Have I learnt anything? Yes I have. Now I would ring the GP and put a lot more pressure on him. That's the one thing I could have done and didn't do. I do that at the drop of a hat now. And I'm getting quite a reputation with the G.P.'s in our town because if the client gives me permission, I'll ring them. I'd say it's been pretty positive since so many are referring clients to me. There's a good feedback loop.

Despite her resolve to be more pro-active and 'vocal' in relation to her suicidal clients, not all of the health professionals she liaised with were supportive of her endeavours or her expertise:

I'm dealing with another highly suicidal client at the moment [and] I've been there for her through a lot of her really stressed out situations. She went into crisis a few weeks ago and went to Community Mental Health and in her words said, "They didn't listen to me". She felt totally unheard and rejected so stormed out of there and came straight up to us. So I rang Mental Health and said, "Look, she has every marker of a highly suicidal person and I really need you to hear that clearly. I'm not prepared to take responsibility for her [over the

weekend] and I'm wanting you to hear that message." And [after some further persuasion] he agreed to let me bring her up to him.

When I asked Elspeth why it had mattered so much that her 'voice' was 'heard' in this instance she replied:

[Because] I wanted [Community Mental Health] to realise that somebody who has an educated opinion was saying that this woman is highly at risk and I also needed them to know that they had dropped the ball in the previous case and that I was being very cautious in this case because of that.

Unfortunately, however, Elspeth's 'voice' and expertise were suppressed, once again, shortly afterwards:

I've recently been called into a case conference [in relation to this woman] with the psychiatrist from Community Mental Health and his two psych. caseworkers plus another counsellor. And the outcome of that meeting was that the psychiatrist said that all he wants for me to focus on is CBT with her and that the only people who should be dealing with crisis situations is Community Mental Health.

[And] I thought, "Well, look, I'm a counsellor, he's a psychiatrist, she's very dependent on that service for her medication and supervision of that side of her treatment which is beyond any service that I can provide and therefore I felt I really had to bow out of the case management plan that the psychiatrist is now going to write up and where I fit into that.

Even in instances where she *had* advocated successfully on behalf of her suicidal clients, Elspeth conceded that some still chose to discontinue therapy, leaving her

with a feeling of powerlessness and a sense of ‘not knowing’ in terms of what had happened to them:

I saw [a woman] once or twice after her [suicidal] incident and then nothing. So I don't know what happened to her. I tried ringing her home number many times but there was no answer and eventually it was cut off. So there was really nothing I could do to find out and I wondered, "Well, how intrusive is that anyway?" I more or less had to let go. I can't solve everything, I can't rescue everyone.

By way of concluding the interview, I asked Elspeth how Rachel might have responded had she been privy to this conversation and heard the ways in which her suicide had impacted upon Elspeth as her therapist. After a long pause, Elspeth replied:

I wouldn't have wanted her to feel responsible for any reaction I had [though] she probably would have. You know, "I've died and caused the repercussions for her that followed." I mean it was a very confronting experience for me and I did ask a lot of questions of myself, "What more could I have done to make sure the Mental Health people heard just how bad she was?" whereas with this current client I've been very precise, very outspoken, so I haven't had the experience of trying to give them a message and for them to discount it but I guess I wasn't, at that time, secure enough in the validity of my own opinion.

Personal Reflections and Lasting Impressions

Elspeth's narrative was the most cognitively-based one I was to hear during the research process, hardly surprising, given her admission that she has a tendency to *switch out of [her] emotions into [her] head too much [and] get into intellectual*

problem-solving. In fact, during our interview, once she had ‘presented’ the details of the cases it seemed as though she had ‘run out of things to tell me about’ and required direct prompting to explore her story from a more personal perspective.

Her non-verbal language, arms folded across her body for the majority of the interview, also suggested that the process may have been a challenging one for her, despite her statement prior to its commencement that she wasn’t nervous or anxious about it. Interestingly, though, despite her reticence to talk about her reactions in relation to these suicides, Elspeth spontaneously engaged in a conversation about a significant death she had experienced in her own life (the suicide of her son) without prior prompting from me.

A subsequent email from Elspeth certainly indicated that engaging in the interview process had been beneficial from her perspective:

I’ve come to realise that [not only had] volunteering to be part of your research been another way of debriefing [but that] it was [also] an opportunity to talk over the suicides, to reflect and do a bit more assimilation in relation to my feelings at the time and my feelings now, a couple of years later.

On the whole, however, I left the interviews feeling that I didn’t really get to know the ‘person’ of Elspeth and therefore missed the opportunity to capture her story in any great depth.

Epilogue

As had been the case with two of the study’s other participants, Jude and Murray, extracts from my initial interview with Elspeth were presented at a conference where she was in attendance. Not surprisingly perhaps, given the audience’s previously

negative perception of Jude's decision to keep his client's ashes in his office, Elspeth's actions of removing Rachel's file from the service's premises were also met with claims of 'breaches of professional boundaries'.

At the conclusion of the presentation, Elspeth asked me if it *would be useful to schedule a follow-up interview to explore a bit further the context of why that file was removed from the office*. This interview took place the following afternoon, providing Elspeth with an opportunity to 're-story' her account in relation to Rachel's file to include concerns about *security* in addition to the *fears about litigation and [the need to] protect the organisation* discussed in the previous interview:

What had happened just immediately before [Rachel's suicide] was that my office was actually broken into and somebody had attempted to get into my filing cabinet, therefore the whole climate of security in the place was under question. Now with that in mind, and this suicide occurring at the time I was studying ethics [and the case of the counsellor who was going on holidays and did not arrange support for her client who subsequently suicided and the organization was sued], when I let the Director know that one of my clients had suicided she thought the best thing to do was to get the file into a safe place. So that's why it went home with me. And I have a locked filing cabinet so there was nothing really much at risk as far as privacy and confidentiality etc.

For me, Elspeth's second account in relation to the removal of Rachel's file raised more questions than it answered. Why, for example, if it had been a matter of ensuring security and maintaining client confidentiality, had *all* of Elspeth's files not been removed from her office and stored elsewhere on the premises with the rest of the organisation's files? Would Elspeth have felt 'compelled' to offer this more

‘professionally acceptable’ reason for the file’s removal (that is, that it had been done with the client’s ‘best interests’ in mind rather than the organisation’s) had her professional ethics not been scrutinised during the conference presentation? Are there certain situations where it is ‘more acceptable’ to ‘breach’ professional codes of ethics than others and who decides what these are?

As I pondered the answers to these questions, I became acutely aware of the ‘professional minefield’ that therapists enter when responding to the suicidal death of a client and the propensity of this minefield to silence their stories as they attempt to navigate it.

Appendix F

HOLLY

Introducing Holly's Story

According to Holly, whom I met at a conference, her reason for volunteering to participate in my study had been three-fold. Firstly, having recently adopted the role of researcher herself, she had *thought it would be fun to be on the other side of the research mike for a change*. Secondly, because she *had not spent much time thinking about or reflecting on* the suicidal deaths of two of her clients, *leaving them raw* instead, she had hoped that the research *might be a nice experience to see what was there as they had been really significant events in [her] professional life*. And finally, as she believed that *most therapists don't talk about their clients' suicides because of the shame and of feeling "I may have been responsible or negligent in some way, may have missed something or didn't do something properly" and that that would reflect badly on them as a therapist or person, put a black mark against them*, she had wondered *how hard it would be for [me] to find informants* so had decided to volunteer her services.

Given that my 'window of opportunity' for interviewing Holly was limited to the five-day conference we were attending, we scheduled our meeting to take place at the close of proceedings on Day Three. After some preliminary 'ice-breaker' conversation about therapy and therapeutic techniques our interview began in earnest.

Holly's Story of Russell

Having initially worked on an individual basis with Russell's wife for several years, Holly was first introduced to Russell when she *started to do some couple's work* with them both.

According to Holly, life for Russell had been difficult from the start. Growing up in an *incredibly neglectful* family that had *always been fragmented* and had *never talked together*, Russell's parents had subsequently died and his siblings *now all lived as hermits, none of them having ever had children*.

It was Russell's upbringing, Holly believed, that had led to him *having very little personality structure, to always be in his head, to have a very limited reality and understanding of the world outside himself and to be very narcissistic*.

Although he *was the only one of his siblings that had ever gone to college*, graduating as a computer analyst, when Holly first met Russell he had been *unemployed for a long time, was very depressed, didn't have any friends and was incredibly dependent upon his wife*:

Everything, everything that meant anything to him he was losing. He didn't have a career, which would have been the only thing that gave him an identity outside his marriage, and here he was about to lose his marriage. And so without those two major things, there was absolutely no reason to live.

Holly's Story of Her Therapeutic Relationship with Russell

During the year that Russell had attended counselling, and despite the fact that they had *done some really extensive work* together, Holly conceded that *Russell had never formed a connection [with her]*:

There are just some clients that never really let you touch them. I worked really hard with him, it was incredibly hard work but I never felt like I didn't do good work. And I think, because of who he was, I had made some inroads [but] not

many. To this day, he's probably one of the most sad and disturbed men that I've ever known, certainly that I've ever treated.

It was only when Russell's wife called several months after Russell's last appointment and left a message saying that *she needed to come in and see [her]* that Holly learnt of Russell's death:

What had happened was that Russell's wife had told him she was leaving and he had taken it fairly matter-of-factly, calmly, and then he'd rocked into his computer room, sent her an email, got in the car and drove away – drove around the corner from the house, didn't go far at all, and then shot himself in the car, on a major street, in our neighbourhood, probably less than a mile from my home.

Holly's Story of the Impact of Russell's Suicide Upon Her

As she reflected upon how she had felt hearing the phone message from Russell's wife, she remembered the comparisons she had made between her reactions then and those she had experienced in relation to her brother's death:

My brother got killed just years before that, and the same sort of thing. I remember where I was standing in the kitchen, I remember what the phone looked like, what direction I was looking. I can picture myself just listening to the message on my cell phone and I just felt like the blood drained out of me as I heard it, trying to catch my breath and all I could do was go, "Oh God! Oh my God!" just that kind of repeating over and over, kinda trying to get a grip and just feeling like I was in the twilight zone, like my head was not in the same place as my body. And I can really compare it to when I heard my brother was

killed, just walking around, not feeling connected but just talking about it. Just that sorta white like the blood's gone from me somewhere.

Despite her initially strong physical and emotional response to hearing the news of Russell's death, the fact that *the guy she had been going out with at that time [and who had been present when she'd received the message] wasn't the kind of person that [she] could have talked to a whole lot about it, meant that she had ended up just saying, "Oh my God, a former client had just killed himself"* and had only talked to him a little bit about what *[Russell's wife's message] had said*. Furthermore, because she believed she *needed to regroup so she could be strong for his wife, after struggling for a while Holly managed to pull [herself] together again enough to get on the phone to call her:*

And when I called her she was more matter-a-fact than I was which sort of brought me back around. She was very contained where I felt very uncontained, just like everything sorta spilt out of me. So I was like, "God, are you okay?" and she was like, "Yeah, I'm fine." And I think what happened after that was I got fairly analytical about it.

Whilst the *real shock* that Holly had initially experienced in relation to Russell's suicide had been due to the fact that *she had never ever thought when they were working together that that would be a possibility because he'd kept trudging along for such a long period of time and there were never any signs at all, no threats, nothing, there was a point, nonetheless, not too far after that initial shock that [she] got back to the analytical part [of herself], started really thinking about who he was and the work [they 'd] done and concluded that:*

Of course he did it. That was the only answer for his life, the only possible resolution for him. I couldn't have imagined him staying alive or any other outcome. So even to this day it almost feels like a resolution like, you know what, that's the only option. I imagine that that was a very peaceful decision for him. That in the last moment he probably felt like this is the thing to do. His life was tragic and the ending must have been an ending to the tragedy for him. So that gave me some peace.

Having acknowledged both the sense of inevitability and resolution she had felt in relation to *suicide being the only way to end Russell's story*, she was simultaneously aware of thinking, *"Did I rationalise this? Am I providing this sort of explanation so that I don't have to feel about it?"* and *"That's icky to feel like I get off the hook."* Furthermore, whilst she had *never felt responsible for his suicide [she had] felt that other people might think that [she] was:*

As a therapist, people place so much responsibility in my lap. Some clients and sometimes even more the community expect that we have so much power and responsibility. [But] for me, in both those circumstances [of client suicide] there was clearly nothing really obvious that I could have done. And it's not my job to save somebody's life. I hope that I can give them reason to live and inspire and encourage them but I can't save people. And I respect both of those clients, I respect their rights to do what they did and feel like it had no reflection on me as a person or as a therapist and I don't think that they would have thought it had any reflection on me [either].

Whilst Holly acknowledged that she *wouldn't have had any problems talking about Russell's suicide to other therapists, it had always surprised [her] that nobody else*

talked about [their clients' suicides], a fact that had led her to always be careful not to bring it up unless someone else raised it first:

Like, not even as therapists do we talk about it. It's taboo. The fact that we don't talk about the fact that we don't talk about it is [also] taboo! I know therapists who've had clients commit suicide but they've never talked to me about it. It's obviously something that you don't talk about. You just don't talk about this stuff with people.

[So] it's almost like I look forward to someone bringing it up in the conversation. I look forward to the opportunity to talk about [Russell's suicide] 'cause it was such a trapped experience for me [in that] there weren't many places to talk about it and just process it a little bit.

Ironically perhaps, it was *lay people* who tended to enquire about whether or not Holly had ever had a client commit suicide. Whilst, ideally, these enquiries might have provided her with the necessary invitation to talk about her experiences, the fact that she felt under enormous external pressure to react or behave in a 'particular' way during such disclosures often left her with mixed feelings:

[When I have disclosed] their reaction is like, "Oh my God! How terrible!" And it's like, "Mmm... Terrible for me? Terrible for the person?" So that's where the guilt comes in too. Was it terrible for me? It was shocking for me but I don't ever remember feeling like it was terrible for me because somehow I was able to remove myself as a responsible party.

Furthermore, the fact that the suicide had occurred *in her professional life* meant that, despite the odd 'generalist' enquiry from lay people or the *use of the suicide as a*

teaching example with students, Holly felt unable to share her experiences in any depth with these individuals since they were outside her professional circle:

If it had been a personal friend [who had suicided] it would have been very easy to go and talk to everybody about it, to process it easily. And yet, it's so odd. Because it's part of my professional life, there's not a lot of opportunities to do that. I did mention it to a few key people – one therapist/friend who I'd confided in about other difficult matters with clients and once in a conversation with other therapists about client suicide – but I didn't feel like I had the same ability to go into depth with it had it been somebody else.

For Holly, the major reason for feeling hindered in her ability to be able to talk openly and deeply about Russell's suicide to the *outside people, non-therapists* in her life was that *there were always the ethical issues involved with that:*

[Because] his death had been splashed all over the news and people knew about it, I needed to be especially careful not to breach his confidentiality around that. I still worked with his wife and she came back in after this happened, so I knew to be careful not just talking about it to anybody in general because I needed to respect her and his privacy and confidentiality. I always wished that I could have asked her about the details of the suicide – but that was my curiosity. I felt like it would have been voyeuristic and self-centred of me to ask.

When I enquired about how she had handled the fact that whilst Russell's death had been a public event she had had to remain "trapped" between her public face and her professional one Holly replied:

That's a good question! I think I was curious to hear what people had heard because I hadn't seen it [on TV] or read about it or anything. So I was just kinda asking questions about, "Well, what did you hear?" being curious without saying, "Well, you know he used to be my client."

Given that Holly didn't have access to supervision at the time but was seeing a therapist, she *did talk to her about it [although she] really, really thought [that having regular supervision] would have been good* because:

We looked at it on a personal angle with my therapist but I think this interview is probably the first time I've actually thought about how it impacted me as a therapist, because we only looked at how it impacted me as a person. So I think [supervision] would have been helpful at the time to process through that. I think a supervisor would have been the person that I could have really explored it with more. [But] I think that would have needed to happen right at the beginning.

When invited to expand upon *the differences she envisaged between talking with her therapist about Russell's death and talking with a supervisor*, Holly hypothesised that in supervision she may *have had the opportunity to look a bit deeper, in terms of how that particular event had impacted [on her] as a person and as a therapist* since in therapy she had had *other things going on in her life* that needed to be discussed too:

It would have been good to have someone who was a peer that I knew I had unlimited amounts of time to spend talking about that in regards to what's happening to me working with other clients. You know, is it bleeding into my work? In some ways I felt that I was under-reacting to it and I think that that made it more significant for me than any reaction that I did have, which was

another reason that I thought this interview would be interesting – to see if after all this time I feel anything more than I did at the time. So I think supervision would have been really helpful to say those kind of things because now that I'm hearing myself say them these years later, it feels like, "That's really okay."

As Holly checked in during the here-and-now of our interview by asking herself, "Do I feel any sadness about it?" she recognised that whilst *there was a little bit, it was strange because she felt sadder more about his life* – a fact that she felt was *really awful to say because she thought [she] was supposed to feel a lot more:*

But once I'd felt the shock and unreality of it and had had a chance to process it through, talk to his wife, think about who he was and my relationship, my non-relationship with him, you know it really felt like, "Yeah, that was the only answer." It was the only conclusion that could have ever happened and so I think that helped me move beyond it. And even the way he had suicided, he had made it tidy. He went away from the house. He sent her an email. So there was something about it that left it contained.

What Holly had found most useful during the whole process, in terms of *getting [her] own resolution*, was being able to *work [therapeutically] with Russell's wife afterwards:*

She had a real peace about her. She had some guilt but she had her freedom now. We didn't have to work together all that long before she felt like, "You know what, I really can let this go now. He made his choice, I had to make mine." So she was able to get some resolution with it and I think that probably helped me a lot, being able to work with her and see how she made the

decisions that she made. So there was a whole set of closure that happened within that.

Having reflected upon her experience of Russell's suicide, Holly automatically began comparing it with that of another client, Petra, who had killed herself several years earlier:

I probably only saw her three or four times at the most. She was very depressed but not actively suicidal when I first started working with her. I called her home to check on her after she missed an appointment and I think it was a family member who picked up the phone and said, "Oh, she killed herself the other day." And I remember feeling curious. I really, really wanted to ask how she'd killed herself, I really wanted to ask but there was this other part of me that said, "You know, if they'd wanted you to know, they would have told you." It felt like my curiosity was going to be intrusive; that that was my own stuff that I needed to know, partly for closure. So I hung up feeling like, "Oh, I wish I could have asked" but knowing at the same time that it wasn't appropriate and that it may have been too painful for them to have talked about it. My head has since imagined that she hung herself [but] it could have been anything. I also had a brief concern, "Uh-oh, are they going to sue me?" and "Should I have offered if anybody needed to talk to me?"

As had been the case with Russell, Petra had also been *somebody that [Holly] didn't really have much of a connection with*, though for somewhat different reasons:

I think a lot of it probably has to do with the relationship and how invested I felt. I'd only seen her a few times [so] I just didn't have time to form a real connection with her, there was no sense of attachment, whereas with the other

one there was. I just adored Russell's wife. I'd loved working with her and we had a long relationship. I didn't necessarily enjoy working with Russell but I worked really hard. And I felt it was really important and I felt for him.

The whole reason that I do therapy is because I want people close in my life. That's a whole other story but I had my own attachment issues and so I think I was drawn as a therapist because it allows people to attach to me and me to attach to them and it fulfils a real need for me. So I just hadn't allowed myself to get that close [to Petra] or the time wasn't there to get close.

Because of the *lack of immediacy of the relationship* with Petra, Holly had also reacted to the news of her suicide differently:

Even though it happened before [Russell's suicide] it didn't feel as devastating as his did for me. I didn't have that whole sort of visceral response going on. It was still like a shock [because] I didn't have any clues that she would be suicidal, so I never thought to put any containment around her. So that was a 'hit square in the eyes' kind of experience, like, "Holy shit! This stuff does really happen!" I guess I can look back and maybe I did miss some things, maybe I didn't assess her, maybe I should have seen her more often. Obviously there were some things I could have done [although] I don't know if the outcome would have been different. I believe that with some people there's almost an inevitability - that it's just a matter of time before they try and they succeed. Maybe that was just her.

Interestingly, as had been the case with Russell's suicide, Holly was also *sort of bothered by the lot of rationalisation* she had engaged in around Petra's death:

I know I have all the cognitive build-up around it and I've never felt grief. Whether I just shut down... That's probably a part of the reason why I don't talk about it as well because I don't think I have the correct reaction. [So] I hope I'm not skewing your data!

As we explored Holly's perception of what the 'correct reaction' would have looked like, she believed that it would have included the shedding of tears and some sense of being really impacted by the deaths:

These were people that I knew, people that I was helping, and to not be touched by it, to never have cried, that makes me really sad, in and of itself. But I have to say too that because I've always had attachment stuff, there have been clients that I've had difficulty attaching to and I think they have the same difficulty attaching to me. I really only let certain people get really close and allow certain clients to touch me. My greatest longing is just to be open for them, a connection point for them, but I do have this capacity to just kinda wrap everything up around it. [So] I think my response has something to do with me as a person and me as a person definitely impacts me as a therapist.

In light of the fact that she'd had two clients suicide, I asked Holly what sustained her in her private practice work. Laughingly, she replied:

It's like my experience of my life has led me to be a therapist. That's about the only occupation that I think I'm naturally bred for. And it's the beautiful moments [in therapy], where it's like our souls are touching and I feel a very solid connection between our hearts, they feel life giving to me. They renew me and [lead me to] believe that I make a difference. But when I think [about] the pain it causes me sometimes to care about people, there are times when I don't

want to do it anymore. [My] backup plan would be to just go and do something that had no impact on anybody's life. [Because] you know, I think it does take its toll.

As our interview came to its natural conclusion, Holly stated that it had been *good in a bad sort of way* to be able to re-visit the suicides and talk about them again:

I still feel the tears behind my eyes which is really interesting and I don't know what that's about (long pause) and now they're in my eyes, but you know, I feel really comfortable sharing it with you and I guess it almost feels like the same process in reverse, like you're creating a real safe space for me, and there's something freeing about that, you know, that I want to let go by stop being afraid of my emotions. I almost feel glad that they're here [now] because I know that something's been washed away. Like I shared with you before, I was looking forward to this interview because maybe there was something to get out of it and it does feel like that [has happened]. It doesn't feel like I'm going to have to go away and analyse this at all or think anymore about what I said. Just the process of being able to reflect on it and talk about it, that was kinda cleansing.

Personal Reflections and Lasting Impressions

Of all the therapists interviewed, Holly was the *only* one to begin with a *personal* account of her responses when invited to “Tell me about your experience of having had a client suicide.” Every other therapist began by presenting their *professional* account of their client's death (that is, some demographic information about the individual followed by a description of the therapeutic relationship they had had with them). Only when they were ‘prompted’, at the completion of their professional

account, did these therapists then move into a more *personalised* story about the impact of the suicide. Unfortunately however, since the format for the Component Story Analysis was derived from listening for the dominant sequence through which the majority of the participants' stories unfolded, the flow of Holly's storyline (though not its content) has become somewhat distorted by the analysis process.

Whilst I can only speculate as to why Holly was the only therapist to begin her account of her client's suicide in the personal voice, I suspect that it was due to the fact that she was also the only therapist to have had some personal counselling in relation to this event and had therefore had a prior opportunity (and been given prior 'permission') to process the suicide from a personal perspective. Having said this, the experience of being able to retell her story within this interview was clearly still cathartic for her. Wide-eyed and highly animated throughout, Holly repeatedly clutched her hand to her chest making circular rubbing motions as she spoke, frequently became teary, and punctuated her dialogue with comments such as, "*Do you want to limit your time because I could talk for a while!*" and "*This feels good to talk about!*"

Appendix G

CATHERINE

Introducing Catherine's Story

Catherine and I had not met prior to her acceptance of the mail-out invitation to participate in my research. Before contacting me, Catherine had spoken with one of my supervisors about her eligibility for inclusion, since whilst she believed that her client had chosen to die, no 'official' finding of suicide as the cause of death had been made. Catherine had therefore been left wondering if she 'fell into the category for my research'.

Having reassured Catherine that the fact that she believed her client had committed suicide was grounds enough for participation, our interview was conducted after Catherine had finished work for the day. Impeccably dressed, Catherine portrayed the image of the consummate professional – efficient, no-nonsense and business-like.

Catherine's Story of Barney

It was through her position as a psychologist that Catherine had first met Barney, *a man in his fifties with an alcohol addiction problem.*

The eldest sibling *in a strict, staunch sort of upbringing*, Barney had immigrated to Australia, without his family, three decades ago. Whilst Barney had managed to make some friends over the years by *doing a lot of voluntary work*, the fact that he *had not had a relationship and had not being married* had led Catherine to consider him to have been *quite isolated.*

Catherine's Story of Her Therapeutic Relationship with Barney

In the *two to three years* that Catherine had worked with Barney *on and off*, they had *been through a lot together in terms of the therapy and [their] therapeutic relationship [having] actually done a fair amount of different types of work:*

He'd had all sorts of issues, lots of stuff. Lots of stuttering; encopresis in his childhood that lasted till high school; very severe DT's when he was withdrawing from alcohol, so much so that he was known by the police and ambulance for them; seizures, those sorts of things that made him 'at risk' [and left me thinking that] basically he might die.

One of Catherine's fondest memories of her work with Barney was when she had suggested that he might like to make his flat more appealing by *putting some plants in it*, to which he had replied, *"Well, you look like you need some plants for your office!"* So I said, *"Okay, we'll have a little competition. I'll get plants for my office, you get some for your flat, and next time we meet we'll see who got the plants first."* And that was *our little thing, our little joke.*

In his more recent presentations, [however], Barney had seemed more scattered and not as clear as usual which started [Catherine] wondering whether he was drinking or whether it was rapid deterioration or something else going on:

He was talking about loneliness issues and [fantasising about having a relationship with] this woman he worked with. It came to the point where he'd been talking about this woman over a couple of sessions, so I was monitoring him in my mind.

It was on a *Thursday afternoon at around 4.30pm* that Catherine received a phone call from the female work colleague Barney had been discussing, saying, *“Look, I’m really, really worried about Barney, can you follow him up?”* [So] *all the Friday I tried to follow him up and couldn’t get in touch with him. She rang back again at 4.30 and I said, “Look, I haven’t been able to catch up with him” and she said, “Oh, that’s okay, I’ve run into him and I’m going to go and check on him again tonight. He’s off the planet, you know. He’s not right. He needs to re-establish some contact and I’m very worried about him.” And I said, “Look it’s too late for me to try and ring him again now” because by the time I got off the phone to her it was ten to five and I had to pick my child up at five o’clock and I’m on this deadline myself, so I said, “What are you doing?” and she said, “Well don’t worry because I’m going there tonight.” And I thought, “Okay, well I know that she’s going to see him tonight, so he’s going to be safe enough tonight.”*

Catherine left work that afternoon therefore *feeling quite comfortable that this woman was physically going there at sort of seven or eight o’clock that night, which was more that [she] could do:*

Then I went into my weekend mode, not thinking about clients or anything. And I do shut off when I go home, unless there’s something really concerning, but I do generally shut off.

On the Saturday morning, however, Catherine had *felt this compulsion* whilst shopping, *to go into the nursery and buy a plant for [her] office, odd behaviour, as she had made a deal with herself [not to buy unnecessary items] because “I’m terrible, before I know it I’ve spent four hundred dollars!”* [She] then went home and

everything was all sort of okay. Unwittingly, this purchase was to prove a very significant one after Barney's death.

It was on the Monday, whilst she was listening to the local news, or reading the newspaper that [Catherine] had heard that there'd been a death from a fire in a flat:

And I just sort of thought, "Ooh, I wonder if it could have been him?" And I went to my manager and said, "Look, I just don't know, it might be this client" and she said, "Ring the police, ask the police." So I rang the police and it was actually confirmed by them that it was him. They told me that he probably would have died of smoke inhalation, but it wasn't even a fire, it was smoke. So they assumed it must have been a cigarette on the couch that just smouldered and he didn't take himself out of the flat, that he was there with all those toxic fumes and died. From there it was sort of a matter of that sinking in for me.

Catherine's Story of the Impact of Barney's Suicide Upon Her

Whilst Catherine had virtually worked out that it was Barney before she had rung the police because she'd known that something was building up, something was coming, she had still needed some sort of confirmation, "Oh well, it's happened", [as] there was a bit of denial and stuff in there.

Because [she] was at work when she spoke to the police, she didn't let it hit her [there] because [she] didn't want to go into [her] emotional reaction just in case [she] got upset and became teary:

Since I've become a psychologist and worked with clients I haven't had, haven't been aware of a client who's died. So I thought, well, I'll just keep the emotional check on this and deal with it when I go home.

Despite needing to keep an *emotional check* on her personal responses within her professional context, Catherine recognised that she *couldn't hang on to it and needed to talk about it, albeit at a very superficial level*:

[After the police confirmed Barney's death] I talked straight away with the drug and alcohol nurse, who was quite objective.

Whilst describing this talk as a sort of debrief, Catherine differentiated it from a psychological debrief because it was more friendly:

She's a nurse and we've got more of a friendship and respect for our professions. She'd only met Barney a couple of times [but] I assumed that 'cause she's a nurse, you know, nurses deal with death, and they're trained to deal with that sort of thing [whereas psychologists aren't]. So that was okay doing the debrief. At least I could get the words out, the words off my chest.

When I asked Catherine what she had been able to share during this conversation she stated that she had *retraced what she had done [in relation to Barney]* including *justifying why [she] hadn't followed-up [after the woman's phone call] as she'd been asked to.*

Having spoken briefly with the drug and alcohol nurse, Catherine *went back to [her] office and rang [Barney's female work colleague] to see how she was doing and to get a bit more information, to see what had happened on Friday night when she had been to see Barney. Since the police had not given out Barney's name yet because the relatives had not been contactable at the time, Catherine had also asked this woman whether she'd heard about what had happened – which she had. From then on it was a matter of looking at the procedural things.*

Had Catherine not adopted the instigator's role, however, *by keeping in touch with this woman and the police, she would not have found out that they were doing an autopsy, when the funeral was, or that the relatives would be out from overseas on Thursday for the funeral on Saturday.* For Catherine then, *keeping in touch with the police and Barney's female friend was about some sense of working towards a closure because it didn't feel like things were closed.*

Having actively sought, and received, information about the funeral, Catherine found herself in a state of conflict between the requirements of her professional role and her personal needs:

I kept going through this, "Will I or won't I go to the funeral? Should I or shouldn't I go? Is it correct in terms of my workplace? Who's going to benefit? There might be some of my other clients there. If I go to one funeral, should I go to every funeral of every client?" And I was also concerned about his relatives because Barney hadn't had a lot of contact with them for a long, long time and I had a lot of information about him so, "What do I do with that information in terms of the family? How does this fit in with confidentiality and ethical issues?" but also, "Should I be supporting his relatives? As the service provider, should I be making some sort of statement to them?" So I was looking at the personal as well as the professional sorts of issues but also the need for closure as well for me and even up to the last minute I tossed and turned about that.

In an effort to resolve her dilemma, Catherine *spoke to a couple of people - but not openly:*

I really wanted to keep this close to me in terms of whether I went to the funeral or not because I was quite prepared that if one of my work colleagues said, "You shouldn't go" that I would still make up my own mind about whether or not I went. I know that some of the people I work with have got very strict boundaries but I wanted it to feel okay for me, and in a sense for him, because by that time I was thinking, and I'm not one for the supernatural or anything, but that compulsion to go and buy a plant for the office, because we had a very good relationship, was that some sort of his presence type of thing? It was as though his spirit was lingering, he was making some sort of contact through the plant with me, "I'm moving on." Oh, I'm getting teary but you won't mind will you?

Having decided to attend the funeral, Catherine went out for a night on the town [the night before] and had quite a lot to drink because [she] was feeling a bit lost, sort of unresolved, not ready to go home and go to sleep. After her friends had left the pub, Catherine ran into a male person that [she'd] known for a long time [and] it all got quite romantic to the point where he asked her if she wanted to spend the night. [However, even though] she was quite excited about the romance happening, "You know, see what comes of it, that sort of thing" she said, "No, no, no. I've got to go to a funeral in the morning" and went home.

Unfortunately, because she'd had a lot to drink and it [had been] a late night, Catherine slept in and found herself re-agonising on the morning of the funeral about whether or not she would have time to get ready and go:

Of course I didn't feel well because I'd had too much to drink but there was something, again, that I did want to be there. I thought, "No, I'll go. If it looks

like I can't get in, I just won't go in." [So] I got myself together and went to the chapel.

It was only once she had entered the chapel and found herself surrounded by others immersed in their grief that Catherine's own emotions came to the surface:

There was some sobbing going on from his sister. I presumed it was his sister. And then that started off an AA friend, his friend in the community, and then it started me off. And then the tears, and I'm thinking, "Oh gosh!" and really unable to keep the tears from flowing. And I thought, "Okay, I just won't look at anybody" but I was terribly emotional.

The depth and power of her emotions, in fact, *really caught [Catherine] by surprise because normally [she] could contain herself publicly.* Furthermore, *because some of the other people at the funeral were clients or ex-clients of [hers] or knew of her as [she] was quite well known as being a psychologist,* Catherine found that she was telling [herself], as [she] sobbed openly and noisily that, *"It's a natural emotion, it's quite okay. It's okay to feel. You did like this man as a person."*

As she reflected upon what her fear of being so emotionally demonstrative had been about, she recognised that it was because she might be 'breaking the rules' about *what others expected of [her]:*

[I thought] they'd expect me to be quite contained. I'm the psychologist so I should be composed. I'm not one of the friends or family, I'm the therapist and I'm not meant to have anything but a therapeutic relationship with the client, which I don't believe I had. We'd worked on boundaries and they'd been very clear in my mind at least. So therefore perhaps I shouldn't show emotions

publicly. It was that juggle between, “Do I allow myself to be human and feel what I’m feeling or do I put on a show because, you know, I should?” And the other thing about being at a funeral is that it brought up memories of other funerals and other deaths. So I’m thinking, “I’ve got to be composed, I’m not going to wail.”

Despite initially attempting to accept that *being human and feeling what she was feeling* in relation to Barney’s death was completely justified, Catherine quickly slid away from her convictions, attributing the depth of her emotions to factors other than these:

I think it was a bit of a combination of having had a big night of drinking alcohol the night before and not a lot of sleep. I think that really took away a lot of my control [so that] I couldn’t control the tears. I think that if I’d gone to bed early and hadn’t had anything to drink the night before I would have controlled myself.

In the midst of her battle to gain control over her emotions, Catherine was faced with another agonising decision – should she accept the invitation made by the minister to the congregation to speak about Barney if they wished to?

And again I went through that, “Will I? Won’t I?” because he had such lovely qualities. And I thought, “Well, okay, no I shouldn’t because I shouldn’t divulge confidentiality, however I could do it without breaching confidentiality. Should I compile something now? Would I get up there and burst out crying?” And then I’m out there on stage basically! And, “Maybe this is for the family and I haven’t even met the family.” So I jostled with that as well and then I decided that I didn’t feel 100% okay about it so I thought, “I won’t.”

The critical factor for Catherine deciding not to speak however was *that [she] might start crying and not be able to talk:*

Just like I'm getting now. I get the wiggly lower jaw, the shaking. Even if people can't see it I can feel I'm getting upset. So I was going through in my mind, "What would I say? I need to do this for him. I need to say some nicer things than are being said." And I felt as the therapist I knew some of his really deep, inner sort of... excuse me getting teary... Yeah, so I felt unique at that service in terms of knowing him.

It was only *once the service was over* that Catherine went and met his brother. Even then she still found herself torn between, *"Do I tell the brother who I am or not?"* And again it was the *ethical, confidentiality issues*. Having decided to introduce *[herself] by name only*, Catherine was surprised by his response, *"Oh! You're his counsellor. I found your appointment slip on the fridge"* as it indicated that he'd already known who she was.

Because she had been *trying to compose [herself]* before meeting Barney's brother, she found herself apologising when she began crying in front of him:

[Before meeting the brother] I'd been trying to have a bit of a joke with this client who saw that I was upset. I mean, I'm still dabbing my eyes and looking for more tissues. Having a joke, trying to compose, but still getting teary. So talking to the brother, telling him what a wonderful man his brother was and how much he thought of his family, [I was] still going through, "Look I'm really sorry I'm getting upset, you know, I'm a bit teary", but unable to control the tears. A bit like I am now! There was distance and I was doing the professional thing between the tears.

When I asked Catherine what the ‘*distance*’ had been about, she replied that she had *felt apart from [her] emotions*:

I felt I was doing my job as a worker, as a professional, that “This is my job so therefore I’m going to convey to you that your brother was doing well, to support you and say nice things about the dead” and to treat him as I would any other family member of a client. And he was obviously quite upset so I thought, “Keep it brief otherwise we’ll both end up sobbing.”

Having spoken with Barney’s brother, Catherine was then introduced to his sister *who was almost like a mirror image of her*:

She was well-dressed, similar body type. I felt really comfortable with her. And there was something in the way her brother had said, “I just want you to meet my sister”, there was something that he was picking up on, and I thought I’d take a bit of a risk with her so I told her the story about the plant. Her face changed and she said, “I’m so glad I talked to you” [and she told me of a dream she’d had and a premonition about having to come out to Australia]. She actually works in forensics and she’s very clinical, doesn’t talk dreams cause it’s a bit too airy-fairy for her, so that in itself confirmed my little plant story a bit more. You know, that I’m not the only one having silly thoughts that these things could happen!

So I felt really glad to have been at the funeral and to have been there for his family and for myself. I’m glad I went because I think if I hadn’t gone I don’t think I’d have gotten so much in touch with my feelings about him and his death.

Once the funeral had ended, Catherine *left and drove someone else home and debriefed again with him*. This debrief, whilst *friendly* like the one she had had previously with the drug and alcohol nurse was more ‘personalised’ in a sense as it was with *someone, who had also ‘known’ Barney*:

He’s one of my clients actually, an on again, off again client, another one that I worry about but not as much. [The talk] was light and it was me again trying to maintain my composure, “Oh gosh, I got teary in there” and he said, “Oh look, you’re only human.” And I think [his comment] just clarified that at funerals we get upset. He was fine about it. He didn’t think any less of me.

When I asked Catherine if it was a concern for her that if she became ‘human’, fell to pieces, and didn’t remain strictly in her professional role that others might *think less of her*, she replied:

Yes. And probably more those that don’t know me, whereas this fellow I was giving a lift home to probably does know me a bit better than the other people who were there. I mean at the funeral I was also looking at potential clients. I’m there crying in the funeral thinking, “God! They’re going to think, ‘Oh! I’m not going to go and see her!’”

Over the following couple of weeks, and *usually probably over a couple of glasses of wine*, Catherine *sporadically had some crying sessions, about three sessions, more sort of late at night, in my bedroom, in privacy, over personal just sort of ‘lost’ stuff*.

The ‘lost’ *stuff* that Catherine was connecting with was *the depth of the therapeutic relationship and coming to grips with the fact that a therapeutic relationship has some similarities to a relationship*:

It was about sorting out, "This was not a relationship." However a therapeutic relationship can be a deep relationship and especially if it's a person I cared about, a person I was concerned about in terms of risk and "Could I have done more? Should I have rung?" I got to the point of, "Realistically, no, I couldn't have done more than I did" but I still went through that beating up phase. [The lost stuff] also included the loss of the depth of the trust, and the understanding and the sharing of personal things, the little bits and pieces of my life. Even though it was a therapeutic relationship, I didn't expect that it would be that painful.

When asked if there had been anyone that she had been able to share her experiences with in-depth during this period or whether she had literally 'cried herself to sleep at night', Catherine replied that *there had been nobody really to talk about it with [at work]* as there would have been *a lack of understanding and an inability to empathise at [her] level:*

[For example], in the last couple of weeks we've had a couple of deaths of clients and I'm actually doing part of the Root Cause Analysis meetings and functions and big investigations that the Health Department wants. You know, do little boxes and flow charts of the procedures that were in place and could be better assessed. And I had to talk to the caseworker, you know, "How do you feel about it?" Totally emotional-less. And here I am, my experience of having a client who's died, and this caseworker, there was no feeling, and that really shocks me and I think, "How can she be so callous and so unfeeling?" And she made a joke about the dead person in public, in a meeting about the relatives.

So [my fear was], if I got upset about my client, would people think I was fond of him? Would they understand the depth? Is one supposed to cry over a client? I mean, they are a client. So I feel really justified in not having shared the stuff about my client with these people because a lot of them are narcissists and they're so cold. So it does make me feel like a bit of a loner.

And it raises the question, "Who can a psychologist go and talk with about something that is not going to impact on work, not going to make me look like a weak person because I'm upset? And what about the confidentiality issues and the questions?" [So in the end I decided] if I'm going to have a cry, I'll have to cry alone.

Her workplace's ethos that, "*Only the strong survive*" and "*Crying is a sign of weakness*" meant that Catherine had *tried to pull [herself] up* shortly after Barney's death as she feared that the ramifications of *getting upset over the death of a client* in such a *tough* work context would be the loss of her *credibility*.

Since that time, *it was more little memories or thoughts* that Catherine had allowed herself to connect with, one of the strongest of these being in relation to the plant she had bought:

I did think, "What if the plant dies?" The plant's a nice memory of him. [I took it out of my office] and I've got it at home now, it's lasted and it's been part of the process for me and that's been helpful.

Although Catherine had chosen not to talk with her work colleagues about Barney's death, she had decided to *tell just the basic story with another colleague on the Internet on the night before our interview because [she] had actually lost a lot of the*

memory of it in trying to move on. Whilst Catherine had recognised that this person was potentially someone she could talk with, the fact that she was not a psychologist and had some issues herself had ultimately led Catherine to feel that this sort of [interview] setting, where I don't have to look at your issues, was of more benefit.

In light of her experience in relation to Barney's suicide, I invited Catherine to reflect on what she would like to be different if another client suicide was to occur in the future:

I think it would be that I just didn't have to do it alone, that there would be someone that could empathise, that could understand or that I felt could. And I think in a sense that's why I wanted to become part of this research because I thought I could use it as a bit of a talking through with someone who is a psychologist, who is able to empathise. Even though it's research, I did think it would be beneficial because it's personal, so personal and I think that the fact that I can still get upset about it today shows that it's still the process happening. I don't think that if I had just thought about the client now that I would get teary but going into depth...

As our interview drew to a close, I decided to revisit Catherine's initial question about her eligibility for inclusion in the study and to better understand why she believed that Barney's death had been a suicide:

[Because] life was really difficult for him and I wouldn't be surprised if he just gave up. He was at the point of saying, "What have I achieved in my life? I haven't achieved anything. My life is useless, futile." I have this image of him juggling a couple of cigarettes in ashtrays, one falling, and him not wanting to go anywhere.

For Catherine then, Barney's death had been a kind of resignation - less about consciously choosing to end his life and more about deciding not to live any more:

I think it's highly possible that he thought, "Well, if this is the end, then let it be." I wouldn't be surprised if he gave up at that point, didn't have the will to get out the door. I really believe that if he had had a strong will to live, he would have got out of that smoky flat.

Personal Reflections and Lasting Impressions

Two aspects of the interview with Catherine stood out for me. Firstly, the strong 'professional' image that her clothing, hair and makeup had conveyed and secondly the 'agonising' process she had clearly engaged in relation to Barney's funeral.

With regard to her appearance, it was the fact that none of the other therapists I had interviewed (including those who, like Catherine, had scheduled their interviews to take place before or after work) had dressed in anything other than 'everyday' clothing that made the image Catherine had portrayed 'stand out' for me. Whether her appearance was due to her employer's dress code, her own personal choice or a combination of the two is not known, however I couldn't help wondering if it had somehow contributed to the major internal struggle she had experienced between the expectations of her professional role/image and her personal needs in response to Barney's death.

Because sitting with Catherine whilst she had recounted her struggle in relation to Barney's death had been so palpable for me, I was struck by the sharp contrast between the 'agony' she had endured about 'what people might think of her' revealing parts of her 'personal' self during the service and her apparent 'lack of qualms' about

being seen as the psychologist who had gotten very drunk the night before Barney's funeral.

Epilogue

Several days after our interview, Catherine posted back the Demographic Details forms she had been unable to complete prior to our interview. Attached to the front of these was a compliments slip containing a brief, handwritten note that read:

Hi Jane - I really enjoyed being part of your research. It was like a free therapy session!

It seemed that by *becoming part of this research*, Catherine's previously unmet need of being able to *talk through [Barney's suicide] with someone who was able to empathise* had been finally realised.

Appendix H

AIDEN

Introducing Aiden's Story

My interview with Aiden took place at his home on a cool autumnal evening. As I walked through the front door I was struck by the warmth and tranquillity of his surroundings. Subdued lighting, candles burning in red glass holders, blazing open fires, flourishing plants, photographs, books, rugs and comfortable armchairs were in abundance, giving the house a really welcoming feel. No sooner had I stepped inside than Aiden took me on a tour, recounting stories about the house's history in a voice filled with deep pride and reverence.

It was not until we were standing in the kitchen, however, that I realised what an honour it had been to be invited into Aiden's home, for as we waited for the cappuccino maker to heat up Aiden told me that this machine was an integral part of the story he was about to share, having been given to him by the school's P and F Association as a thankyou gift for his support after the suicidal death of one of the school's students. When I enquired about why they had chosen that particular gift Aiden replied that it was the result of a conversation he had had with the Association's members in which they had asked him how he had *managed to cope with it all* and to which he had answered *by taking time out for myself to sit and have a cup of coffee*. Shortly afterwards the cappuccino maker had arrived on his doorstep.

Aiden's Story of Carl

Carl was Aiden's first, and to date, only client to commit suicide. A long-term student at the school, Carl and his family were *already a little bit known* to Aiden through his ongoing, everyday interactions with the school's students and parents.

It was towards the end of Aiden's second year as the school counsellor that his relationship with Carl became therapeutic in nature. Now in Year 12, Carl was referred by one of his teachers who *was concerned about some family stuff, unhappiness at home particularly around Carl's distant and conflictual relationship with his father.*

According to Aiden, Carl's *unhappiness at home did, in fact, get much more difficult [to the point where] he actually ran away.* He was also *smoking pot, probably heavier than we realised, had disappeared from school a few times, been disciplined and brought back in.* It was at that point that he was referred to Aiden for counselling.

Aiden's Story of His Therapeutic Relationship with Carl

Despite having been at the school for almost two years prior to working with Carl, Aiden's therapeutic relationship with him was nonetheless, in many ways, a 'baptism by fire':

Oh! I'd never worked in a counselling context before. My background, I had worked in a hospital setting. I worked with children, more from a pastoral counselling role, never worked in schools. So that was a steep learning curve. I'd arrived in an environment where I was really learning about counselling as well as expected to do it at the same time, and all that sort of stuff. So anyway, that was the steep learning curve.

In describing his work with Carl, Aiden remembered *having had lots of conversations with him, more in a pastoral role than seeing any signs of things I needed to look at more seriously and more significantly. There had been no red flags or obvious warning signs.*

When I asked Aiden what the *red flags or obvious warning signs* would have been for him he stated:

Well, you know, had he started to withdraw, those classical signs when a person's on their way out. Letting things go, isolating themselves, all that obvious sort of stuff. And I still don't think there were any signs there. I still don't think that.

It was on the afternoon before Carl's suicide that Aiden was informed by the Deputy Principal that Carl had *gone missing from the school and that they couldn't find him*. Aiden remembered reassuring the Deputy at that time that *all would be okay* as Carl had probably *just gone off on one of his bit of time out stuff* and would return.

At ten o'clock that night, however, Aiden was woken by a knock on his bedroom window. It was the local police informing him that *they'd found a boy....they'd taken the body down to the mortuary, and found out that it was Carl, so that was that*.

Aiden's Story of the Impact of Carl's Suicide Upon Him

Whilst Aiden's initial response to the police's news was that it *felt absolutely surreal, just like being in a bit of a dream*, he nonetheless *knew what he needed to do at that stage and went into autopilot despite the non-reality about it*.

This *autopilot* not only included *contacting the Deputy Headmaster, all that sort of stuff*, but also, at the request of the police, meeting with Carl's family, the details of which were still clearly etched in Aiden's mind:

I remember speeding across town, through a red light and I went straight to their home and going up to their door, knocking on the door, and the mother came to the door. And I remember she broke, she was crying. Both his mother

and father were there and they were obviously in shock and were making phone calls. So I stayed there with them for quite a long period of time.

Whilst Aiden acknowledged that he too had *broken down* during his meeting with Carl's parents *as the grief of it all, the unreality, all just sort of hit home*, he was quick to point out that he *was still functioning, and could do what he needed to do* in spite of this.

For Aiden, the *doing what he needed to do* in the immediate aftermath of Carl's suicide encompassed much more than 'simply' attending to the needs of Carl's family members. In fact, as the *unreality of [Carl's death] hit home*, Aiden was struck by the realisation that not only was there *a whole school community that was going to hear this news [but that] the school had never had a suicide before in all its history, so there was nothing, no policy to draw on and how do you manage that?*

But manage it he did by *kicking into his professional role [which] then allowed him to keep going:*

I'd had my cry, let a bit of pressure off, so was ready to keep functioning. There was still that unreality of it all, but you know, you still had that bit of a mental checklist about what you needed to do to set up things for the next day.

This checklist involved *making a whole lot of phone calls to key staff and various personnel around the school*; deciding upon the support strategies that needed to be put in place the following morning when the staff and students were informed of the death; speaking to the doctor about *talking to the staff about grief, about shock, about what signs to watch out for with the kids*; and *getting a few key staff together and*

sitting down to map out and set up mechanisms of support for Carl's closest circle of friends.

Because he was under supervision at that time Aiden also contacted his supervisor *at the first available opportunity, because again I hadn't experienced anything like this, so needed to have some conversations about, you know, "Hang on, what do I do here? What services are available?" and "What responsibility do I have?" And she came around straight away which was really good.*

It was only after Aiden had spoken with his supervisor and felt sufficiently confident that an action plan had been formulated for the following day that he returned home:

And I remember going home and feeling still quite shocked. And I knew I needed to come home and have a bath, and warm myself up, and just try and connect with myself again after all that, "I'm in my head, I need to keep functioning" stuff. So came home and did that. Sat and had a couple of beers and crawled back into bed about 2am.

It was not long, however, before he needed to resume his professional role, a requirement he found to be quite challenging:

The next morning when I got to school I was in this sort of dualistic frame of mind. In one sense being so conscious that "I don't know what I'm doing!" well, I had an idea of what I needed to do, the theory behind it all, you know, I was so steep in my learning, and yet, on the other hand, knowing that I could perform and exude that confidence, which is not really deep (laughs) because I know how impoverished my own inner resources in all this were.

Because he knew that he *wanted to hold everyone together he gathered [the staff and students] in the school hall and spoke about what had happened, very briefly, without unnecessary detail. The kids were then sent into their pastoral groups so that they all just got a chance to sit silently or speak with their pastoral person.*

Aiden then decided to *do some sort of symbolic thing, some sort of ritual stuff when it's not appropriate to use words because the group is so diverse. Soft music of the students' choosing was played, a candle lit in the centre of the school hall's floor and the students given a chance to sit quietly or to lie on the floor, whilst being reassured that support was available to them.*

In the days following Carl's death, Aiden found himself remaining in *automatic pilot mode, knowing the key things we needed to do. Resource people [counsellors] were brought into the school to offer additional support to the students; an 'open door' policy to his counselling rooms was provided so the kids could congregate and just talk amongst themselves and have coffee and cigarettes if the weren't in class; a bus trip to the site of the accident was also arranged at the request of a group of Carl's closest friends and time was spent with this group whilst they made a cross and nailed it up on the power pole.*

Despite *the school being a bit nervous about what sort of hysteria could happen, Aiden also arranged a trip to the funeral home for a group of Carl's closest friends so that they could sit with the casket and express their grief. Whilst he admitted feeling fear [during that visit] of losing some control and not seeing if there were any crises, he also remembered speaking really strongly on behalf of the students when the funeral director attempted to stop them from having items placed in the casket. In the*

end, however, Aiden decided to just *step back and go with the flow really, and to let these guys [the students] do what they needed to do.*

As he reflected upon the role he had played in orchestrating these events he realised that:

Again I was running on autopilot, and I was just amazed at myself. I was amazed at how you just sort of know what to do. Even though part of me was so self-conscious that I didn't have the professional resources and was feeling quite impoverished with that, there was still that intuitive sense.

Despite his intuitive knowing, he still felt under enormous pressure from those around him *to have all the answers:*

I think a lot was weighing on me, resting on me, in terms of making sure we were doing the right thing. You know, people were asking me "What should I do here? What should I look for here?" and whilst I was able to give some suggestions, and I think some reasonably good suggestions, I still needed someone else here that I could unload to, someone up the chain so to speak.

Since the school's Headmaster was away on annual leave at the time, it was Aiden's supervisor who assumed this crucial support role, *working alongside him and [being] very good in terms of being quite directive in her style. "You need to do this, this and this" which was really helpful.*

When I asked Aiden what had been happening for him during this period, he replied:

I think I really hadn't begun to attend to myself at all. Well, I hadn't really begun that sort of reflection at all. I was still in the consciousness, awareness

of, “ I need to keep functioning. I need to keep doing what I need to do.” My professional role was still there. I was functioning okay, probably pretty tired but running on adrenaline at that point. I guess I was probably running around just checking up and trying to monitor the whole school situation.

It was in the midst of these school-related activities that Aiden received a phone call from Carl’s father, asking if he would accompany him to view Carl’s body at the hospital chapel. Although Aiden remembered feeling *a sense of, “Wow! That’s a very special invitation to walk beside someone during a thing like that”* he also became aware of his own *fear of “What will I see?” and his heightened anxiety about all that.* In spite of this, he chose to accept Carl’s father’s request, as *he knew that he had to go because that’s what Carl’s father wanted.*

As had been the case when he had met with Carl’s parents immediately after Carl’s suicide, Aiden’s memories of the time spent in the chapel were also very powerful:

I went with Carl’s father to the door of the chapel, opened the door, and I remember the smell there, and the reality of that [was] sort of quite confronting, “Gee this is very real”, so that my sense was in overdrive.

Even as these powerful images and smells were bombarding him, Aiden remained firmly within his professional role so that he was able to be with Carl’s father and *care for him and do what he needed to do* as he spent time with the body of his son:

I knew I was in shock but I was also very conscious of what might have been happening for him [Carl’s father]. I wasn’t feeling a lot of like immense sadness or anything like that, it was just surrealness, and obviously my way of dealing,

of holding together the professional stuff. So there was detachedness from myself, detachedness from my gut.

It was only when he accompanied Carl's father back home and was *brought into the circle* by Carl's parents as they discussed the chapel visit that Aiden felt *it was okay for me to be there with them, to share that conversation with them*, and to drop the professional mask he had been wearing:

I think the thing about [working in a] school is that even though you have your professional role, you actually get to know people and families and parents. The role blurs slightly and so I was sitting there, not in the role as a counsellor, but as someone sharing the story with them.

When I enquired about how it had felt for him to be able to abandon his professional role during that conversation he said that he *remembered feeling a bit guilty about it later on* as he believed that he *had probably been expected [by Carl's parents] to maintain that professional role.*

Having said this, he also readily acknowledged that because his *counselling style had changed, grown and developed* over the years since Carl's death, he now *wouldn't differentiate it that way anymore, and that [in retrospect], it had actually been quite okay to do what he had done.* In fact, he now firmly believed that being with Carl's family in a professional role *wouldn't have worked, wouldn't have been right for them at all so that what I did intuitively was right but in my head I was wrestling with it afterwards.*

Shortly after visiting the chapel with Carl's father, Aiden was asked by the school if he would organise the funeral service, a role he was really glad to take on:

This particular diocese sees suicide as quite bad, not evil per se, but not going to Heaven as such, which I mean, well, whatever language you use, I thought, “Oh shit, the family don’t need to hear those sorts of messages.” So there was a sense of relief that the funeral had ended up in my lap to put together. I felt quite comfortable shifting roles between the counsellor and the pastoral person. That seemed to blend quite naturally.

Given the multiple professional roles he had had to assume, it wasn’t until the week following Carl’s death that Aiden was finally able to *begin to attend to himself* and to engage in *the sort of personal reflection* that had had to be put to one side whilst he’d *held together the professional stuff*:

Once the funeral service was over, it then caught up. I suppose it came in stages. I connected more with it when I was meeting with my supervisor, on the phone or debriefing with her. She raised the question of, “Well, this may go to court, the coroner may well have an investigation into what happened” and I remember the butterflies in my stomach and the anxiety just shot through me. So I suppose that was the first moment when it actually started to catch up with me.

When questioned about what the ‘it’ was in his statement “It started to catch up with me”, Aiden replied:

How I was feeling. “Me” came to the surface.

The “me” which Aiden was referring to contained *a number of things, the biggest of which were all his voices of self-doubt which were quite disarming and even bigger when you’re tired*:

You know. I've arrived at this school with only a pastoral background. So there were questions of "I'm not worthy of this job", "I don't have the background", "I've failed this kid", "If there'd been a trained counsellor this may not have happened." In hindsight I realised that I didn't have the training to pick up the signs and so I also went through a stage of guilt after Carl had died, repeatedly thinking, "What had I missed in that lead up time?"

Interestingly though, when invited to hypothesise about what Carl might have said if he'd been privy to Aiden's conversation and had heard his account of his feelings of guilt about having "missed something", he replied:

I get a sense he would have a smile on his face and he'd say, "It's okay. You know, you did all that you could do." You know he made some choices which I think is unfortunate but with that said I do get a sense of (pause), being forgiven is the wrong word, I don't get a sense of he's looking at me angrily, of, "You missed the boat here and I would be here if you had have..." so if he was here I think there would be a smile of, "Yeah, it's okay. I've moved on, you can move on."

And, yeah, I did go through that guilt to start with that was connected with the self-doubt [but] I've now reached a stage in my own understanding where I realise I can do only so much. I can try to look out for all the signs that I'm aware to look out for, but in the end I can't be there 24 hours a day and I'm okay with that.

In addition to the self-doubt and guilt, a further aspect of Aiden's 'Me' that came to the surface was *the anxiety that hooked in:*

Oh, I went through a stage, and Carl's suicide heightened it all, of feeling really, really conscious about not having qualifications as a counsellor and of thinking "If anything goes wrong, I'm out of my depth" and the big one, "What if I have to go to court?" I didn't keep notes of counselling sessions through some of those tentative, initial counselling sessions in the first year and I went through such stages of heightened anxiety about all the things that could go wrong! So whilst this thing with Carl was happening, I was aware of that thinness and of lying in bed at night till one o'clock, two o'clock thinking "Oh what did I miss? What have I not done? What did I not do?"

So that sort of stuff got out of balance and I over-identified with those feelings of self-doubt and anxiety and worry about court. That was all plaguing me, playing on my mind, but I was still able to contain that whilst I was doing my job, and able to do that reasonably well. I can contain things well when I've got support from someone that I can really open up with.

Again, Aiden's supervisor was the person that he felt *able to be open with about what I was struggling with:*

My relationship with my supervisor was one where I felt quite comfortable sort of talking about my fears and my anxieties. I could maintain the professional role at school but be able to be vulnerable with her when those self-doubts crept in.

Whilst Aiden acknowledged that he had also had *good support at that time from the staff at school* he conceded that *even though these relationships were relatively close, he was still seen as the counsellor by them:*

So whilst the conversation might be a bit open with them, they were staff asking for help with advice and guidelines so I couldn't tell them, "Well, actually I'm not really sure, I'm really doubting my ability here." And I was conscious of the fact that "If anything goes wrong here my credibility is going to be on the line."

Being seen in the counsellor role meant that other parts of Aiden's "Me-ness" also had to be 'kept in brackets' whilst he was around them, increasing the tension he was already experiencing between what was happening at a personal level, and what was required outwardly of him in his professional role:

I remember going through a stage of being pretty angry with God, "Why the hell would you allow this to happen?" I certainly had to keep that contained because I remember feeling quite anxious that if I touched that with the staff then I probably would have said some professionally inappropriate things. I could do that with my supervisor, I could let them out knowing that however long it took was quite fine, but my fear was that if I allowed these things to come out [with the staff] that they'd probably have kept coming out, and in terms of my role...

In addition to the support he received from his supervisor and, to a lesser degree, the staff at the school, Aiden's *really, really close friends in town* were also able to be there for him, albeit in a very different way:

They were people I felt comfortable just going and having a beer or enjoying a meal with. They're my own age and that was supportive just being with a peer, in terms of just another adult peer, not a role peer or anything, but just an adult friend. So that was really helpful in just being able to get away from here.

When I asked Aiden if he had talked about the suicide with his friends he stated that whilst he had, it had been in a brief, *more detached way about what had been happening at school*, rather than anything in-depth:

I don't think I told them as much as I would have told my supervisor in terms of my own struggles with the professional stuff, with the self-doubt, but certainly it was a really close relationship in terms of just being able to sit and not even say anything. Just to be together is a really regenerating thing. So that was really helpful.

Despite having experienced this 'baptism by fire' in relation to Carl's suicide, Aiden readily connected with a number of positive *shifts that had come about* as a direct result of the experience:

There's a bit of a smile on my face when I think about the shifting from the self-doubt to the greater confidence in, "Look, I can do this okay" which may not have, I may not have made those shifts in the same way, had the same opportunities for growth, [like going to Uni and doing a counselling degree] if I hadn't have been through that experience, so that's a bit of a different twist on it. And [as a result of Carl's suicide] I made some really good friends around town, in terms of professional colleagues I could draw on. It's amazing, isn't it, how there can be little glimmers of light amongst situations like that?

As our interview drew to a close Aiden reflected upon what it had been like to talk about Carl's suicide again:

I'm absolutely astounded at how the conversation has flowed, the memories have flowed, I mean absolutely astounded! I certainly haven't done that in

*years, I haven't recalled this situation and the details, including the smells!
Isn't it amazing how it just stays? I'm sure I've reconstructed it in terms of time
and bits of story but it's amazing how it's come back. So it's been pretty special.
Thank you!*

Personal Reflections and Lasting Impressions

For me, it was the multiplicity of roles that Aiden had had to assume as a result of his client's suicide that set him apart from the other therapists I had interviewed. Whilst the other client-counsellor relationships post-suicide had often expanded to include members of the client's family, the 'family' Aiden found himself attending to encompassed an entire 'community'. As I listened to him describe the seemingly endless number of professional responsibilities he had assumed or was assigned during this period, I was struck by how pragmatic he had been in putting his personal responses 'on the back burner' in order to fulfil these expectations. "Service to others before service to self" was the credo that kept coming to mind as I reflected further upon his story.

Appendix I

SUSAN

'Over the Line'

Introducing Susan's Story

Whilst Susan was the eighth therapist to participate in my study, the reason for her inclusion was different to that of the others involved. Although Susan *had* had a client suicide in 1994, it was a more recent suicide, that of a psychology intern she had been supervising, that she wished to speak about as part of my research.

Susan's name was provided to me, together with Dirk's (who I was to interview subsequently) by her supervisor - a long-term friend of mine. Since I lived in another state and would not have an opportunity to meet Susan face-to-face prior to our interview it felt important that some initial threads of connection be established before this time. Brief emails and a short phone call were therefore made to introduce both the research and myself.

The interview took place at the end of the day at Susan's private practice. Purpose built by Susan and her partner, the rooms were filled with a deep sense of peace, enhanced by stunning views of the nature reserve directly opposite Susan's office.

Susan's Story of E.J.

Susan's first contact with E.J. had been as the *co-ordinator of a college-based, two-year registration programme* for intern psychologists. Having conducted E.J.'s initial interview, Susan had subsequently become involved in *sorting out lots of troubles E.J. had been having* with her supervisor:

One of E.J.'s biggest issues was anxiety and I think, unfortunately, the way the supervisor approached this in terms of E.J.'s placement was to really push her

to work in an area that wasn't appropriate for her. I suspect she set it up to build her confidence but it was actually very counterproductive as it was at a time when she didn't have any support and I think it would have been a very difficult context for anyone.

In reflecting upon E.J.'s initial difficulties, Susan acknowledged that *one of the drawbacks when new psychologists [like E.J.] start young* is that not only do they have *practically no experience in counselling [and no] life skills that they can compensate with but there's a kind of arrogance that sometimes goes with our profession that gives the message that we don't need to do our own work.*

Because this message was *something that really offended [her]*, Susan had decided to *take this up quite strongly with [her] interns because one of the things [she] often found was that to even get them to a place where they could start functioning in some reasonable way in a placement, [she] was dealing with a lot of their personal issues.*

In E.J.'s case these issues had included health problems as *she had a lot of physical pain and always seemed to have something wrong with her; and lots of issues with her father [who was] a fairly typical, traditional, authoritarian man:*

It was almost like, that as a counterpoint to her father's criticism, E.J.'s mother really did everything for her, babied her in a way. E.J. had this knack of both inviting people in to rescue her and then also inviting people to scapegoat her, the two things I think she experienced in her parenting. On the face of it I'm sure her parents, especially her mother, felt that they were building her resilience [but the reality was that they were actually doing the opposite].

Whilst E.J. might have had *a burning ambition to be a psychologist, her passion was actually for horticulture - a dream her father absolutely ridiculed*. Pursuing registration as a psychologist had therefore become, Susan believed, *E.J.'s way to gain acceptance from him*.

It was only when E.J.'s original supervisor left the programme, however, that Susan decided to *take E.J. on* as by that stage she *had a lot of compassion for her* and felt that they *had built quite a strong relationship* over the past twelve months.

Susan's Story of Her Supervisory Relationship with E.J.

During her two-year supervisory relationship with E.J., Susan found herself *fluctuating between frustration and satisfaction*:

I think it's fair to say that we put more effort into this young woman than probably any other intern in the programme but there was always this thing, you'd just get her over the line, "As long as she can meet us, we'll keep in there with her", and she'd just kind of skim in and we'd go, "Well, alright..."

Much of this 'two steps forward, one step back' experience was due to E.J.'s *block about being self-initiating, about being independent in her work and about being able to be given a task and just follow it through*. Susan therefore found that *a lot of the talking [in supervision] was [her] attempt to work with E.J. on that and to challenge her fear about trying new situations, initiating the, "You just gotta get in there and do it and not be dependent."*

Because Susan *didn't hold the view that [supervisors] need to be really rigid about the boundary between the personal and professional* (as she believed that *one informed the other*) she also felt comfortable working with E.J. on much more than

just the ‘pragmatics’ of her placement and the attainment of the certificates required for full registration as a psychologist.

Despite this more holistic approach to supervision and her belief that there were times when it was *really appropriate to work with supervisees’ personal lives*, Susan nonetheless conceded that there was a line for [her] where [she] was not going to be their therapist:

If it’s clear it’s a big issue for them that they have to address, they must make a commitment to go and get counselling. [Then] we link it back into their work. You know, “How is this affecting you in your placement? What is going to happen if you don’t address this? What do you think the client is triggering in you?” that kind of stuff.

I think one of the reasons E.J. valued me so much was that I was able to find the balance of being quite authoritative, setting a firm boundary without rescuing her but still showing care for her. So not falling into those extremes. I challenged her a lot and I think she liked that because it wasn’t coming from a critical place. I’d say, “You can’t keep avoiding this, until you deal with this I don’t see how we can go further”. [You know] if ever a person needed intensive psychotherapy she did and I think unconsciously that’s what E.J. wanted from me.

At one stage E.J. had actually asked Susan *if she would be open to doing therapy with [her] at a later date*, to which Susan had replied, *“Look, I don’t have any problem with that transition as long as you know that we can’t go back.”*

It was towards the end of her second year of being supervised that E.J. *began madly applying for jobs everywhere [as she] was desperate to get away from her father whose criticism was soul-destroying.*

Whilst Susan had assumed that their supervisory relationship had ended when *E.J. got accepted [into a job in another state in Australia]*, several years later she received a phone call from the College advising her that *E.J. had been in touch* and that after *much miscommunication, struggle and all this drama about getting her back into the programme* they had agreed to do so. Susan's recollection of that phone call was that she had initially thought, *"Oh God, they can deal with it" as by then it had been very frustrating and this was always a symptom with E.J. You know how some people unconsciously invite the same response, haven't done their work on themselves?*

Although Susan *did her best to keep out of it until it was sorted*, she nonetheless offered to provide the fifteen hours of telephone supervision required by E.J. to complete her registration. When I asked Susan what her 'yes' had been about, given the enormous amount of time and energy she had invested in E.J. in the past, she acknowledged that *as much as E.J. had often frustrated [her], [she'd] really cared about her too [as] she was a likeable young woman and also, because [she] knew so much of E.J.'s personal struggle, there was this place of wanting to support her.*

Having said this, Susan acknowledged that she *had also felt some discomfort about it:*

Two years had elapsed since I'd last seen her so although I had a good sense of her when she'd left, I felt like I didn't really have a good picture of how things were in her new work. So I said to her, "Look, I need to really have contact with your primary [workplace] supervisor too, once a fortnight for an hour, as long

distance isn't going to be enough for me to really assess your competency" and she was fine with that.

And so began the second phase of Susan's supervisory relationship with E.J., a phase characterised, as had been the first, by alternating periods of satisfaction and frustration:

She seemed to be really struggling in her new job. In my heart I felt all through that time, had this sense often when I was talking to her about what she was doing that, "You're still not operating at a level that I would expect after so many years." It was still a little bit amorphous what she was doing, and lots of avoidance, not much exposure to face-to-face work.

Despite Susan's repeated suggestions that she get counselling to deal with her issues E.J. would *always find something to sabotage this* leading Susan to conclude that she was not making *any really significant shifts*. Susan's opinion was confirmed by E.J.'s workplace supervisor during *a fairly depressing conversation that contained all the sort of stuff that [she'd] kind of half expected but hoped [she] wouldn't hear.*

Whilst E.J. had been *devastated* when Susan had *fed this back to her* she had also tried to shift the blame for her lack of progress onto her workplace, a situation Susan found *tricky* to deal with as she was *working from a distance*. It was around this time that Susan remembered *getting really quite angry* with her:

The Registration Board was on her back [about a progress report they had been expecting from her] and suddenly she's expecting me to just have this done or to do it with her on the spot and I'm going, "Hey, this isn't okay. This is the stuff that doesn't work. You need to have better planning." And she was deeply

apologetic. She wrote me this email saying, “I’m sorry. You’re right. I know it’s something I have to change.” And the thing is, when E.J. went to that place she was always sincere. Then she’d fall into this hole again.

Crunch time soon came, however, as E.J.’s supervisory hours began running out and Susan found herself *unable to sign off ethically on her registration, as much as [she’d] wanted to:*

So it was a hard decision for me to pull out because I had to be guided by my own sense of ethics and values and secondly by the feedback from her primary supervisor. It was clear that she wasn’t ready for her full registration and she was kind of swanning me to keep going and I said, “I’ve really thought about this. I don’t think I’d be doing you a good service [by continuing as your supervisor] because I’m simply not in touch enough with the work you’re doing at a distance to be able to give you the supervisory assistance you need.” [I also said to her] “Maybe you really need to ask yourself the question “Is it that important that I become a psychologist? Am I doing this for myself or my father?”

Despite attempting to reassure E.J. that *pulling out was not just about not wanting to be her supervisor but also about acting in a professional way in terms of what was the best outcome for her and the Board*, Susan conceded that this conversation had been *full on*, particularly when E.J. had asked, “*Would you consider being my counsellor by phone?*”:

And I remember how I felt. I felt totally washed out and thought, “Ugh, I just can’t do it.” I think personally, if I’m really honest, I was in that place of being totally drained by her. But I felt that the reason I gave her was a valid one,

professionally. I said, "I think that if I did that I'd be feeding into your avoidance stuff of distance [but] if you ever come back here to live I'd be happy to be your counsellor." And I'm glad I said that, that made me feel better. So I wished her well but I was glad. I kind of breathed a sigh of relief about just working through that in a way that completed my relationship with her, up to that point anyway, but in a way that I thought both offered support and good boundaries.

The last contact Susan had with E.J. was when she received *a really empowered email saying, "I've really thought about what you said and I've made a decision. I want to be a psychologist. I've arranged to see a counsellor and I've found an external supervisor."* And I went, *"Oh that's great!"* and sent an affirming email back.

Susan was therefore caught completely by surprise when, six months later, she got a *phone call on a Friday afternoon from E.J.'s primary workplace supervisor saying, "I thought it would be really respectful to tell you that E.J. killed herself last weekend."*

Susan's Story of the Impact of E.J.'s Suicide Upon Her

Although she was aware that E.J. *[had] struggled with depression [as she] had talked about feeling very depressed and maybe at times hinted that life wasn't worth living,* Susan had *never seen her as suicidal* and was therefore *really shocked* by the news of her death, particularly since her *last contact with her had been a really up one.*

In an attempt to answer her emergent question of *"How do I make sense of this?"*, Susan *talked with E.J.'s supervisor for quite a long time* about the *last few months* of E.J.'s life. This conversation, however, did little to alleviate Susan's difficulty in reconciling what had happened:

What was puzzling was that, for all intents and purposes, she had seemed to be doing better. She was going to counselling, taking more steps, seemed more determined, had developed a friendship group, so things looked like they were going along. [But] that's the thing with something like this, you hear lots of stories.

The bit that [Susan] still struggled with the most was that E.J. had hung herself, a fact she found really hard to get with in terms of someone who was so fearful:

Like, to me it's such a violent death. As you know it's more men than women who do that, and also, and maybe it's my stuff being an asthmatic myself, but to die not being able to breathe...like you'd think she'd take tablets or something. I don't get it.

[But] who knows what goes on for someone when they're about to die, what's easiest for them? I don't know. I just think that she, somewhere in there, had the capacity to kill herself. Not that I got the signs. What was going through her psyche? I don't know. I don't know.

It seemed that E.J.'s father had also struggled with the way E.J. had died, *holding onto the belief that she was actually murdered rather than committing suicide.* Whilst Susan didn't actually believe this, she acknowledged that *as she couldn't really gel with the first scenario, in some ways it might be better off to find out that she was killed but that was a horrific thought because at least when you kill yourself there's some choice.*

The fact that *the police had destroyed the evidence* in relation to E.J.'s case, as everyone had just assumed it was a suicide, meant that Susan's level of doubt had

been further raised during the subsequent inquest that had been instigated by E.J.'s father while he looked for answers and someone to blame. Given his need to attribute his daughter's death to someone else, Susan was relieved that when he had initially phoned her he hadn't blamed her because he'd read all E.J.'s stuff and knew what an important person I had been in her life, more important than maybe I had even realised.

When I hypothesised about what impact blaming her might have had, Susan stated that she thought *it would have been hard but I don't think I would have taken it on because, like I know I'm not to blame, I gave her something good and so my only question is, "Was there more?" not "Did I create this?" That's not the kind of question I have.*

Whilst admitting that she *didn't mind the first conversation she had had with him, the fact that he had then rung again on several occasions had left her feeling kind of "Err!" [and] hoping that he wouldn't ring anymore because every time he did it really stirred up the pain of E.J.'s death.*

As she reflected upon the ways in which this pain had made itself known to her, Susan acknowledged that it was through:

Needing to cry, thinking about E.J., kind of going through stuff in my own mind, but mainly the intense sadness. It still really sits with me now. What a waste. Even with all the work I've done with depressed and suicidal clients over the years, it's still inconceivable for me to really imagine how someone gets to such a place and especially when I think of all the life E.J. had in her, all the possibilities.

In addition to her confusion about how E.J. had actually died and the intense sadness she now felt, Susan also questioned the role she might have played in preventing the suicide's occurrence:

[The fact that] E.J. was deeply private and did open up to me a lot can take me back to feeling a bit responsible. Not that I know I am, cognitively, but it's that question of, "Could I have done something different that would have saved her?" And it does come back to that question, "What if I'd said yes to being her counsellor? What if, in that moment of despair there was somebody she could trust?" And then I go into the self-talk that says, "Well you hadn't seen her for six months. You don't know who was in her life. You don't know how much she talked to others." And that's true.

Because she had recognised that *it's very impactful to have someone suicide* Susan had made a conscious effort to *talk to friends and [her] partner* about her experiences:

I practise what I preach, you know, to make sure I get support. I think the other thing is that, pragmatically, there was a lot going on in my life and I was feeling like I was kinda carrying so much.

The talk she was able to engage in was around *checking in that there was nothing I could do differently. Needing to know that for myself, especially around that question that she'd asked me on the phone [about being her telephone counsellor]. Just having a place where I could honour my own grief and talk over my own sadness.*

Whilst she *hadn't felt like she needed a lot of support from the staff at the College, she had sent an email to all the supervisors on the evening that she'd gotten the news*

[about E.J.'s death] both as a way of honouring E.J., of making her more than just a statistic, and to ritualise [her] grief.

Interestingly though, despite recognising the importance of being able to talk about her experience of E.J.'s suicide, *it was something that she hadn't ever talked about in this much depth [before].* Whilst admitting that the *obvious answer* for this would be that she had been constrained by *time, energy and space* at the time of E.J.'s death, she actually believed that it was more about being *the kind of person that processes things reasonably well* by themselves:

In the last few years I've created a bit of a visualisation which I also used with E.J. I imagine this beautiful room with stained glass windows where I'm standing at the door just watching my clients pass into the light. That's kind of got a spiritual element to it in that once you're gone, you're in peace. It's like the pain and suffering's gone. The only way that I can reconcile so that I don't stay too angry and too wounded myself is to focus on the letting go.

The fact that E.J. was not [her] client, not [her] relative, not [her] friend had also meant that *there was some distance:*

E.J. wasn't part of my life as such. I cared about her but she wasn't there in my life in an ongoing way. I think that when you lose somebody, well I suppose even with a client that could be true if you were in the middle of work and you were expecting to keep seeing them, it's like a void, a gap. Like we'd already terminated our connection so I don't feel that void, that loss of her in my life. I feel sadness that she doesn't have her life and that she's taken away her opportunities to live out all she could be.

Having said this, Susan recognised, nonetheless, that *it doesn't matter how long after you've had some kind of loss, there's still a capacity to go into the sadness:*

With grief, I think if you haven't worked through it, it keeps coming back in a way. So by talking with you in depth now I can go back into my sadness and anger. I haven't talked about my anger, maybe because it's not there now, it's a bit more integrated [but] I certainly did go through some anger too. You know, "What the fuck were you doing? Why didn't you ring anybody? It would have been okay to ring me." So therefore I come back to the place of, "Well, she didn't want to and that was her choice." And if it wasn't, if it was just too hard or too painful, then I can't be responsible for that.

You know, we as therapists are more exposed to pain than most and we have to learn to find a way to find that balance of letting it in enough to be present to our clients and remain empathic and compassionate, and keep it out enough so we don't carry it and it doesn't wound us. And I think it's quite difficult.

Ironically perhaps, Susan still found herself involved in E.J.'s supervision six months after her death:

It goes on months after. I've just had a letter from the Director of the College asking me about E.J.'s confidence and what competencies she had passed because her father wants her to be awarded her registration posthumously. I've since had all my reports sent from the Board because they needed to get my signature to release all that to the father, so that was interesting to read back my reports and I felt good about what I'd written because I think it was very constructive, kind of recognising where she needed to work on.

She had, however, gotten rid of the file she had kept on E.J.:

[Although] I do keep everything on file for interns, I destroyed that one. I didn't read it, I didn't look at it, I just threw it away because I didn't know how far her father will take it and I think what she'd told me about him, it's not going to do that family any good to hear how much pain he caused her. He did subpoena the stuff from the Board, my reports, and that keeps it at a professional level. I mean, that was my role. Again, I wasn't her therapist.

Postscript

After our formal interview ended, Susan discussed a male client who had killed himself several months after she had seen him and his family for family therapy:

And I didn't even know [about his death] until his wife rang me. She came and had one session with me. She was just wanting to kind of join with me in recognising how damaged he was and that really he knew he couldn't change and she said, "So it was better that he killed himself." But again, as things go, she could have come back and said, "You know, he was so upset after that therapy session..." People, you just can't predict it.

And in a way, like you never want someone to kill themselves, but I can reconcile that one much more easily than E.J.'s because he actually freed his children not to have to go through the horror he had had to go through. And I can feel very, very sad for what he went through but, interesting therapeutic question, and again, no answers, "Is everyone saveable in terms of being able to heal themselves?" I don't know.

Suicide's just always big, especially because of what happens in the therapy room. It's such a private and vulnerable space.

Personal Reflections and Lasting Impressions

First and foremost, it was the 'minute-by-minute' account that Susan provided about her supervisory relationship with E.J. that stood out for me. I remember my growing awareness, three-quarters of the way through the interview, of Susan still being deeply immersed in her story about this relationship rather than in her story of the suicide's impact upon her. However, given Susan's obvious need 'to make sense of it all' through this re-telling process, I chose not to rush, interrupt or circumvent it.

Several hours after my interview with Susan, I caught up with her supervisor for coffee. When she asked how the interview had gone, I replied, "*Great, Susan's an exquisite human being with an exquisite story but I won't go into details as I don't want to breach confidentiality.*" I remember how her response (which was given with such conviction) of "*Oh don't worry, I'd have heard it all anyway*" had evoked an equally strong, yet completely contradictory, one within me of "*Oh no you haven't!*" How many other supervisors, I wondered, were also operating under the false assumption that their supervisees "told them everything"?

Epilogue

In reviewing the transcript of her interview, Susan had noted how *difficult it had seemed to string a full sentence together* in response to my questions:

Part of the reason for this [disjointedness] is about that internal struggle to make sense of a precious life lost and to come to terms with it. That takes time and although I had talked about it in the past, the depth of reflection with you

was very helpful. I was left with the recognition of how important it is to tell these stories.

Appendix J

FAITH

Introducing Faith's Story

Faith's inclusion in my study was due to the generosity of one of my colleagues. Having heard Faith speak at an interstate conference about her client's suicide, my colleague approached Faith to see if she would be interested in contributing to my research – an invitation she readily accepted.

Due to the tyranny of distance and prior commitments on both our parts, Faith and I conversed for several months via the Net before actually meeting. Having had this opportunity to share aspects of both our professional and personal lives prior to the interview, when we finally did meet face-to-face, there was an instant rapport.

The location of our meeting couldn't have been more idyllic. As Faith's home-based practice was nestled in the lush, green hinterlands behind a major metropolitan city, the panoramic views from her house were simply breathtaking.

Trained in Emotional Release Counselling and Sandplay Therapy, Faith's counselling room was lined with rows of bookcases holding hundreds of symbols for therapy work. Comfortable cushions were scattered on the floor and a large sandtray took pride of place in the centre of the room. Whilst Faith busied herself making cups of tea, I gladly took the opportunity to absorb the sights and sounds around me.

Faith's Story of Ryan

Although it felt like a *really big question* to answer, Faith chose to focus upon her experience of Ryan's suicide during our time together.

Seventeen going on eighteen, Ryan was the son of deeply Christian parents, his father holding a very respected position at a religious school as the principal or curriculum head. Because Ryan was addicted to drugs and had been admitted to a drug rehabilitation centre for adolescents, it seemed that his father [felt that his] image was at stake around Ryan, that Ryan had to get cleaned up and then he would be okay again and fit back into life somehow.

It was Ryan's mother, however, having come along and done a weekend workshop of Faith's called "Dealing with Anger and Aggression in Children and Adolescents" who had first approached Faith saying, "I have a son I'd like you to see."

Faith's Story of Her Therapeutic Relationship with Ryan

As Faith worked part-time at [Ryan's] Rehabilitation Centre training counsellors, she sometimes saw Ryan there and sometimes at her practice:

I really only had three sessions with him, about once a month. After the third session he didn't want to book again. I felt that during that session he was not participating in the same way he had been. He'd been very keen to work before but this third time there was a level of shut down. It was a difficult session. [It was] only when he said at the end that he wasn't going to make another appointment that I realised he was actually finishing. He hadn't really told me directly until right at the end and I said to him at that time that we were just opening up, just getting ready to get to the stuff that we could work with at a deeper level.

One of his issues was that he had never stopped taking the drugs while he was at the centre. He was getting all this kudos and being hailed as the perfect student, an example of the centre's success, and at the same time he was

continuing to take drugs, and he decided, of his own accord, that he wanted to come clean with the centre and to leave the programme as he felt he'd done his time there and wanted to move on. But he didn't get the boot [as he'd expected] so somehow he was kind of trapped. He also had a huge dilemma with God, doing God's will. What he longed for was a relationship with God, he really longed for that.

Interestingly, it was at this point during our interview that Faith exclaimed, “*I'm actually more telling you the story of him rather than my own experience!*” to which I replied, “Most therapists seem to start with the story of their client first.”

A few weeks after [their final session], while she was packing one Thursday evening to get ready for a five-day Sandplay training she was flying out to the following morning, Faith received a phone call from Ryan's father saying that his son's behaviour was scaring him and that he was worried because he thought that he was taking drugs again.

During the conversation that followed, Faith suggested, *probably inappropriately*, that “*Maybe Ryan had never stopped [taking drugs]*” in the first place and that the father should *talk to and listen to his son (as she'd felt that the father's need to have status somehow overrode his ability to listen to his son)*. However, because she was *doing all that last minute packing stuff, going through all her resources and making sure they were there; [and since] she felt that she had given him a good hearing and it felt like she was going back over stuff with him*, thirty minutes into the conversation she'd said, “*I need to go.*” It was only when Ryan's father asked when Ryan's next session was that he'd found out that *Ryan had finished counselling with her.*

Faith was to learn of Ryan's death the following week. *Getting back from the conference on the Friday evening, Faith got up Saturday morning thinking, "Ah, I'm having a weekend off" only to receive a phone call from Ryan's mother inviting her to Ryan's funeral at ten o'clock that day:*

Apparently the father had taken Ryan sailing on the Sunday. On Monday morning the staff at the centre couldn't wake Ryan, they couldn't wake him, and they realised that he was dead and that drugs were involved.

Faith's Story of the Impact of Ryan's Suicide Upon Her

Faith's was *in shock* when she got the phone call from Ryan's mother:

(Begins to cry) It was horrible. She was so calm and cool, so matter-of-fact. That shocked me too, you know. I was in tears and she wasn't. I'm a person who has easy access to my emotions and if there's any unexpressed stuff around I'll start to cry for no apparent reason. I just felt the pain in my heart and I just could not stop weeping and she was very [contained] so I felt like an idiot in some ways actually because I had lost it, had absolutely no control, where she was absolutely in control. So we were like opposites, total opposites.

Ryan's funeral was held *out in the open, on the bank of the river, with hundreds of people around*. As Faith had had no prior inkling that Ryan had been suicidal, *it was hard [for her] to believe that the person who was lying in the open coffin had been moving and full-bodied* last time she had seen him.

As anyone who wanted to speak [at the funeral] could, the funeral had been going for three or four hours [when Faith] decided to leave. When I asked her if she too had chosen to speak, she replied:

I didn't. I was going to speak but I couldn't trust my emotions (begins to cry). I knew I would crack up and people, no-one would have been able to hear me anyway. I just could not stop sobbing when I talked about it, the pain in my heart was so intense. I suppose I don't have a lot of experience with death either [though] I don't think it would have made any difference at all [even] if I had. I think it was that I had felt such a connection with this person. Even though he said he'd stop coming, I actually didn't feel that it was finished.

Upon reflection, Faith believed that it had been *very helpful to go to the funeral because it had given her a big picture to sit something in:*

It gave me an inkling into his friends and what I noticed when they were telling their stories of Ryan was that it sounded as if he'd been saying goodbye to every one of them.

Attending the funeral also provided Faith with the opportunity to speak with Ryan's mother, an experience Faith again found far from satisfactory:

There was a time when people could go and speak to his parents but when I was with the mum again, I just could not stop sobbing and it was like she felt that she had to comfort me. I didn't feel like I needed to be comforted at all but she said, "It'll pass" and I thought, "I don't want any of the platitudes. This is just my raw emotional response and I think it's okay." So I really couldn't speak to the mum all that well.

Several months later, Ryan's mum rang and asked if Faith would meet with her [as] she wanted answers and she wanted to know what had happened and what Faith had done with him. Even though Faith had thought at the time, "I don't want to go", as

there was a bit of the unknown there and she didn't know what the parents wanted or whether they were going to blame her, she also recognised that it's natural for anyone who's lost a child in that way to find out as much as they can about what happened, so decided to accept Ryan's mother's request:

I put myself in her shoes (begins to cry). "If I was a mum, what would I want?" and I thought, "Well, the client's dead. Do I still need to hold to confidentiality?" They could get a court order perhaps to get access to my records and I thought, "Well, I don't want to go through that" so I decided that I would give them or disclose whatever they wanted. I did photocopy his card and I gave them the photocopy and kept the original in case something happened down the track. These were parents who weren't happy and who may want to take recourse against people.

Despite her initial hesitancy and concerns, when Faith met with Ryan's parents *it felt really good:*

I had some supervision before I went to clear anything of my fears and reservations so I went feeling very open and positive, and I thought, "I'll just report to them, answer their questions. I don't have to cloud the situation with a whole lot of information."

Perhaps more valuable for Faith from this three hour meeting with Ryan's parents was the fact that because *the mum was [now] more distressed than she was at the time of his death they [were able to] cry together:*

That felt really good. It felt more normal in a way, more real. She felt more real. I'd felt quite distant, not really connected with her at the time of the funeral but later, after that meeting, [that changed].

Despite the positive outcome from her meeting with the parents, Faith acknowledged that *something had happened to her confidence* - “*Can I trust my feelings? How come I didn't pick [Ryan's suicidality] up? How can I trust my intuition?*”

As a result of her decreased sense of confidence, Faith found herself radically modifying her practice:

I decided not to take on any new clients. You see he was a new client, so I decided not to, to protect myself I think. I feel that through this tricky time that I'm going through, I can work with clients who know me and who I have a relationship with [because] they know enough of their processes and how they are connected with their process that they are self-managing enough. It's almost like I didn't want anyone depending on me. I started referring my child clients on [too] as I thought they were the most vulnerable with me at that time.

As I explored with Faith what her fear had been in relation to working with vulnerable clients who depended upon her, she began to cry, saying:

Can I be trusted? Will I pick up what needs to be picked up? Are they safe with me?

As her confidence faltered, Faith found herself sliding into a deep depression – a depression which was to last *two years, basically since it [the suicide] had happened*, and required treatment with anti-depressant medication:

[It got to the point where] I didn't want to get out of bed. Clients would cancel and I'd say, "Great!" And it was like it all felt too much and I started to feel that there must be a way out of this and I started to think about suicide as well. And in that very deep, dark hole I couldn't write, I couldn't talk about it, I just drew all these spirals down into nothingness, lost in the wilderness, just lost.

When I asked Faith who had been 'in the loop' and privy to her experience at that time she replied:

Some of my friends, although some of them wanted me to be (claps hands), "Come on, hurry up, just get on with it and come back [to us] when you are!" I felt very uncomfortable with the intensity of my feelings and they're so used to seeing me 'together' and being in charge of my life that they didn't like the fact that I wasn't. I thought that they might dismiss my feelings so I didn't talk to them about it. And I felt very alone (begins to cry) when I didn't see them. It was quite stressful actually to feel that alone at times. And my husband also felt that I should have been over it, that I was making it mean something [and] that somehow I was failing to get my mind around it, get on top of it mentally. My emotions were very messy for him. He needed me to be 'cool'.

There was one person during this period, however, who was *absolutely wonderful* - the Director of the training team Faith had belonged to:

She was probably my closest confidante all the way through. She couldn't counsel, she's not my counsellor, she's my co-worker and I needed to keep that relationship free of her being my supervisor. So I didn't get any supervision from her as such but we walked through it together. She just allowed me to be who, whatever I was, over and over again. She listened and she coached me,

she comforted me. She kept reminding me of my qualities because in that black space I couldn't see anything good. She kept coaching me when we did teaching together, saying, "That was a brilliant lesson you gave." Long-term clients would also give me feedback at times and that kind of kept me going in a way but she kept me going in the training field. It was every day, on the spot, moment by moment whenever we worked together.

During this period, Faith was also having *quite a bit of supervision but it just wasn't doing it, just wasn't cutting through it somehow [as] she just wasn't getting over it:*

The supervision was in Emotional Release Counselling so there was talking, narrative. [And] I believe that if you tell your story it does help but I got to the point where I just didn't want to hear my story anymore. It was like it's not doing it somehow; [that] it wasn't true that to keep telling your story [meant that] you start to get over it. I [just] wanted [the pain] to go away, I just wanted it to be like it was before [but] when somebody dies it isn't.

Disappointed with this outcome, Faith ceased supervision and *went to a guy who did voice dialogue:*

I was having lots of dreams and he was working with them, and I found that was more helpful somehow. It was like I was right down into the emotion and didn't need to find anymore to drag up, I was in it. So I didn't really need Emotional Release Counselling at that point. I mean I'd cried, I'd yelled and screamed and done everything to clear my body of it but my mind was the issue. I thought my mind needed a bit of help.

Faith also *had a very long session, probably three hours, with a colleague who had had a similar experience [of having had a client commit suicide]:*

She just kept funnelling me down into the feeling and then looking at the negative belief that I had about myself around that and then coming to another place of another possibility. That helped a considerable lot.

Unfortunately for Faith, however, the relief gained from this session was short-lived:

I think what was lacking was that I didn't take it and build on it [so] the old pattern came [back] and took over again, reasserted itself in my understanding of what happened and it was like I continued to make it mean something negative about me. I started to become quite reclusive. I started to feel like I wasn't a good trainer, so I resigned. [It was like] "Well, how can I teach people about this when I don't even know how to do it myself?" "I'm a fraud," sort of thing.

So profound was the impact of this negativity upon Faith that she *decided to take three months leave* from her practice and *moved all her clients on:*

I was absolutely ruining my business the way it was. I couldn't answer the phone calls and my business relied upon me being on the phone at times. I was just hiding away, climbing into a hole and hibernating. [But even] after three months I said to my husband, "I'm not ready to go back. I'm just not ready." New clients started to come, particularly children, and then I went, "I can't book them in." I kept telling them about some other good therapist.

Faith *decided [therefore] to take another six months off, to not push herself to get back to work, to take time-out and to do other things like a twenty-one day retreat,*

holiday things and nourishing things. It was through participating in a personal development course, however, that Faith really began to *feel a new lease of life*, as she came to realise that she had made a professional event a personal statement about herself:

I had made it [the suicide] ‘me’ – that ‘I was an unworthy counsellor and not to be trusted’. And that’s the personal, this basic feeling of unworthiness that most of us have, being projected into my counselling role, into my professional role. I also remember reading an article by an educator in South Australia saying that you can’t separate the personal and the professional because any decision is actually made by the person. She was a real advocate for personal development being part of professional development. It fell on deaf ears a lot of the time but she said that you might be in a role but when it really comes down to it, it’s you, the person, who makes the decisions.

Despite having done the course and feeling that *that’s where her new energy had come from*, when Faith did return to work *she decided that the only people who really got appointments with her were the people who were old clients and who pushed her and said, “Well, I don’t want anyone else, I want you.”* And it was [through] working with those people that she started to get some confidence back:

I really opened up again. I started to see kids, I felt normal (begins to cry). But I’ve still been on kind of “Go slow” [because] I’ve been overly weighted in the self-doubt department, more than I’ve ever experienced before. At first I was overly cautious. Like I’ve set up my practice but I don’t do much to build, to grow it. I wait for people to come and really I’m only operating on survival if I do that. And the question I’m asking myself now is, “Do I want to keep

operating on survival or do I want to grow or do I want to step into something else?”

When I asked Faith what would need to change in order for her to move out of “Go Slow” mode and to grow again she replied that she would need to change her perceptions about the experience of having had a client suicide:

The question is, “How have I been with this all along?” and I’ve been with it in a way that has disempowered me. So, “How can I be with it in a way that empowers me?” that’s really the question. And I’ve only come to that in the last week or so. Because it was, for a long time, a rejection of the experience, like I wish this hadn’t happened.

As part of her attempt to ‘re-empower’ herself and to validate the experience, Faith had spent some time talking with a psychologist at a course she had recently attended:

We fell into talking and I mentioned about the suicide and he mentioned that he’s had some clients that had suicided and as we talked he said, “You know, it might be really good for us to write an article together.” And I could see that it would be a real healing process to do that. It’s almost like writing myself to wellness in a way or writing my way into something that works. But we never did it, we never acted on it.

Whilst Faith was unsure about ‘what had gotten in the way’ of writing this article, she suspected that it may have been due, at least in part, to her fear of what others may think after reading it.

She *had* chosen, however, to speak at a conference about her experience of the suicide:

I thought, "I'm not going to keep this a secret any longer. Everyone's keeping it a bloody secret!" It's like anyone who loses a client is a failure or something and I thought, "That's not fair and it's not real." No-one's talking about it but something's going on. What the hell is going on that no-one's talking about it? Only after it happened to me did a few [therapists] admit that something had happened to them. Some people came up to me after [my presentation] and spoke quietly and shared something of their experience. [But] it [felt like] it was very secret.

Despite her resolve to 'break the silence', Faith still drew the line at having her paper published in the conference proceedings:

I didn't want to publish it in the conference papers. I actually withdrew. It all felt too difficult. I felt I'd gone out and exposed myself in that public place where people could talk to me or respond or react [but] I actually didn't want it in writing [as in that medium] you're not there to answer people's questions or to challenge people's assumptions. You're left open to the whim of whatever they want to make it mean and it's not in your hands.

As Faith reflected upon what her 'worst fears' were about what people would make it mean, she acknowledged that it was that, "I'm not going to send anybody to her":

Well, we don't refer a plumber if they can't fix things do we? It's like in our commodities sort of way of thinking, everyone's got to do the best job or be the best, that sort of stuff. So it doesn't look like your best foot, you know? It could be a real liability. So how do we educate [people]? The reason I said yes to your research (begins to cry) was because it redresses the situation. Not enough

is said about what it's really like. It's like we're always promoting the "ideal" and that comes out of trying to be something we're not.

As our time together drew to a close and Faith reflected upon the process of having been interviewed she concluded that because *the suicide had been a very disempowering experience*, telling her story had allowed her to *feel like she was being with it in a more empowering way, making plans, seeing possibilities:*

At first [after the suicide] I thought, "I must be really bad because it doesn't happen to other people" I actually had no idea! The suicide of this client totally cracked open every illusion I had about myself, like I had all these 'try to's', all these selves I'd developed to try and cope and be everything to everybody – the 'pleaser', an efficient, effective counsellor, it was all a lie. What the death did, it connected [me] not only to the 'perfectionist' I alluded to be, tried to be, but also [I] got in touch with the imperfections of my actions. I got in touch with, "I'm not always right, I'm wrong", so I'm very grounded in my vulnerabilities [now]. I'm much more real. I think I'm much more authentic as a counsellor and my response is more authentic, so I feel I'm actually a better counsellor.

I've come through to this place. I think I actually did have to go through there [where] everything was shattered. Go through the shatter and go through the breakdown, though I didn't think it would take two and a half years. Maybe if I could have surrendered into it faster it might have taken less time, I don't know. And so I feel like I'm coming out the other side and starting to see possibilities for myself [and] I suppose they are the fruits and the gifts of it, that I've found more of myself really. Yeah, the fruits and gifts of the whole experience [but] I wouldn't wish this on anybody.

When I asked Faith if she still thought about Ryan she acknowledged that she *often* did and also *wondered what his mum was doing now*. Whilst admitting that she was *not against ringing her up and finding out how she is*, Faith was concerned about whether *that was what [Ryan's mum] would need or if it was just her need or curiosity*:

I think it's a bit like, you wait for the client to phone and make contact, you don't harass the client. I feel a bit like that with the mum.

Almost as an afterthought, Faith concluded the interview with the following words:

One thing I'd like to say is that the parents never ever said that he had committed suicide. Never spoke those words. They said it was "an accident." They were finding a lot of other reasons for why it could have been. I think that being the very religious people that they were, that it was very difficult for them to admit that it was a suicide.

Because of the parents' denial about the way in which their son had died, Faith found herself thinking that she *might be making something up or overdramatising*:

I thought, "Maybe I was wrong, maybe it was something else?" but the enquiry happened and Ryan's mother was going to let me know what the outcome of it was but she never did. So I still don't really know. So it did sort of create a bit of a ripple for me that the parents never said it was a suicide, never. It was always something else.

Personal Reflections and Lasting Impressions

Whilst Faith's ongoing vulnerability in relation to Ryan's death was certainly apparent during the interview process, it was the question she asked me as I was leaving her home that struck me most profoundly.

Accompanying me to my car to 'see me off', Faith tentatively said, "*Can I ask you something... did anyone else cry when you talked to them?*"

For me, the fact that Faith had felt compelled to ask this question *despite* her training in Emotional Release Counselling and her belief *that raw emotional responses were okay* really highlighted the pressure she felt under, nonetheless, to remain 'strong' and to 'hold it all together' in the aftermath of her client's suicide.

Appendix K

DIRK

'With Good Intent'

Introducing Dirk's Story

The possibility of Dirk's participation in my study was first raised by one of my friends, Kate, a fellow psychologist, who had provided supervision for Dirk several years earlier. As Dirk and I had both been invited to her upcoming wedding, an informal meeting was arranged during the reception so that preliminary talks about my research could occur. It was therefore over wedding cake and wine that Dirk and I first met. Striding up to my table and shaking my hand, his words of introduction were somewhat 'unusual' given the context - "*Hi Jane, I'm one of those therapists who kills their clients.*"

It was not until four months after our initial introduction, however, that I was able to interview Dirk. This meeting, which lasted for almost two hours, took place at Kate's home. Due to a lack of space and the need for as much privacy as possible, a 'make shift' interview area was set up in her spare bedroom – not ideal by any means but a source of laughter when it came to checking the tape-recorder's sound levels, as when asked to 'say something into the microphone', Dirk responded, "*Oh baby, do it, do it. You know you want to*" - a tongue-in-cheek reference to our 'unusual' interview surroundings!

Having heard Dirk's comment whilst I'd been setting up the tape-recorder that *he just wanted to get the interview over and done with*, I felt that it was important to check how he was feeling before we commenced. When asked what his trepidation in relation to the interview was about he stated that it was because *during the last two weeks two things had happened, I started having all these flashbacks and bizarre*

nightmares [about the two suicides] and at the same time I started reading a crappy novel about a guy who's a therapist and who had a patient, very young in his practice, die and the offspring of this patient had come back twenty-odd years later to seek revenge. And that's my worst nightmare!

Dirk's Story of Jason

Jason was the first of *two clients, both male, to commit suicide towards the end of 2002*. Although Dirk had had *other people commit suicide or have overdoses earlier in his career*, he hadn't really had *too much of an emotional response to those, other than to feel sad*. However, *these two most recent clients were something very different because:*

With the first one [Jason] I felt that we were making progress and then realised that we weren't and the second one, I probably should have been more insistent that he continued with counselling and I wasn't because I didn't like him, he was a prick.

Jason, the son of a *man who was a troll, a bizarre, fairly unintelligent guy and a woman of average intelligence who had realised that Jason had slipped through the cracks*, was someone Dirk saw as having *been completely chewed up and spat out by the system, being told at the age of thirteen, his last year at high school, that, "We have nothing for you. You obviously have lots of learning disabilities but we can offer you a job as the assistant gardener."*

Whilst Jason had stuck at his gardening job for several months *he soon decided that life was pretty pointless, so he went down the track of mixing with an interesting crowd, got involved with drugs and not long after, at the age of fourteen, got involved with gun running for one of the bikie gangs.*

Given that Jason's recent decision to *break away from the drug scene* had led to threats from the bkie gang that they were going to *kill him because of all the information he had*, Jason believed that *he was probably going to die and that he had no future whatsoever*. By the time Dirk met him, *Jason was 19 years old, a fairly heavy speed user and in a fairly significant state of despair*.

Dirk's Story of His Therapeutic Relationship with Jason

Jason was originally referred to Dirk's private practice by a *bloke at the Community Centre because he had turned up there and they'd gone*, "*Oh, we don't know what to do with you.*"

Since Jason was *illiterate, with very limited verbal skills, limited eye contact, the whole works*, Dirk quickly found himself sharing his belief that *his life was pretty pointless and that he had no future whatsoever*. Despite this, Dirk started to work with Jason on a weekly basis for about six to eight weeks, exploring both his issue [*that pretty much everyone had abandoned this kid in his life*] and his interpersonal skills.

The fact that both Jason's *interpersonal skills and his relationship with Dirk started to improve* during the period he attended counselling was to prove a double-edged sword for Dirk since Dirk's *take on it, having looked back over it, especially over the last two weeks* was that he *now realised that what had happened was that I had managed to raise his mood and level of self-awareness just enough for him to come to the conclusion that he had no future*.

In fact, shortly after his last session with Dirk, *Jason attempted to commit suicide by stringing himself up with some electrical wire in his garage and his father found him and took him to mental health and they called me and said what had happened*.

Whilst Dirk had *considered suicide a huge possibility, always a risk* with Jason, he was nonetheless surprised by his attempt as:

I had probably convinced myself that we'd got him to the point where we'd moved him beyond that possibility or that he'd started to generate some thought processes that maybe he could look beyond his current dilemmas, but I think I was kidding myself. I think I just really raised his mood enough to go, "Well, my life sucks."

During the forty-eight hour period in which Jason was admitted to the mental health unit, *his mum and dad rang [Dirk] and said, "He wants you to go and see him", to which Dirk had replied, "I can't do that, I don't have privileges there, I just can't lob up to mental health, they won't just let me in, it's as simple as that."*

When I asked Dirk if he would have visited Jason had that option been available, his response was that he'd *have had some ethical problems with that since what [he'd] been told was that if you build a therapeutic relationship with somebody in your room then that's the therapeutic relationship and that when you take it outside of that then it changes the dynamics.*

Furthermore, because Jason was *already surrounded by health care professionals at mental health* Dirk had been *reasonably ambivalent about it* anyway, though he *guessed that if they had been insistent enough, and it was an option, [he] may have taken it, although [he] wouldn't have been too thrilled about it.*

Dirk's parting words to Jason's parents had therefore been *"Give me a call when he's out and bring him to see me as soon as possible."* However, upon his release from the

mental health unit, *Jason hung himself, did it properly, when his parents left him on his own.*

Dirk's Story of the Impact of Jason's Suicide Upon Him

It was *a couple of days* after Jason's suicide that his parents rang Dirk to inform him of his death. Despite believing that *people make their own decisions* and that *this was what Jason had decided to do*, Dirk was still *really sad, very sad*, when he heard the news and also *a little relieved* because:

For the first time in any client that I've ever seen, here was a kid that I thought to myself, "You don't have a future" so my relief was that it felt like he was released. But then the inevitable guilt came about feeling this way. It was like, "Oh, that's pretty arrogant of me to feel, to think that it's a relief to be dead. Who the hell are you to be thinking that?"

Whilst not directly acknowledging it as such, Dirk's guilt also appeared to be attached to the fact that Jason's parents *made it pretty clear that in their minds I had let him down and that he'd hung himself because I wouldn't go and see him and I suppose I felt the same way:*

I gather from his folks that he felt pretty abandoned because I wouldn't go to see him. And he believed that I was somebody that had put some effort into him, probably one of the few people, and he began to build a rapport with me and I think he thought, "Well, here's somebody else who's kind of flipped me aside. I'm not important enough." [And so] I felt a bit sad about the fact that at the end of it I went, "Too hard mate [to come down to the mental health unit and battle the bureaucracy], sorry can't do it." So I ended up thinking, "Wow, I fucked up. I let this guy down."

The self-reproach in which Dirk engaged was counter-balanced, to some degree, by a more *rational, pragmatic* mindset which argued that, “*Well, hang on a minute, you did everything that you were supposed to do and you stuck within your ethical boundaries*” and *I believe that I did [in the sense that] I established very clear boundaries around that therapeutic relationship and maintained that therapeutic relationship.*

Dirk’s insistence on drawing very clear boundaries around his relationship with Jason had been borne out of earlier counselling experiences with another client he had *done some outreach work with and who had come to build up a degree of dependency upon him.* Conversations with a colleague at that time had led Dirk to question, “*Okay, am I a social worker or am I a counsellor? I need to choose what I want to be. You can’t be all things to all people.*”

Although Dirk was now able to acknowledge the fact that *he couldn’t be all things to all people, it hadn’t always been that way, particularly when [he’d] first started in private practice:*

I was certainly reasonably new and you do think yourself God-like and, “Wow! I’ve got all this power!” I’ve always been fairly honest about the power and acknowledged that it exists. You know, I often read counselling and psychology textbooks that turn around and say, “You should have an equal relationship with people” and I sit there and go, “What a crock, it’s not bloody equal at all! We’ve got all the power!”

As he oscillated between bouts of recrimination and absolution in the aftermath of Jason’s suicide, the words of one of his past lecturers, *an incredibly experienced, very authentic, gentle man [who he’d] thought the world of, had come flooding back.* This

lecturer had taken him aside and said, *“I want to give you a warning. At some stage you’re going to have a client who’s going to do it to you, who’s going to kill themselves, and they’re going to say it’s because of you. So you’ve got to be prepared for that.”* Whilst Dirk acknowledged that he had been able to take some comfort from these words *it didn’t make [him] any less sad.*

It was shortly after Jason’s death that another of Dirk’s clients committed suicide. This, together with the fact that he was being stalked by a third client and had had to breach confidence in relation to a fourth client’s illegal behaviour led him to question *“Hang on, what’s going on here? You’ve had a couple of people who have died, you’ve now completely screwed up any therapeutic relationship you had with this young girl, you’ve got somebody stalking you, what is it about me that I’m doing wrong?”*

When I asked Dirk how he had dealt with that question, given its profoundness, he answered, matter-of-factly:

I went on holidays overseas and drank tequila. I stopped answering the phone. It was a physiological response of fear when the phone would ring. Clearly burnt out, clearly burnt out. And I think all these things came to a head and it was enough for me to go, “Fuck it, I can’t do this anymore.”.

It was the companionship of his long-time friend whilst overseas that provided Dirk with the necessary support to get him through this period of his life:

He’s a very close mate. It’s an unusual relationship in that I would genuinely describe it as an intimate relationship and I remember we were walking down the street in one of the towns [about three weeks into our trip] and I started

whistling and doing a little bit of singing as I used to do and he turned to me and said, “You’re starting to feel a bit better aren’t you? The music’s back, isn’t it?” And we’d not talked about anything to do with my practice. He knew there was a whole heap of stuff going on but we’d not talked about it and he was comfortable enough to give me space.

Whilst Dirk was not sure whether it had been a conscious choice not to share his experiences up until that point, his friend’s comment provided him with the necessary invitation to talk about them then, although Dirk admitted that the talk had *been about superficial stuff to start with:*

After he said, “The music’s back, isn’t it?” that was the first time we sat down and had a beer and talked about it. Just little bits of it, not any great outpourings, just, “Well mate, a few things happened, couple of people died, couple of difficult scenarios.” And he goes, “Yeah, I gathered that.”

Dirk’s decision to share only *little bits* at first was based upon his need for *self-protection since, having started to feel better again, he was frightened that if he touched on it too much that he would feel as if it was all just a bit too hard again:*

As I said, even over the last two weeks, reading this novel, knowing this was coming up, it all came flooding back. The parent’s saying ‘It’s your fault’, feelings of sadness and guilt. It was like, “Wow! That was bloody horrible!” And he had been cool with that. He’d actually worked in the field, so had some insights.

Despite finding his friend’s non-intrusive approach helpful, Dirk also recognised that the ‘cost’ of his virtual non-disclosure was that his friend *didn’t realise how much of*

an impact it had had on his life and the fact that it just niggles away at you a little bit, erodes you away a little bit at a time.

It appeared, in fact, that very few people in Dirk's life had known *anything about any of this, [let alone] just how much of an impact it had had on his life:*

No-one knew about the first suicide. The second one I did ring up the lady from Survivors of Suicide [the referral source for that client] but that was a very brief conversation and again that was all about self-protection. "I think his mother's going to sue me" and when she said, "No" I just went, "Well, okay." So I didn't do anything, didn't tell anyone. Went and drank tequila. Works well. I'd recommend it to anybody.

The self-protection that Dirk felt he needed to engage in was also to cause him a great deal of shame and to add to the self-recrimination and self-reproach he was already engaged in:

I remember being very ashamed when the mother rang me up and said, "You said that my son wouldn't commit suicide. Well, I buried him today because he committed suicide last week." And my first thought was, "Oh fuck! She's going to sue me!" And when I played it back in my head, every response to her was purely from the basis of self-protection professionally. And again I can justify that. I've spoken to other people, doctors, psychologists, counsellors, all those sorts of people, and again they all say it's not an uncommon response, particularly in today's society which is fairly litigious, but it didn't sit particularly well with me. I sort of went, "That's a bit pathetic. Here's a woman who's just buried her son, literally that day, and my only response was to think about me." [My job] is to connect with people on a more human level. I didn't

think that that was very human. Well, it is human but I thought I was above that, putting purely my own needs on that level.

Although Dirk was engaged in supervision at the time of the suicides, he *didn't take any of it there either:*

In fact, Kate [my supervisor at the time] said to me about a year ago that she'd concluded that I never took the tough cases to supervision. I always left them aside. I took the other cases.

For Dirk, the decision *not to take the tough cases to supervision* had been based upon his belief that he *didn't think Kate would understand*. Ironically, perhaps, Dirk had chosen her as his supervisor specifically because *she had no experience in the substance abuse field and could therefore offer a different perspective:*

But at the end of the day [after the suicides] I thought, "Yes, you're getting a different perspective but you're not getting the perspective from somebody who's immersed in the field. And so I think, partly unconsciously, but to some extent consciously, I made a decision, "You know what, I'll take to supervision the cases that you will be able to relate to and understand."

Dirk's reticence about taking Jason's suicide to supervision, however, encapsulated much more than simply his belief that his supervisor *wouldn't understand:*

Supervision's bullshit! It's something we've created to give us the pretence of professionalism. And certainly the feedback that I've had from a lot of other people is that I'm not the only person who doesn't take the tough cases to supervision. I think there's an element of, "We will take the cases to supervision that are going to make us look the best." And the other factor is that there's no

voyeuristic component to supervision for the most part. I mean some people will tape sessions but most people don't. Why is that? Why don't we do that? We don't do that because we don't want to put ourselves on display, so therefore we take to supervision the neat ones.

Do I admit that [in one of the sessions with the client who was stalking me] I was sitting there going, "Damn you're attractive, I can actually imagine getting quite horny." Fuck that, I'm not taking that to supervision! Cause you're not supposed to think that way. What bullshit! Of course you do! I could go off and joke about it with this mate of mine but you're not supposed to admit that. You're supposed to go, "No, I put myself above all that." Bullshit! I think it would make us a far more real profession [if we could challenge all those artificial rules]. I hear so many things come out from people that are just clichéd bullshit.

Whilst acknowledging that not everyone, including his supervisor, would have responded to his experiences from a position of *clichéd bullshit*, Dirk also felt that their responses, although caring, would still not have 'hit the spot' for him:

I think that certainly [some of] the people I know and trust would have been very understanding, very empathic, very sad and all of those appropriate things but maybe it's not what I wanted to hear.

In fact, what Dirk realised he may have *wanted to hear* were people being completely upfront and challenging him in relation to his experiences:

Maybe I just wanted somebody to turn around and say, "You got arrogant. You got full of yourself. You thought you could save the world. You fucked up"

because that might have been more real for me, more real in terms of being honest. "Now I can be honest."

Again, it was his *long-time friend* who was able to meet this need most fully since *the enormous amount of trust* that had built up between them over the years meant that *whenever [Dirk] fucked up in any aspect of his life, his friend would turn around and say, "Well, you fucked up" and vice versa:*

So, to a large extent, he was able to tell me what I would have wanted somebody to tell me. "So basically you think you're fucked up. You think you're responsible for two blokes killing themselves, and just out of idle curiosity with regards to the stalker, what did you do mate, cause I know you? I know you would have been enormously flattered to have some half-decent glamorous [stalker] come along and say, 'Do you realise that in my last session I wasn't wearing underwear?'" He goes, "I don't know of too many blokes whose head wouldn't have been done in by that." And I said, "Look, you're right. I'm not supposed to acknowledge that, I'm supposed to be very sort of ethical and go, 'No, I put that away'".

And I couldn't take that sort of stuff to supervision because I thought someone who was my supervisor and is now my friend would go, "You sleaze bag. You prick. What did you do?" Whereas there was no judgement from him besides, "Okay, you fucked up, so you're human."

So I don't have a supervisor now but what I do have are people who have nothing to do with this profession whatsoever who I'm game enough to say to, "This is what's happened, I think I fucked up, give me your perspective, what do you think?" One's a GP mate, and he'll give me an interesting perspective.

One is my mate I went overseas with and he gives me a dark perspective which is always nice, and then, it's interesting that I will occasionally run things past my kids but in a very distant way and they'll come up with something simple but interesting. And I've got a mate of mine in Sydney who's a highly intelligent guy and would probably be described as being eccentric. He's a good listener for a start and honest enough to go "You're being a dickhead." I'm able to ring him up from time to time and vice versa. I have no interest in going back into professional supervision. I'd just sit there and think, "No I feel I can be far more honest and get more out of it from the so-called non-professionals."

When I asked Dirk whether he felt that it was impossible to be *honest and human* in a professional context, not only did he agree but added:

And it's something that I get very angry about in our profession because we put ourselves up on a pedestal at a higher standard than basic humanity as if we're this all-knowing presence. We're told, "There should be no power imbalance. We shouldn't judge." What bullshit! [When I think about] some of the things that I've observed from my colleagues and myself with regard to our practices I go "Fuck off. We're not all-knowing, we're human too."

The message I try to get across to my students at the College where I teach is, "Move outside of the bullshit scenario. That's what you're told but that's not the reality." So I'm often being pulled aside by the Admin going, "You're not supposed to be saying that kind of thing!" Sometimes I go to the Educators' meetings and I do stir the shit a little bit because I want people to go, "Break down those barriers! Stop being full of hypocritical bullshit! Join the fray!" and I can see some of them champing at the bit to join me but they're not game to.

And I have this real problem now because I'm not sure where the ethical standard is or what the reality is. I think to myself, "Well, what do I do? Do I take the party political line or do I go 'Bullshit'?" And that's mostly what I do. I live in my own little world and do what I think from an ethical perspective.

When I asked Dirk what impact the suicides had had upon his professional practice he admitted that after returning from overseas he had initially *made the decision to change his focus and to not do substance abuse counselling anymore or take phone calls from the Survivors of Suicide Association [in case someone else committed suicide]*. However, he'd soon found it *really boring* just seeing the *'I'm slightly bored' neurotic housewife whose life sucks a little bit*.

It was then that he experienced a real *crisis of confidence*, asking himself, *"What is it about me that the best work I do is with the dark clients, the ones who are really violent or are really heavy drug abusers?"* As a result of this crisis, Dirk had spent the *last couple of years working fairly hard on [himself] personally* and had now reached the point of saying:

Well look, you are the whole and you have this dark side too, we all do, but you're predominantly good. I call my dark side 'Evil Dirk' and he does rear his head every now and again. You know, it's interesting that I joke when I say that I went overseas and drank tequila but let's be realistic, that's about self-abuse, that's about 'Evil Dirk'.

Despite his crisis of confidence, Dirk stated that he could *now look at the experiences with the suicides and the stalker and all that sort of stuff and reckon it was probably the best experience I could have had [because] it broke down all the façades for me.*

When I asked Dirk what difference being able to break down the facades had made to the way he now worked with suicidal clients he replied that although he still chose to *very rarely do that kind of work* he had recently accepted a referral from the Survivors of Suicide and that *once [he'd] gotten past the initial fear of, "My God, another one of these"* he had concluded that he had:

Worked pretty well with her because I think it was far more authentic. I wasn't working from a textbook and saying, "Well, this is what you should do", I was working from a place where, "Well, you know what, at the end of the day, she might kill herself, she might not. And if she kills herself that will be very sad, but it ain't my fault."

You know, you can do all the good work you like and she still might kill herself. That's reality. And I think I'm also more therapeutically aware now [of the] need to watch my steps a little bit in terms of not having that arrogance. So some good's come out of it.

After almost two hours, my interview with Dirk drew to a close. As he reflected upon the experience he remarked *you know, this hasn't been as bad as I thought it would be! There was angst before I started and it was quite surprising angst too. I'm really tired, really tired now. But no, it's been good. I feel lighter.*

Personal Reflections and Lasting Impressions

The most striking aspect of my interview with Dirk occurred shortly after its completion, for as we re-entered the lounge room in Kate's home, not only were we met by her but also Susan (whom I had interviewed the previous day). What became glaringly apparent within minutes of this meeting was that although Dirk and Susan had moved in the same professional and social circles for a number of years, neither

had been aware of the other's experience of having had a client suicide until now. It was only when Kate announced that she had been the one who had provided me with both their names as possible participants in my study that 'the penny dropped' and they were able to acknowledge, for the first time, that they had both encountered the death of a client by suicide.

Epilogue

Several days after emailing Dirk a copy of his transcript for proofreading I received his response, requesting that his story be entitled "*With Good Intent*" because *I have to believe that I had good intentions with these clients and that the profession also has good intentions even though some of what exists may be a façade.*

Having read his transcript, Dirk also realised that *whilst reflecting upon that period and the deaths was still a very sad affair he nonetheless hoped that it would stay that way.*

In closing, he thanked me for my *very good interviewing skills* and for my *gentleness and empathy*, an interesting comment given his previously stated belief that *having people be very understanding and very empathic and all of those appropriate things [was] maybe not what he'd wanted to hear.*

Appendix L

MATT

'Glass Half Full'

Introducing Matt's Story

Whilst Matt and I had met occasionally during the six years prior to our interview, having moved in similar professional circles over that period of time, it was a mutual colleague who first approached him to participate in my study.

My interview with Matt took place early one morning. As I set up the tape recorder and organised consent forms to be signed, Matt asked me *how long the interview was likely to take*. Given the tight scheduling of his work-related commitments that day, I assumed that his question reflected his fear that our time together might be somewhat limited. As most of the therapists I had previously interviewed had spoken for between one-and-a-half and two hours I assured Matt that we could easily schedule a follow-up session if required. Matt's exclamation, therefore, that he *couldn't imagine having more than about fifteen minutes of things to say* caught me somewhat by surprise. Interestingly, despite Matt's initial belief that he'd have little to offer, our conversation lasted for just over ninety minutes.

As the tape began recording, I asked Matt how he had been feeling in the lead up to the interview. Given that he *hadn't wanted to re-live the suicide and be pre-occupied with it*, "Oh my God, what is it, when was it and why did it happen?" he stated that he had chosen *not to focus too much on trying to recall it* prior to our meeting:

I personally had some apprehension I guess, "Will I have any aftermath?" I still have, I still feel emotionally involved you know. I don't feel bad about that. I still get goose pimples and the tears well up. But I recognise the need to talk

and talk and talk it out of my system, not in a meaningless way but in a constructive way.

Matt's Story of Josh

It was in Matt's last year of training as a psychiatric nurse that he met Josh. Working in the clinic of a city-based psychiatric hospital at that time, Matt was *one of a team of people trained in facilitating encounter groups to be selected to be the therapist for the group* Josh belonged to. Whilst Josh had been a patient at the hospital *for two to three months before he committed suicide*, it was only during the final *six to eight weeks* of his life that Matt had contact with him. Josh was, in fact, Matt's *first experience of having someone die at work*, an experience he now believed *had impacted on him a lot more than he had given it credit for at the time.*

Matt's Story of His Therapeutic Relationship with Josh

Matt's involvement with Josh occurred in the early 1970's in a clinic run by a very progressive psychiatrist who *had brought in the new psychotherapeutic approach to client management where we talked about issues and looked at the 'whys' and 'wherefores' rather than just pumping medication into people.*

As part of a team of psychologists, psychiatrists, social workers, psych nurses and God help every other, the baker, the butcher and everyone else dealing with Josh and his mental state, Matt's role had been to run group therapy sessions with Josh, to try to get to know him [and to help him, through group work] to learn in terms of how to deal with his issues, rather than having some expert coming in and telling him what to do.

Although Matt was also involved in some *one-on-one sessions* with Josh, these were generally conducted by *the psychiatrist and social worker and psychologist.*

Unfortunately, whilst there was an expectation within the clinic that *if there was anything significant that happened in the group, by way of feedback it had to be written up*, “*Josh was very teary in group but wasn’t able to verbalise, articulate what his emotional state was*”, this expectation was not reciprocated, with Matt *never getting feedback on the one-on-one sessions*:

So never once did the psychiatrist, psychologist, social workers sit down with the psych nurses who were doing the group work with people like Josh and say, “Hey look, this aspect is a little bit fragile so be careful” or “This is where I’m at with him so if he’s playing games be aware of it.”

This lack of co-ordination and information sharing in relation to Josh was to play a critical role in Josh’s decision to ultimately commit suicide since, according to the suicide note he left after taking an overdose one evening, *the contradictory messages* that each of the team members had been giving him, together with his *passivity throughout the whole thing [and the fact that] he didn’t have the assertion or the fortitude to come up and say, “Look, get your act together. Everybody’s giving me a different message. For Christ sake, leave me alone!”* was what, Matt believed, had led to Josh *taking his own life*.

Whilst Matt *couldn’t remember verbatim what Josh had written in his suicide note*, a note which had *cut him to pieces* when he’d read it the following morning as part of the report prepared in relation to the death, *the [flavour of the] message was, “Thanks to you bastards I’m really stuffed in the head now.”* So therefore we went, *“Oh God!”* and looked at the staff and everybody who had something to do with it. And then there was a big emotional hoo-ha because we *hadn’t anticipated the suicide because there*

had been a complete lack of case management. It wasn't talked about, wasn't taught in those days.

Matt's Story of the Impact of Josh's Suicide Upon Him

Whilst acknowledging that he was not his brother's Maker, and therefore couldn't be responsible for Josh's life or for monitoring him twenty-four hours a day, Matt nonetheless felt that it had been professional inadequacy that they didn't have the foresight or the insight to get together and talk about this person on a consistent basis for as long as he was a patient.

Matt had therefore been struck by a profound sense of shame, the shame as a professional that I had let somebody down, combined with guilt upon hearing of Josh's death, feelings which haunted him for a while and took maybe three to six months to come to terms with.

In addition to the shame and guilt, Matt also experienced anger towards Josh, "Why did you put me in this situation? Why me? Why not somebody else?" which was followed for a brief time by almost overcompensation, shifting the blame, "It's nothing to do with me, it's all his bloody fault, he's mentally unsound and this happens." However, when Matt found himself thinking negatively towards Josh, he would quickly sit down and look at it in the calm of the day and say, "Hang on, he was here for a very good reason because he was mentally unsound, and that's all the more reason why it was my responsibility to look at what were the risks involved. Why didn't I pick up the indicators there?"

When I asked Matt about not picking up the indicators he replied that it was because in those days, nineteen sixty-nine, nineteen-seventy, they were never talked about:

It was the pioneering days. Risk assessment, what's that? There was no in-house educational session to make your competency level current. After you left your training, that was it. There were no measures put in place to check how you were going, what you were doing, evaluating what the outcomes were. Nowadays, there are all sorts of methods of dealing with it.

As Matt reflected on the mood of the clinic at the time of Josh's death he admitted that *the initial stages had been a bit uncomfortable and that it had been a sombre place to be because the suicide had exposed us to a raw nerve [in that] we could obviously have done certain things differently, like joint case communication, meetings.*

When I asked Matt what impact Josh's suicide had had upon the way people had coped in the workplace he replied:

In the early days it was false bravado. We didn't have in-house debriefing sessions, clinical support or supervision like we have these days. So how did we cope? We drank too much, we took drugs, we became sexual deviants, obsessed about one thing or another. At lunchtime we use to go and have a beer, some people would drink to excess, that's how we coped. So it was a big bravado, [the suicide] was dismissed all together.

At other times, Matt found himself *having to go numb to survive:*

That was my defence. You know, feel nothing. I could have been a robot walking in to work. And at the end of the day I'd either go and get drunk with my mates or play, take my frustrations out on the field or whatever.

Whilst the majority of the staff managed to maintain *dismissive attitudes* in relation to the impact that Josh's suicide was having upon them, "What are you talking about? Everything is fine mate. It happens every day", not everyone, including Matt, was able to engage in these *defences and pretences* on a continuing basis:

One could have said, "Me thinks you protest too much either by your words or your behaviour. What are you trying to hide?" It was almost like they didn't have any appropriate feeling to what had happened. In fact, what we were trying to hide was like a cancer, the guilt was eating away at us, most certainly at me. And that's when some of us started talking about, "Hey, come on. This is not getting us anywhere. There must be other ways, healthier ways of dealing with it."

Matt's *underlying fear* however was that if he *dropped the false bravado* and actually told people how vulnerable he was feeling that *they would think that [he was] such a bloody sissy, a weak person. Blokes talking about their feelings, "You poofter bastard, just get on with it." You know, "Why can't I maintain the façade like the other fellas, like my mates seem to have? Why can't I be so dismissive? Is there something wrong with me?" So they made me think, "Wow! Are you supposed to be so insensitive that you can't even feel?"* For Matt then, the challenge was not to let these messages become statements about personal deficit but rather to acknowledge that they reflected an *unsupportive work environment*:

I believe the health system has got a lot to answer for. It espouses due care and concern but it never practises it with its own people. Nobody comes around in a caring way to find out and say "How are you going?" or "Is there something else we need to do?" that flow on effect. Nothing happens and that's one of my

many disillusionments with the system. We talk about care but do we practise care? [It's like case closed] move on guys, there's more work to be done so just get on with it.

This “*case closed, move on*” mentality had certainly existed in relation to Josh's suicide, since *once the identified patient had gone almost everything came to a standstill*. The fact that *only the psychiatrist and the outreach worker continued to deal with [Josh's family]* meant that Matt was left thinking:

“Hey, what about us?” We were very much a part of his life and therefore his family's life. We had connections with them in group sessions. What about us saying [to the family], “Hey, I'm sorry, give us a hug. How do you feel?” That would have been of benefit not only for their healing process but for mine too [as it would have helped me] come to terms with the fact that I can still help the living who were a part of his life. But all that was denied. We never had that kind of closure.

In light of the above, the only option available to Matt at the time of Josh's death was *to quietly go away and talk with the psychiatrist, “Well mate, I can't sleep because...”* Eventually however, the psychiatrist, who was also the Director of the unit, recognised the need to put some steps in place to provide some formal, in-house support. This support took the shape of weekly group sessions since *the suicide had impacted on the group and therefore needed to be dealt with by the group*.

Whilst some of this group work had involved a ‘clinical post-mortem’ in relation to Josh's death *as the psychiatrist was astute enough to know that there was a lesson to be learnt from this and that it needed to be dealt with to avoid any future Josh's, the sessions were more about working on the personal stuff, so that we'd be comfortable*

with ourselves and not blame ourselves. He'd ask, "How are you feeling? Why do you blame yourself?" and at times be really challenging, "Maybe you are the culprit?" an approach Matt found very provoking emotionally, very challenging because it meant that you had to really deal with it:

He was very good at that. [He'd] leave you to think about it and sweat on it. It grounded us a bit more, "Why am I taking the weight of the blame all myself? Am I that kind of martyr?" So he was being the Devil's advocate, the provocateur because he didn't want us to take those issues home and to personalise them. So he'd say, "No, deal with it here, deal with it emotionally but don't get emotional, try and think of the facts."

It was interesting to note that the group sessions, which were *pioneering stuff* back then, further highlighted the almost diametrically opposed responses to the suicide that existed amongst the staff:

Within the group our experiences were chalk and cheese. There were some people who had no compunction about, "Wasn't anything to do with me" and others who had gone to the other extreme of, "It's all to do with me. I should have been more diligent. I should have woken up to the signs."

As well as the group sessions, Matt also engaged in some *one-on-one with the psychiatrist when they were having lunch to discuss the sort of lingering aspects that were still niggling at him*. These *lingering aspects* not only included Matt's diminished sense of confidence about his capacity to conduct group sessions with patients and to identify individuals who were 'at risk' but also a more fundamental concern about *his choice of career*:

There was like a cloud descending upon you, making you feel, “Am I competent enough?” and “If I am, how come I didn’t pick [Josh’s suicide] up? Can I hold myself up and say to the group, ‘Okay, we’ve lost Josh, how does everyone feel about that?’” So sitting in the group it was very uncomfortable to be actually involved, I felt incompetent, the wind was taken out of my sail. “Should I even be doing this job? Have I got the right mental to do this job? I should have chosen some other career path.”

In fact it took a long while, three to four months for the numbness, the detachment [Matt] felt from the Unit, the work, from other patients to dissipate and for him to feel at ease with the clientele within the unit again and to feel part of the group.

When I asked Matt how he had managed to navigate his way through this crisis of confidence he credited the psychiatrist with having *gotten him through it*:

I looked at him as my mentor, my guru really. He was like a father figure. In a way I was asking for reassurance I guess, from Big Daddy, “Tell me that I’m okay!” (Laughs) He was good, very skilled at that, because he wouldn’t say, “yes” or “no”, he’d say, “What do you think you could have done?” and “Come on, we’re just human beings” that kind of thing. So he was a moderator in that sense if you like and a real champion of taking down facades. We’d work it through and that usually happened after a beer too when you were far more relaxed and not consciously holding back the defences and pretences.

As Matt reflected up what might have happened to him had the psychiatrist not been there to guide him and be the steady influence in the aftermath of Josh’s death, he acknowledged:

I would have been terribly unhappy. I would have felt worn out because the rest [of the staff] had a survival mentality, “I need to survive or I’ll die and I’ll do that every which way I can by any means available to me”, and that was to drink excessively, take drugs excessively, get into fights. [In fact] I think I would have left because in the aftermath I was very emotionally fragile.

In addition to the critical role played by the psychiatrist, Matt also *looked towards two other workmates for support and strength.* The bond [they] established was based on the fact that they had *some commonality in that they were not overtly trying to prove a point [about needing to be macho],* which meant that Matt wasn’t left feeling like a *freak:*

When we ran groups, one or the other would be there to give the other support and to give a nudge if you were full on in your thoughts and looking very distant. You know, “Come back here”, that kind of stuff, which was good.

Outside the work context, however, Matt had no-one with whom he could talk in-depth about Josh’s suicide. The decision *not to pull other people into [his] work issues, most certainly not [his] family* was based upon Matt’s belief that *because work was bad and sad enough he didn’t want to bring it home because it could become an obsession and upset the balance in [his] life.* Therefore, whilst he might have told his mates, *“Gee, I had a shit of a day at work”, we never got into it in an analytical way or in a way that you can be constructive instead of dismissive because that was done at work, that’s where it was relevant. Anything outside of that didn’t matter.*

His partner at the time, *who happened to be a mental health, psych nurse too,* was also not privy to his experiences:

We talked about it in terms of, “Silly bugger, he died on us” that sort of stuff but didn’t go into it.

The fact that his relationship with his partner *went cold at that time and then finished* shortly afterwards, may have been *partly due*, Matt believed, to *not dealing with Josh’s suicide in an overt and conscious way, because it was very hard not to look at your partner and say, “What’s the matter? What’s going on? Where are you?”*

Whilst acknowledging that Josh’s suicide had *most certainly made a mark in his life*, and had been *a shock that [he] would never get over really because [he] could still recall it, see it, feel it, to some extent*, the experience had certainly not been a completely negative one. In fact, over time Matt had come to regard Josh’s suicide as having been *very instrumental* in contributing to his professional development:

It became a turning point in my life, particularly in relation to that business of, “Am I worthy of my position? Have I got the capacity to move on from here within the profession and not run away from it?” [So] I think it prepared me in terms of my emotional exposure to mental illness, suicide and all that. With Josh I was totally emotional and subjective but now I can pull back very quickly, put my emotion aside and do an objective analysis of the situation. Not that I feel good because I wasn’t responsible [for the suicide] but now I know I’ve done everything possible - documentation, clear communication, case management, goals in terms of the person, being a bit more diligent, more open, more honest, more probing. There’s nothing to search for in your mind in terms of, “Did I do this? Did I do that?” And that becomes a very good teaching tool for other people. As long as I know I’ve given every effort I’ve got no qualms in feeling bad or guilty. That’s all I can do.

By his own admission, Josh's suicide had also helped Matt to discover *the happy medium between being so non-caring, so flippant to the point of masking it, "Yeah that happens in life mate, get on with it, move on" and getting so bogged down that you go home feeling bad or having haunting thoughts or whatever:*

At the end of the day [having a client commit suicide] is nothing to be ashamed of or to blame yourself for as long as you've done everything you were supposed to do. Suicides always happen, we can guard against it [but] we can't stop it. It's how we move along from that that really matters.

In the concluding moments of our interview, I decided to return to an earlier comment Matt had made which had 'gotten lost' in the flow of the conversation but which had struck me as sounding quite significant. When I invited Matt to expand upon what he had meant, in relation to the psychiatrist, by his comment that *the problem with all gurus and mentors is that they have their own problems themselves* he stated:

You know, it's amazing that for all his wisdom, for all his knowledge, this man [the psychiatrist] committed suicide and blew his brains out with a gun. Not only did he do that but he took his wife and two young sons with him. The very man who made other people see the right path to take couldn't see his own path in the end. It's a very risky game we're in, we need to be able to put things in perspective or they can consume you, eat you up. He finished up that way. So we should never take anything for granted.

It was on this very poignant note that the interview ended.

Personal Reflections and Lasting Impressions

Immediately after my interview with Matt I was struck by two quite powerful awarenesses. The first related to the ‘tragic irony’ that seemed to surround Matt’s mentor’s death. Left with a burning desire to further explore the impact that this must have had on Matt, I initially toyed with the idea of scheduling a follow-up interview. However, the fact that Matt had chosen *not* to expand upon this part of his story during the initial interview seemed indication enough not to ‘push my agenda’ into territories Matt had chosen not to enter.

The second revelation (which I scrawled in capital letters in my journal!) was that despite thirty-plus years having passed since Matt’s experience of having had a client suicide, with the exception of the introduction of improved suicide risk assessment and management, “NOTHING MUCH SEEMED TO HAVE CHANGED!” in relation to the stories I was hearing from therapists who had recently experienced a client suicide, particularly with regard to disenfranchisement.

Epilogue

A follow-up email from Matt revealed that reading the transcript of his interview had evoked *a strange yet calm feeling* in him as it had made him *realise how far he had come since this “early incident” in his professional life without succumbing to the shock and horror and sea of negative emotions of the initial realisation of the suicide.*

It was because he felt *good in his capacity to turn the “negatives” in his life into “positives” [that he had chosen] to call this episode “Glass Half Full”.* In Matt’s own words:

Despite the early anguish, guilt, shame and a range of other negative emotions like intense anger, self doubt and the like, commonsense and common good

prevailed in the end. Rather than seeing the “glass half empty” and live immersed in inadequacy, self-doubt and lacking in self trust in my own capacity for productive work, with the caring and continued support from my “guru” I began an accelerated healing process, beginning to see the “glass half full”, using the experience to grow.

Experience in the above process tells me:

Self-flagellation is unproductive

Validation of the initial emotional impact is essential

Reconciling what has happened, how we fare and what we need to do in the future is equally as important

Moving on, regaining self-composure and confidence is paramount

Having sustained support in the initial stages is ever so essential

And last, but not least, having the opportunity to tell your story again and again is so much a part of the healing process.

Even now Jane as I write this to you I am quietly crying away, - both sad and glad of my own recovery from that early trauma. Narrative therapy [and being able to tell one’s story] is, I believe, integral in one’s emotional healing, so I thank you for allowing me to vent whatever residual emotions were still embedded in my being. Yet again, I feel a sense of relief.