Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

The Resilient Practitioner: How are counselling psychologists affected by clients' disclosures?

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This portfolio is dedicated to my beloved family and Theo;

your unwavering belief in me and support helped me

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City University Declaration

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Preface

'*As you set out for Ithaca hope your road is a long one, full of adventure, full of discovery*'

C. P. Cavafy

Counselling Psychology adheres to the scientist-practitioner model and to the reflective practitioner model, which recognises the significance for practitioners both to flourish and develop research and practice skills, and to be reflective throughout the assessment, formulation and therapy processes (Corrie & Callahan, 2000; Shon, 1983). This portfolio represents three integral and essential components required for the completion of the doctorate in Counselling Psychology, that is, a research study, a combined client study and process report, and a publishable journal article. An overarching point that links together all three parts of the portfolio is the importance for counselling psychologists to commit to the process of continuous deep reflection and self-awareness, which can aid in building resilience. David (2012) proposed that personal resilience is regarded as a factor in preventing professional burnout, therefore sustaining resilience is crucial for fostering psychologists' wellbeing. A further central theme of this portfolio, similar to one of the core values of Counselling Psychology, is that the main vehicle for alleviating psychological distress is the therapeutic relationship (Jones Nielsen & Nicholas, 2016).

Facing people who experience mild to severe mental health difficulties on a daily basis is not an easy task, irrespective of the professional's academic or training background, because the professional is first and foremost a human being who can be emotionally affected by clients' narratives. Epictetus stated, '*Remember this general truth, that it is we who squeeze ourselves, who put ourselves in difficulties. And, actually, it is our opinions that squeeze us and limit us*' (quoted in Morris, 2004, p. 76). This suggests that our views or opinions can affect the way we respond to a situation rather than the actual event. Therefore, in order to learn how to cope with difficulties, an individual has

to direct their attention to their attitudes to these challenges (Grayling, 2005). According to HCPC's standards of proficiency for practitioner psychologists (2018), practitioners have to '*be able to manage the physical, psychological and emotional impact of their practise*'. Thus, the first step for psychologists in understanding how to manage the personal impacts of their work is to focus on their responses and experiences and be open to reflect upon and make sense of them.

This portfolio pays special attention to counselling psychologists' experiences and responses to clients' disclosures. The first part includes a qualitative research study that explores counselling psychologists' experiences of working with suicidal ideation. The second part is a client study that shows the complexity of interpersonal relationships and attempts to demonstrate my ability to be aware of my own processes during sessions and my emerging skills and knowledge of the person-centred approach. Lastly, the third part presents the most important elements and findings of my research study in the form of an article to be published in the quarterly *Journal of Counselling Psychology*. My aim is to make a contribution to the field of Counselling Psychology and make my findings easily accessible to a wider population. Although the submission of this portfolio might signify the end of my enriching doctoral training, I acknowledge that my journey of learning does not end here; instead, it is a stopping station at which to acknowledge the process that I have made so far and refuel myself to continue developing my personal and professional identity.

The preface will continue with a more detailed description of the three aforementioned components with the aim of highlighting the following themes: the importance of maintaining and building a good therapeutic relationship; enhancing self-awareness by being mindful of emotional responses to clients' disclosures; and the use of self when delivering therapy.

Part 1: Doctoral research

When I started considering the research study that I wanted to conduct as part of my doctorate, I was instinctively drawn to the subject of suicide. It was a topic that made me feel curious, as I wanted to understand what might be going through the mind of an individual who has suicidal thoughts and how a psychologist might support the individual who is suffering. The phenomena of suicide always felt like unfamiliar

territory to me, but simply recognising the increasing rate of suicide evoked feelings of immense sadness in me for both the individual who ended their own life and the suicide survivors who were facing such a loss. I was always wondering whether there were any warning signs prior to the act, or whether a mental health professional could have prevented such a suicide.

Although this was a topic of interest to me, I was surprised to be confronted with clients who had suicidal thoughts from the early years of my clinical practice, and for it to be a recurrent theme in clients' presentations. Encounters with clients who expressed suicidal thoughts left me with deep emotions and, largely towards the end of my training, I realised that it was due to the many expectations that I had of myself to protect my clients, something that went beyond the limits of our duty of care or powers as professionals.

These feelings and experiences fuelled my academic pursuit of understanding the world of counselling psychologists working with suicidal ideation. The aim of this study was to explore the subjective experiences of counselling psychologists and how they feel before, during and following their sessions with clients who have expressed suicidal thoughts or ideation. Findings shed light on psychologists' experiences, including thoughts and emotions that can influence the progress of the therapeutic relationship between the therapist and the client with suicidal ideation (Levy et al., 2019). A growing literature has highlighted that feeling a connection with the therapist can be lifesaving for individuals who may be contemplating taking their own lives (Aherne et al., 2018). Therefore, this study, reflecting the principles of Counselling Psychology, places the importance of the therapeutic alliance at the centre.

It is hoped that the findings of this study will promote psychologists' wellbeing and resilience in order to improve the support being offered to service users. Also, the suggestions for training, supervision and practice might allow counselling psychologists to use themselves to the fullest and feel less constrained by personal or professional vulnerabilities while working with clients with suicidal ideation. In line with what makes Counselling Psychology a discipline distinct from other fields of psychology, this research study takes a non-medical stance and promotes a humanistic standpoint, which suggests that emotional wellbeing can be restored

through human connection and appreciation of the uniqueness of each individual (Jones Nielsen and Nicholas, 2016; Woolfe, 1990).

Part 2: Combined client study and process report

This section presents a reflexive account of my therapeutic work with a client that I have worked in a person-centred way. The client study shows the integration of my clinical skills with psychological theory and summarises background information and key aspects of my interaction with the client. The process report offers a thorough description and analysis of a transcribed audio-recorded segment of one of my therapeutic sessions with the selected client. This part outlines challenges and learning experiences that have helped me grow as a practitioner psychologist. Additionally, it aims to demonstrate that the identity of a counselling psychologist is not only shaped by their knowledge and training but also by their personal experiences and parts of themselves (Jones Nielsen & Nicholas, 2016). I support Vanaerschot's (1993, p.49) view that '*the important part of the therapist's attitude is not the fact that, in his contact to the client, the therapist eliminates himself as a person, but the very way in which he applies himself*'.

The case study intends to show the application and benefits of a person-centred approach when working with a client whose problems were rooted in not feeling understood. The client wanted to make sense of why she over-reacts to situations, to develop a better understanding of herself, and to become more empowered in her life. Developing a good and caring therapeutic relationship allowed her to become more confident and gain a stronger sense of identity. She was also encouraged to acknowledge the vulnerable parts of her in a safe and confidential space. Through this piece of work, I wanted to show that assessing suicide risk is essential no matter the therapeutic approach or the presenting difficulties. Asking direct questions to assess whether a client has suicidal thoughts/ideation is part of our duty of care and can also normalise the presence of such thoughts and encourage clients to respond honestly. What's more, this client study demonstrates the importance of being mindful and aware of my emotional and physical responses during sessions, and of exploring them openly in supervision. I valued the importance of having hope for the potential and development of each individual. I acknowledged the necessity of having a compassionate attitude towards myself, which itself can aid the client in developing

self-affirmation (Mearns & Thorne, 2013). Last but not least, this case study shows how an authentic and trustworthy relationship can facilitate change. As Rogers (1967) stated '*If in a given relationship, I am reasonably congruent, if no feelings relevant to the relationship are hidden either to me or the other person, then I can be almost sure that the relationship will be a helpful one*' (p. 51).

I hope that the skills, learning experiences and realisations that are described in this part of my portfolio might be fostered when working with other clinical presentations, such as a client with suicidal thoughts or ideation. Professionals ought to be empathetic, active listeners, and show unconditional positive regard irrespective of the presenting issue or the therapeutic approach they apply. If they are struggling, they should recognise it, process it in supervision or personal therapy, make sure that they work within their limits of their competence and ensure that a good therapeutic relationship with clients is built and maintained.

Part 3: Journal article

The journal article presents two of the five sub-ordinate themes that emerged from the research study: Therapeutic Relationship and Feeling Vulnerable. These themes were chosen because of their direct implications for psychological practice, training and supervision. This article aims to add to the existing literature, as until now no study has been identified that solely explored counselling psychologists' perspectives of working with suicidal ideation. It aims to contribute to the specialist field of Counselling Psychology by positively influencing training and practice, promoting ethical practice and professionals' wellbeing and encouraging practitioners to be reflective. In addition, from my side, by taking into account counselling psychologists' narratives, I wanted to communicate the importance of therapeutic relationships when working with clients who have disclosed suicidal thoughts or ideation. It is evident that suicidal clients' disclosures affect professionals' wellbeing, as such disclosures make them feel both personally and professionally vulnerable. This indicates the need for a change of attitude towards suicide and how psychologists cope working in this area. I strongly believe that self-awareness can help counselling psychologists build resilience and allow them to use themselves in therapy and consequently provide a brighter therapeutic journey for clients with suicidal thoughts or ideation.

Conclusion

The process of conducting a qualitative research project, reflecting on my clinical work and experiences and writing an article has allowed me to evolve as a person and as a professional. Alongside my determination to understand counselling psychologists' experiences of working with such a sensitive and critical matter, I was prompted to reflect on a deeper level upon my personal experiences, beliefs about suicide and to face my fears and vulnerabilities. Throughout my training, I believe that I have grown and matured as a person and I have entered the promising world of Counselling Psychology, which is extremely intriguing and full of learning opportunities for personal and professional growth. My aim is to keep encouraging colleagues to consider their beliefs and presumptions about suicide and to be aware of and open to having conversations about taboo feelings and experiences when working with clients with suicidal ideation. Last but not least, I fully intend to continue fostering authentic and congruent therapeutic relationships with my clients as a means for therapeutic change.

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Part 1 – Doctoral research

How do counselling psychologists experience working with clients with suicidal ideation?

Supervised by Dr Jacqui Farrants

Abstract

Taking into account the magnitude of the concerns regarding suicide and the profound impact it has on mental health professionals, this study focuses on counselling psychologists' lived experiences. The specific experiences of counselling psychologists working with clients with suicidal thoughts or ideation have not been previously addressed and this indicates that there is a lack of public awareness regarding the clinical cases that counselling psychologists are exposed to. To address this gap in the literature, eight HCPC-registered counselling psychologists were recruited to participate in this phenomenological research study. The semi-structured interviews were analysed with the use of Interpretative Phenomenological Analysis, which allowed five super-ordinate themes to emerge: Therapeutic Relationship; The Overriding Feeling of Trepidation; Sense of Urgency; Raison d'Etre and Feeling Vulnerable. Each super-ordinate theme consisted of sub-ordinate themes which helped illuminate an overarching dimension and elucidate different aspects of participants' experiences. The findings indicated that following clients' disclosures the therapeutic relationship does not remain unchanged. They also illuminated the emotional responses of practitioners and how sitting with the uncertainty and ambiguity of clients' disclosures might affect them in their personal space or counselling room. The findings offered insight into how counselling psychologists get into a different mode during the therapeutic sessions. Participants' narratives demonstrated how the profession of being a practitioner psychologist is interweaved with working with suicidal ideation and how they perceive the nature of their work in relation to their duty of care and limits as professionals. Lastly, findings have also highlighted how vulnerable professionals feel both personally and professionally. This study brings to light counselling psychologists' complex responses while working with such a sensitive and critical matter, and these are discussed in the light of existing findings. Implications for counselling psychologists' practice, training and supervision are discussed and further areas for exploration are suggested.

Introduction & Literature Review

Overview

The first chapter of my doctoral research study begins with an introduction to the topic of interest with the aim of demonstrating how I have built my rationale of conducting a research study on counselling psychologists' experiences of working with clients with suicidal ideation. It will include an extensive literature review with a wide range of theories, existing findings, and concepts that are relevant to the topic of exploration. The chapter will end with my research aims and research questions.

Introduction

Suicide is a major health concern globally and is considered to be the 15th leading cause of death worldwide (Wasserman, 2016). Every year more than 800,000 people die from suicide and this increased tenfold for suicide attempts (Wasserman, 2016). Data published in September 2019 have indicated that the number of suicides continues to rise in England and Wales (Lacobucci, 2020). The Office for National Statistics reported that in 2019 the rates for suicide among females have increased, as there were 5.3 deaths per 100,000. These figures were the highest since the previous high of 2004. In addition, for males, the 2019 figures demonstrated that there were 16.9 deaths per 100 000, which was the highest rate recorded since 2000 (Lacobucci, 2020). In 2019 there were 5,691 deaths registered in England due to suicide, of which 4,303 were men and boys. The latest data published for the second quarter of 2020 recorded 6.9 suicides per 100,000 individuals in England. However, this finding is provisional as due to the pandemic of COVID-19 many inquests were put on hold, hence this finding should be interpreted with caution (Lacobucci, 2020). The World Health Organization (2014) highlights the importance of taking drastic measures and conducting research studies in this field since estimations suggest that there will be around one million deaths due to suicide until the year 2030. Due to the unforeseen pandemic, this estimation might not be accurate, as deaths from suicide might be climbing because of the effects of the crisis.

Suicide seems to affect the whole community and not just family, friends or psychologists. Consequently, it is very important to enhance awareness regarding suicide survivors and professionals' experiences of working with such a sensitive matter. Dixon et al. (1994) have suggested that suicide is a concerning issue that can be completed by anybody irrespective of socio-economic status, gender, age or cultural background. However, males show a higher rate of completing suicide than women in almost every country, although women exhibit higher rates of suicidal ideation and behaviour (Beautrais, 2002; Henderson et al., 2016).

Regarding counselling practice, Rogers et al. (2001) have demonstrated that 71% of counselling psychologists have had at least one client with a suicide attempt and 28% from their sample had a client who died due to suicide. Furthermore, it has been suggested that these tragedies could have a large impact on mental health professionals (Kleespies et al., 1999). In one study conducted by Wachter Morris and Barrio Minton (2012), it was found that 80% of Counselling Psychology trainees have experienced a client with suicide ideation. Therefore, this enhances the importance of conducting research on suicide because it could have a positive impact on counselling psychologists and their training and practice.

Taking into account the magnitude of the concerns regarding suicide and the effects that these are having on suicide survivors as well as mental health professionals, this literature review will pay special attention to therapists' experiences. Although a client's suicide can have a significant impact on the professional, it is equally important to address how practitioners are feeling while they are working with clients with suicidal thoughts or ideation. The specific experiences of counselling psychologists have not been previously addressed and this indicates that there is a lack of public awareness regarding the clinical cases that counselling psychologists are exposed to and overlooks the importance of understanding their point of view.

Literature Review

Literature search method

The purpose of this literature search was to identify all the references related to working with suicide risk and how mental health professionals experience it. An electronic search of PubMed, PsychInfo, Google Scholar, and City Library without any restriction as regards time was made, using suicidal ideation, experiences of psychologist, suicide, suicide attempt, suicidal ideation, counselling, interventions, mental health professionals' perception, psychologists', counsellors' and psychotherapists' experiences working with suicide risk, as key words. Published papers were thoroughly examined including original research, reviews and meta-analyses. References found in several articles were also explored to identify any relevant papers. Studies that were chosen to be included in this review had to be published in a peer-reviewed journal and had to be directly relevant to the research question. Also, most of the studies that were selected had counsellors or psychotherapists as participants, as limited studies were focusing exclusively on psychologists' experiences.

Defining suicide

Before looking at how mental health practitioners experience working with suicidal clients and the role of counselling in supporting individuals effectively, it is worth considering the definition of suicide.

Durkheim (1897, p. 44) described suicide as '*the termination of an individual's life, resulting directly from a negative or positive act of the victim himself, which he knows will produce this fatal result*'. Similarly, Murphy (1992, p. 10) stated that suicide is '*an act of voluntarily and intentionally taking one's own life*'. Suicide is '*frequently regarded as the ultimate expression of distress. That is the point when there is no vision of a future, when it seems that every aspect of life has become so futile or overwhelming, that there is no possibility of coping, and the only option is of complete and final destruction*' (Hawton & van Heeringen, 2000, p. 702). Over the years there have been many attempts to define suicide, but one common feature of these definitions is that there is an intention (Tait et al., 2015). Henden (2017) reported that the coroner is the person who can officially conclude that a death is due to suicide when there is evidence

that it was the individual's intention, and it was not accidental. For the purpose of this study suicide will be defined with the following short but specific definition, '*the action of killing oneself intentionally*' (Oxford Dictionary of English, 2020).

Moreover, it is important to note that suicidal behaviours refer to behaviours, such as self-harm, and thoughts that are not fatal (Fincham et al., 2011). These thoughts include suicidal ideation, which is when an individual thinks about ending their own life and considers a suicide plan, which is the formulation of the way in which the person will end their own life. The suicide attempt is when the individual engages in risky behaviours that could end their life (Fincham et al., 2011). Lastly, according to Milton (2001), suicidality refers to suicidal behaviours, which include suicidal thoughts and actions.

Prediction and prevention of suicide risk

Despite the fact that suicides are committed due to mental health disorders, there are many factors that could lead an individual to suicidal behaviours (Turecki & Brent, 2016). Campos and Besser (2014) suggested that most people who died due to suicide were suffering from depression. Also, the strongest predictor of suicide has been indicated to be a previous suicide attempt or a history of suicidal behaviour (Barzilay & Apter, 2014; Carroll et al., 2014; Oquendo et al., 2004).

The main focus of the literature regarding suicide is to understand the risk factors and be able to identify them to respond appropriately. Although being aware of the common risk factors of suicide is undoubtedly useful for psychologists and can help them assess and monitor any signs of suicide risk, it can be argued that it is not always used to inform their practice. As Reeves (2010) suggested, mental health professionals in the presence of suicidal thoughts or ideation conduct risk assessments and rely heavily on questionnaires that are based on risk factors to identify the risk of a potential suicide. Research studies have called into question the efficacy and reliability of such structured risk assessments, as they do not provide insight and in-depth understanding of the likelihood of a potential suicide. The statistics regarding suicide risk factors are mostly used as a source to justify the '*prescriptive*' decisions of the professionals in order to follow organisations' policies and protect themselves legally. Reeves (2010) referred

to that mentality as Prediction-Prevention culture, which is influenced and operated based on government policies and subsequently organisations' policies. Reeves (2017, pp. 2-3) stated that '*there had been no meaningful increase in the accuracy of prediction of suicide over the last 40 years*'. Although identifying risk factors can be beneficial, these are not considered to be adequate in understanding the despair of the individual, therefore in-depth suicide exploration is crucial.

It has been suggested that psychologists experience risk assessment as a challenging and aversive task and it has been found to be the most stressful part of psychologists' work (Kleespies & Dettmer, 2000). One well-known suicidologist, Robert Litman, stated the following: '*When I am asked why one depressed and suicidal patient commits suicide while nine other equally depressed and equally suicidal patients do not, I answer, I don't know*' (Litman, 1995, p. 135). This statement underscores the importance of not relying solely on risk factors to guide the best treatment plan for clients (Tucker et al., 2015). Findings have demonstrated that many high-risk clients do not end their own lives, but some low-risk clients do (Large & Ryan, 2014). Therefore, as Sommers-Flanagan (2016) argues, developing a collaborative relationship with clients is crucial for an effective assessment and treatment plan to be carried out. Ganzini et al. (2013) recommended that showing genuine interest to clients, being empathetic, and building a trusting relationship are significant when working with clients who disclose suicidal ideation.

Suicide is not considered to be an act of madness, on the contrary, findings have demonstrated that it is a normal thought that many 'normal' people have sometimes. Suicide is considered to be an option and a way out of the suffering or difficulties that they are experiencing (Henden, 2017). McLaughlin (1994) suggested that every one minute one person in the United Kingdom has suicidal thoughts. It has been suggested that anyone could become suicidal if they experience emotional pain in response to the challenges of life. That pain might be perceived as endless, unbearable and indisputable (Chiles and Strosahl, 1995). Therefore, it would be useful for therapists to hold a non-judgmental stance towards the occurrence of suicidal thoughts or ideation, to validate them and become able to explore them unreservedly during therapeutic sessions.

Ethical and legal considerations

According to the Suicide Act, 1961, suicide is legal in the UK, however, assisting and abetting the act of suicide is illegal. Despite the fact that according to mental health legislation clinicians are not obliged to prevent an individual from risky behaviours, clinicians and hospital trusts might face civil suits for negligence for failing to prevent suicide (Sarkar, 2013). In a case known as the Rabone case, the trust in question was found responsible for failing to prevent suicide, as the death of formal and informal patients is considered to be negligence (Rabone v Pennine Care NHS Foundation Trust 2012).

In this law case, Lord Walker stated that '*if there was a real and immediate risk of suicide at [the material] time of which the trust was aware or ought to have been aware, then in my view the trust was under a duty to take reasonable steps to protect [the patient] from it*'. The definition that was given for a real risk was the following: '*a substantial or significant risk and not a remote or fanciful one*' and immediate risk as '*present and continuing*' (Rabone v Pennine Care NHS Foundation Trust 2012). However, it is noteworthy that the way that risk is quantitatively calculated might not be accurate and hindsight bias should be taken into account (Large et al., 2012). It is undoubtedly challenging to estimate the probabilities of suicide and to decide what is the best treatment plan and when is the right time to act.

According to the HCPC, a practitioner '*must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible*' and '*be able to critically evaluate risks and their implications'* (HCPC, 2016). Sarkar (2011) suggested that assessing the risk and acting to protect the individual present similar clinical challenges to managing the risk of violence. Although Beck's Suicide Intent Scale is one of the most validated instruments, it predicts 4 out of 100 individuals who are engaging in self-harming behaviours that die due to suicide (Harriss & Hawton, 2005). This finding demonstrates the lack of predictability of suicide and the difficult and fragile position of the clinicians who might go through legal procedures in the wake of a client's suicide. Several actuarial risk factors have been identified, including gender, age, past suicide attempt, but no precise algorithm has been identified to allow professionals to recognise who from those that tick several risk factors would go on to die from suicide (Sarkar, 2013). Additionally, it is evident that some individuals who die from suicide did

not present any risk factors and their suicide was seen to be an impulsive act. After a suicide, the risk factors might seem evident in all these cases, however, this is a cognitive illusion and hindsight bias (Kahneman, 2011).

Part of the role of clinicians is to make judgments and decide on life-or-death scenarios in the name of their clients. Clinicians have to bracket their personal views of what is a life worth living or worth saving and separate this from societies' views that might not be comparable. In response to the ethical dilemmas experienced when working with individuals who are at risk to themselves or others due to their mental health disorder, the mental health law was established. However, there is a delicate balance between respecting autonomy and acting in respect of the public duty to protect the vulnerable (Sarkar, 2013). As Sarkar (2013) suggested, working with clients who present self-harming behaviours and managing suicide risk are multifaceted matters. Clinicians are required to assess the risk of suicide and assess an individual's capacity to make sensible and reasonable decisions. However, the phenomenon of fluctuating capacity has been overlooked (Sarkar & Beeley, 2011). A client might appear to have capacity during an assessment, but this does not mean that this will remain static for the next hours, days or weeks. Therefore, Sarkar (2013) suggested that clinicians should adopt a more dynamic way of assessing capacity. He proposed the enhanced tripartite model of capacity judgment in relation to a wish to die. He argued that clinicians should follow the following three tasks: '*judge whether the decision (e.g. to self-harm, discharge from voluntary admission, go on leave from hospital) is informed and balanced, judge whether it is communicated clearly and unambiguously and judge the conviction with which it has been made by assessing its stability and endurance over time: the more important the decision and the more final its consequences, the longer the time frame should be over which its stability is assessed*' (Sarkar, 2013, p,300).

All these findings regarding the lack of predictability of suicide and uncertainty regarding the best treatment plan enhance the importance of exploring how counselling psychologists experience it and how they are feeling in the counselling room with their clients. It is equally important to understand whether the legal implications impact their work and wellbeing.

Elements of competence and ethical practice

Working with suicide risk has been argued to pose significant professional and ethical hazards for psychologists (Jobes et al., 2008). Therefore, it is important to consider several ethical issues regarding clinical work with clients with suicidal ideation. First of all, informed consent with a client can be used at the start of therapy to set the boundaries, rules and structure of the therapeutic process (Jobes, 2016; Rudd et al., 2009). Apart from the informed consent, thorough risk assessment are considered to be a necessity for ethical practice (refer to Standard 9.02, Use of Assessments; APA, 2002). Psychologists are required beyond asking about suicidal ideation to explore and understand in depth the presence of suicidal thoughts and/or behaviour. Clinicians have to explore and record any history of suicidal behaviours or attempts and any relational, cognitive or environmental factors, such as access to the means to carry out suicide (Beck, 1986; Joiner, 2005; Lester, 1989; Rudd & Joiner, 1998). Additionally, objective assessment tools can be used to complement interview-based risk assessments (Jobes et al., 2008). Rudd et al. (1999) suggested that evaluating the risk '*is one of the most challenging tasks the mental health clinician can face'* (p. 437), therefore counsellors ought to be confident and ask clients about suicide openly and directly instead of attempting to make sense of metaphoric statements. Wollersheim (1974) suggested that using a normalising frame when asking questions about the presence of suicidal ideation should be perceived as normal and ethical practice. Additionally, normalising suicidal thoughts and gently assuming that they are present can make clients feel that the practitioner feels comfortable working and dealing with this matter (Nystul, 1994; Shea, 2004).

Inpatient hospitalisation is considered to be one intervention for supporting suicidal clients. However, it has been found that repeated short-stay admissions in inpatient units might not be helpful and might have a negative impact on clients' presentation (Jobes, 2016). Despite the significant role of inpatient units, outpatient units also need to adequately respond to clients' suicidal ideation. The use of no-suicide contracts has been criticised as they are not seen as sufficient for the safety of vulnerable clients. They can work against clinicians' defence should a legal case be brought (Rudd et al., 2006). The use of alternative approaches that involve coping action plans, with a focus on what to do in case of a crisis rather than on what *not* to do, have been proposed (Brown et al., 2005). Behavioural activation and cognitive coping can be helpful for

suicidal clients, who, with the help of their psychologists, develop a novel repertoire for coping and averting a suicide (Jobes et al., 2008). Medications are also considered to be a primary treatment plan for clients with suicidal thoughts or ideation, however, Linehan (2007) suggested that psychosocial interventions are the most beneficial for this client population. Similarly, Jobes et al. (2008) argued that empirical findings demonstrate that medication alone is not an adequate approach to managing and alleviating risk.

If clinicians take into account all of the above and use clear informed consent, assess suicide risk in depth, and are empirically well-versed regarding outpatient suicide treatment plans, it will adequately indicate that they are working in the best interest of the client. Embracing the above findings is consistent with ethical practice and reduces the prospect of a successful legal case for negligence. Jobes et al. (2008) underscored the importance of psychologists widening their boundaries of competence in order to assess and manage suicide risk ethically and for the benefit of the client. Apart from expanding their knowledge and committing to being continually informed about how best to assess and manage risk, it would be worth understanding how clinicians are experiencing working with this client population and how they experience following protocols and guidelines. Enhancing knowledge about psychologists' wellbeing when working with such a complex matter can help us identify support resources that will help them to self-soothe, which might consequently allow them to assess suicide risk in depth and manage the risk efficiently and ethically without letting their own responses impact the process.

Moving away from medicalisation of emotional distress

Historically, specialists, including physicians and mental health professionals, were perceiving suicide ideation as deviance (Szasz, 1986). Dr. Thomas Szasz, who is a psychiatrist and psychoanalyst, is regarded as one of the most indefatigable critics of the medicalisation of suicide. Szasz did not support the idea of suicide as a mental illness or disease and disapproved of the term 'commit suicide', which implies an act similar to a crime (Szasz, 1999).

There is not enough evidence to support the view of suicidality as deviance or the idea that psychopathology can be helpful for clients (Silverman & Berman, 2014a). On the contrary, if mental health professionals are experienced as judgmental or following rigidly medical models when treating clients' suicidality, clients might react with psychological reactance (Michel & Jobes, 2011). Reactance occurs when the individual might feel that their freedom is under threat, which leads to enhanced attempts and willingness to restore their freedom. Hence individuals with suicidal ideation might act on their impulses or suicidal thoughts to show that they are free (Lester & Schaller, 2000). The reactance response hints that clients with suicidal thoughts or ideation might benefit from less directive approaches (Michel & Jobes, 2011).

According to the medical model, professionals place emphasis on the diagnosis to direct the treatment plan in a top-down way (Jobes, 2000). Nowadays, within the social constructionist approach, clinicians are encouraged to minimise the emphasis on the diagnosis and perceive suicidal ideation as a normal symptom of distress (Linehan et al., 2015; Silverman & Berman, 2014a). Putting into practice a social constructionist approach has been suggested to promote a natural discussion between the clinician and the client, where expression of suicidality will be perceived as an important disclosure that requires a collaborative and problem-solving approach (Sommers-Flanagan & Sommers-Flanagan, 2014). Reactance could be stimulated if the mental health professional is experienced as judgmental or if feelings of stigma are sensed (Linehan et al., 2012). Clients might become more reserved in disclosing their thoughts; therefore, psychologists should adopt a more compassionate and welcoming stance. As Nietzsche stated, it might be a coping strategy and a source of comfort to contemplate suicide as an alternative to a life that might be experienced as painful (Lester & Schaller, 2000).

Carrying out a suicide risk assessment and treating clients with suicidal ideation can be a challenging activity. It requires a two-way interaction between the clinician and the client, therefore both can be affected. Clients' and psychologists' experiences, such as anxiety, might intermingle, which might lead to undesirable outcomes (Geltner, 2006). Psychologists' anxiety might affect the therapeutic work and might leave them unable to understand the subjective experiences of their clients or to assist in problem-solving tasks (Large & Ryan, 2014). Therefore, a collaborative rather than a medical

approach can reduce psychologists' anxiety and contain countertransference (Sommers-Flanagan & Shaw, 2016).

Responsibility and duty of care

Most Western countries support Libertarianism, which asserts that each individual is an autonomous individual who has the right to decide for themselves (Beauchamp & Childress, 2012). According to this view, an individual has the right to choose to end their own life. Szasz (1999) argued that suicide has to be seen as a natural human condition that was always present and we ought to speak about it in a comfortable and calm way. Szasz (1999) suggested that suicide is a moral and political problem, which does not need the knowledge of a professional to understand it. He suggested that we only have to vividly open our eyes and see what is in front of us (life or death). Szasz (1999) suggests that we are responsible for both how we choose to live and how we choose to die. He said that we have sufficient evidence to understand that suicide is a non-medical issue, hence he suggested that we have to change our attitude towards it, so de-medicalising and destigmatising it. Conducting research studies on this subject could perhaps contribute to this shift in attitudes and influence the way in which psychologists talk about their experiences.

On the other hand, organisations are expected to follow protocols and prevent suicides. Hence the occurrence of suicide is seen as a failure of prevention (Ho, 2014). This view begs the question of who is responsible for an individual's life, which then leads to searching for someone to blame. Holding this stance towards suicide indicates that legitimacy no longer exists when we are referring to unendurable emotional suffering. However, if suicide were recognised as a valid option for ending emotional and physical pain, it would not be perceived essentially as a failure (Cameron & Dunn, 1997; Nordenfelt, 2007). Inviting professionals to talk about how they experience working with this client population can help them become more aware of their limits, responsibilities and vulnerabilities as professionals, which will help them build the resilience required.

Abiding by the ideal that suicide should never happen has resulted in therapists of several therapeutic approaches experiencing the loss of a client due to suicide as a therapeutic failure (Wildman, 1995). Stern (1986) has highlighted that it is important

for psychotherapists to acknowledge the limits of their role in determining a client's life and outcome. Trimble et al. (2000) conducted a survey and received responses from 437 clinical and counselling psychologists. They found that professionals agreed that it is the client who is ultimately responsible if they end their life. Similarly, Sommers-Flanagan and Sommers-Flanagan (1995) found that it is essential for psychologists to be aware of their own feelings and beliefs when they work with clients with suicidal ideation. They found that many of them held the belief that it is the clients' responsibility to continue living or ending their own lives. However, other researchers have indicated that therapists feel anxious because of the expectation of their work with clients with suicidal ideation (Moerman, 2012; Whitfield, 2011). Reeves and Mintz (2001) demonstrated that counsellors felt pressure and obligation to follow their organisations' policies, which resulted in increased anxiety and a sense of responsibility when working with this client population. Counsellors in this study reported that they were highly conscious of the consequences of a potential suicide for both the organisation and their own professional reputation. This study included solely counsellors, therefore exploring counselling psychologists' experiences could add information to the existing literature regarding the felt anxiety and sense of responsibility that they might be experiencing.

The role of counselling

Nowadays the demand for counselling from individuals with severe mental illness has increased. Counselling is considered to be a viable and respected substitute or accompaniment to hospitalisation and medication. Therefore, counselling psychologists are being exposed to more challenging and suicidal clients. Preliminary studies have supported the finding that a positive therapeutic relationship, a connection with other people, and expressing emotions are imperative factors for overcoming suicidality (Eddins & Jobes, 1994; Hoover & Paulson, 1999).

Reeves et al. (2004) have highlighted the central role of the therapeutic discourse between a client and a therapist, which aims to encourage an effective dialogue that will help clients change perspective and move to a better place, where they will be able to function emotionally and in their everyday lives. During and throughout counselling, a risk assessment is carried out to confirm whether or not counselling is

an appropriate or sufficient treatment for the client. If it is not deemed suitable or sufficient, additional or alternative therapeutic routes should be considered and suggested (Reeves et al., 2004). Researchers have suggested that the therapist should explicitly name 'suicide', despite their anxieties and fears around asking direct questions about suicidal ideation. Counselling can be a reflective approach; however, it has been argued that such an approach could confirm clients' despair, which could maintain their sense of hopelessness. Therefore, it is imperative during the counselling process to aid the client in seeing change as a possible prospect (Reeves et al., 2004).

The importance of the therapeutic relationship

The paradox of a client contemplating suicide and at the same time trying to engage in therapy can be intimidating for mental health practitioners. However, the power of connection between the therapist and the client should be recognised (Aherne et al., 2018). Therapists have to trust the process of therapy and hope that if the client senses a connection in the therapeutic space this could be lifesaving for them (Aherne et al., 2018). Studies have suggested that taking time to foster a therapeutic alliance and invest in that can have positive outcomes when working with suicidal clients (Casey, 2010; Scott et al., 2008). Feelings of connection can help suicidal clients change their perceptions of relationships and allow them to see that someone in their lives cares about them and is aware of their difficulties (Aherne et al., 2018). Moreover, the therapeutic alliance has been found to be a strong predictor of treatment outcome and an essential condition for clients' engagement (Arnow & Steidtmann, 2014; Horvath et al., 2011). Studies have demonstrated that the therapeutic alliance is enhanced when there is structured therapeutic work and the client complies with goals and activities (Arnow & Steidtmann, 2014).

Additionally, Plakun (2001) suggested that the stance and role of the psychodynamic therapist when working with suicidal clients can influence the outcome. He highlighted three points that therapists should take into account: 1) being mindful of establishing and maintaining a working alliance; 2) identifying and exploring any vicissitudes of the alliance, which could deepen the therapeutic relationship and process; and 3) not rejecting the transferences.

Michel et al., (2004) put forward the hypothesis that it might be more helpful for clinicians to concentrate on clients' personal narratives than on psychiatric diagnoses to make sense of clients' understanding regarding their suicidal crisis. They interviewed clients following their suicide attempts and they found that the therapeutic relationship was rated significantly higher when the interviewer used a narrative approach and phrased questions with the use of words 'tell' or 'story' (e.g., '*I would like you to tell me in your own words or I would like to hear the story that is behind your suicide attempt*' (Michel et al., 2004, p. 205). The findings of this study were discussed in a conference, which then led to the development of the Aeschi Working Group and the biennial Aeschi conferences. The Aeschi Working Group believes that the human connection between the therapist and the client is of great importance for preventing suicides. They formulated a set of guidelines for clinicians, which pays special attention to the relational aspect when working with suicide risk. They suggested that the goal for the clinician is to reach a shared understanding with the client regarding their suicidal ideation without disregarding the diagnosis, which can be an essential component of the assessment interview (Michel et al., 2002). They highlighted, that '*the active exploration of the mental status, however, should not be placed first in the interview, but follow a narrative approach*' (Michel et al., 2002, p.434). The Aeschi Working Group proposed that '*the clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect*' (Michel et al., 2002, p. 434). They suggested that clinicians should hold a non-judgmental stance and be supportive with suicidal clients especially at the first encounter, which could determine the client's compliance and progress in therapy. They also emphasised that the assessment interview should begin with the client's autobiographical narrative because it can encourage the development of a sense of self and mastery (Michel et al., 2017). As Adler (1997) stated, '*When we are able to formulate the right story, and it is heard in the right way by the right listener, we are able to deal more effectively with the experience'* (p. 28). Additionally, the Aeschi Working Group proposed that '*the ultimate goal should be to engage the patient in a therapeutic relationship*' (Michel et al., 2002, p. 435). The group strongly supports that recognising the action of suicide as a behaviour that is goal-directed and linked to life-career aspects might be useful for clinical practice. They suggest that we should not see clients as '*objects displaying pathology but as individuals that have their good reasons to perform an act of self-harm*' (p.435), as this can improve the rapport.

Clients' perspectives

An extensive literature has focused on how clients with suicidal ideation experience their therapist and the counselling process. Exploring this topic from clients' perspectives has brought to light the strengths and weaknesses of therapy, which can help us consider suggestions and make adjustments to meet clients' needs.

In a mixed-methods study conducted by Paulson and Worth (2002), 9 males and 26 females with a previous suicide attempt were recruited in order to explore the client's perception of counselling for suicide. Findings acknowledged three therapeutic processes that helped clients overcome suicidal thoughts or behaviours. Firstly, participants emphasised the importance of a supportive and validating relationship in order to reconnect with other people and with oneself. Secondly, acknowledging and dealing with emotions, such as despair and helplessness, was identified as the most beneficial aspect of counselling, and thirdly, developing a new identity and enhancing self-awareness was found to be vital. However, due to the retrospective nature of this study, some important elements might have been neglected or misinterpreted. The methodological approach used in this study was concept mapping, which is a method that is participant-oriented and uses both quantitative and qualitative tools. This method might not have yielded detailed information; therefore, Interpretative Phenomenological Analysis could be a more suitable methodology for exploring in depth how participants understand and make sense of certain experiences. Additionally, the sample had significantly more females than males. It is important to have an equal number of each sex or ideally to investigate each population separately since gender differences should be taken into account.

Moreover, a systematic review conducted by Winter et al. (2014) stated that studies that have explored clients' views considered an understanding, empathic and non-judgmental therapist as helpful (Araminta, 2000; Colbert, 2002; Crouch & Wright, 2004; Cunningham et al., 2004; Sinclair & Green, 2005). Also, validation was something that appeared helpful for clients. Validation refers to how the therapist/counsellor makes the client feel understood and not judged for the way he or she feels (Araminta, 2000; Sinclair & Green, 2005). Further studies that involved males with a previous suicide attempt have indicated that trusting and respecting the mental health professional is essential for men to engage with mental health care services

(Grace et al., 2018; Jordan et al., 2012; Player et al., 2015; Reading & Bowen, 2014). Hence, suicidal men who feel connected and understood by the mental health professional are enabled to reconnect with the real world.

Literature notes that therapists are anxious about death (Birtchnell, 1983) and often fail to understand the client (Krieger, 1978). Nafisi (2007) found that clients' concealment of self-harm and hesitancy to talk about important things in a therapy session was due to their fear of rejection or judgment, which acted as a barrier to therapy (Nafisi, 2007). Additional barriers according to clients were gender issues, pressure on clients to face painful matters, and the use of language (Nafisi, 2007). Findings have also demonstrated that counselling psychologists who did not address the topic of suicide with clients who had suicidal thoughts were perceived as unsupportive (Paulson & Worth, 2002). Additionally, simply asking the suicide question and assessing the client has not been considered sufficient; there is a demand for therapists to be prepared to explore the idea and thought of suicide with the client in depth (Reeves, 2017).

Mental health practitioners' perspectives

Confronting death can be a frightening and distressing prospect. The therapeutic work with and risk management of suicidal clients is regarded as being the most vexing and puzzling dilemma that a therapist can experience in their career (Moore & Donohue, 2016). Therefore, findings from research studies that explore clinicians' experiences of working with this client population are developing.

Moore and Donohue (2016) conducted a study with Irish psychotherapists to explore how they were affected by working solely with suicidal clients. This study used Interpretative Phenomenological Approach as a method to analyse the interviews of seven practitioners. Findings indicated that psychotherapists reported overworking with this client group, as they might offer more sessions, extra support over the phone, and might think of this client population after working hours. Another remarkable finding was that they felt that there was an inner transformation and a change or disruption to their professional identity. Professionals said that they did not feel that they could be there for their loved ones, as they were feeling exhausted, and that

clients' disclosures were consuming them. Another striking theme was that working with suicidal clients can be a 'blessing', 'gift', or 'privilege'. Although this study generated interesting findings, the fact that the researcher knew the participants was a limitation, as participants might have been filtering their responses or trying to please the researcher. Also, the psychodynamic lens that was used to interpret findings might have also acted as a limitation, as in IPA the researcher has to bracket not only their own beliefs but also their professional identity and theoretical orientation.

Evidence has suggested that professionals experiencing a client with suicidal tendencies feel emotionally and professionally affected, as they might experience hopelessness and feelings of failure (Richards, 2000). Richards (2000) indicated that therapists sense a pressure within the transference that leads them to take a stance that might confirm clients' perception of seeing others as rejecting. Participants in this study reported that they felt like a container to clients' suffering (Richards, 2000). Therapists reported that they felt that suicidal clients were attacking them or the therapeutic process, while clients appeared to be craving closeness but at the same time were feeling scared about it. Therefore, in this study, it was suggested that paying attention to countertransference responses can give an insight into clients' worlds and interpersonal relationships. Richards (2000) emphasised the significance of maintaining firm boundaries and remaining present as a therapist.

Nicholl et al. (2016) recruited five psychotherapists registered with the BACP or UKCP and carried out a narrative analysis to explore what it is like for psychotherapists to work with suicidal clients. It was found that the culture of preventing suicide concerns psychotherapists, as they believe that it restricts client decisions (Nicholl et al., 2016). Participants also expressed ambivalence about the benefits of involving other professionals in the care of the client, as they question whether it is for the benefit of the client or for protecting services from risk. An important point of this study was to find new ways of approaching this subject and to de-medicalise suicide. Although valuable findings emerged from this study, a different method of analysis, such as Interpretative Phenomenological Analysis, could have explored the lived experiences of participants in more detail.

In an exploratory study conducted by Reeves and Mintz (2001), four female person-centred counsellors were interviewed about their work with suicidal clients. The person-centred approach (Rogers, 1959) has been considered as the basis for dealing with suicidal clients and its stance is that listening empathetically is enough. However, in this study counsellors expressed that they felt anxious, panicky, powerless, and were doubting their own professional capability when they were facing a client with suicidal thoughts. Also, they reported that they felt that they were letting their clients down when they had to break confidentiality. Moreover, counsellors' personal views of suicide seemed to affect their responses, and the fear of being accused of malpractice led them to break confidentiality when there was no high risk of suicide (Reeves & Mintz, 2001). In this study only white, female person-centred counsellors participated, therefore further studies could explore the views of both male and female therapists from different cultural backgrounds, who use different or integrative approaches, as new areas of consideration and development might emerge.

Furthermore, an online survey was carried out to explore the impact of a client's suicide or suicide attempt on psychotherapists or allied professionals (Scupham & Goss, 2020). Findings demonstrated that professionals felt overwhelming emotions when a client died by suicide. They experienced a range of distressing emotions, including shock, sadness, anger, guilt and helplessness. Also, findings suggested that the impact of this experience can remain and have an effect on the professional for up to seven years following the event. Participants said that losing a client or having a client who had attempted to end their life are unforgettable and horrific events that can leave them feeling anxious or apprehensive when they face clients who disclose a level of suicidal ideation or similar past experiences. Given the significant strong emotional responses that psychotherapists and other professionals experienced, the researchers highlighted the importance of understanding that in the occurrence of this event, negative reactions are normal and should be anticipated, therefore professionals and organisations have to be prepared (Scupham & Goss, 2020). One apparent limitation of this study was that therapists from different professions were recruited, therefore a study focusing solely on counselling psychologists could bring to light findings and recommendations that were directly linked and addressed to this population and associated training needs, which might be more accurate and easily implemented.

In a recent national survey that used a mixed-methods design, it was indicated that working with clients with suicidal ideation is not significantly easier for more experienced psychologists than less experienced ones (Dundas et al., 2020). This suggests that psychologists have to work in a different way with this client population, as what they have learned from their training institutes might not apply to this client population. Dundas et al. (2020) argued that clients with suicidal ideation might appear non-engaging, therefore a workable alliance cannot be developed. They suggested that psychologists have to think of alternative solutions that might not be in line with collaborative work or their normal practice to help them cope with clients who might appear angry or desperate. A conclusion from this study is that confidence does not grow with years but might grow with specific training for working with this client population. Research findings have suggested that most of the psychologists have expressed a concern about training not being adequate to prepare them to deal with suicidal clients (Trimble et al., 2000). It seems that although some recent studies focus on psychologists' perspectives, the need to understand their emotional reactions and identify the best training for them to deal with these cases is increasingly pressing. Enhancing awareness of their lived experiences and identifying any errors of treatment could improve their skills and make them feel a sense of mastery in working with such client groups.

Conclusion

To sum up, from this literature review it seems that there is a growing body of information regarding suicide and working with suicide risk. However, further attention should be given to mental health professionals' experiences. Nowadays, counselling psychologists are working with clients with several mental health difficulties, including suicidal thoughts or ideation, that can become a recurrent theme during the therapeutic work. Therefore, urgency emerges in the literature to enhance awareness regarding perceptions of counselling psychologists working with suicide risk, as gaps in current knowledge regarding their preparedness for working with this client population were identified.

Research question and research aims

Researchers have placed great emphasis on identifying risk and protective factors to prevent suicide (Kessler et al., 1999; Mann et al., 2006; Nock et al., 2008). Also, research studies and literature regarding clients' perceptions of suicidal thoughts, behaviours or counselling experience are growing. However, since counselling is a two-way interaction, it is also imperative to investigate and understand mental health professionals' experiences and emotional reactions of working with clients who have suicidal thoughts, which has been overlooked.

There is emergent literature on working with clients' suicidal ideation that has given insight into allied professionals' experiences and has offered invaluable recommendations for training and practice. However, this literature raises additional questions about counselling psychologists' experiences and emotional responses. Although the discipline of Counselling Psychology is rapidly growing, there is insufficient literature dedicated to this field. Thus, this study aims to contribute to this distinct and specialist field, promote ethical practice, encourage practitioners to be reflective, prioritise self-care, and influence the training and practice of counselling psychologists.

Taking into account the existing findings and the lack of attention to Counselling Psychology, it is more than justifiable to explore the experiences of counselling psychologists, as the expectations and the responsibilities that are given to them by their organisations and society are increasing. It would be beneficial for the profession of psychology to explore counselling psychologists' views about suicide and experiences of working with clients with suicidal ideation within organisations and private practice.

Paulson and Worth (2002) have found that according to clients' views the disconnection between clients and professionals reinforced their feelings of despair. Therefore, it is suggested that the feelings of mental health professionals, such as fear or anxiety, could lead to disconnection with their clients and enhance clients' despair. If a counselling psychologist's state of wellbeing is negatively affected, then the client cannot be supported effectively and the psychologist might cause additional harm to the client, which goes against professional ethical guidelines.

Although the HCPC's standards of proficiency for practitioner psychologists (2018) outlined that practitioners have to '*be able to manage the physical, psychological and emotional impact of their practise*', no clear routes to attain this have been suggested. This consideration directs the focus of this study on counselling psychologists' wellbeing and emotional responses to suicide since these strongly influence clients' mental health and progress in counselling. Emotional robustness, although an intrinsic competence of being a psychologist, is not 'taught' or 'monitored' in most doctorates in Counselling Psychology, therefore paying attention to counselling psychologists' experiences will help us enter their emotional world and address this. The significance of increasing the knowledge of the psychological effects experienced by counselling psychologists is to help secure and sustain ethical practice and lead to emotionally stable practitioners working with clients with suicidal thoughts. This study will help to strengthen counselling psychologists' identity and endorse client wellbeing. Exploring counselling psychologists' experiences of working with clients with suicidal thoughts/ideation will aid in developing a better understanding of therapists' perceptions of suicide in general and will also help to enhance the effectiveness of supervision, education and training. This study, similarly to Rossouw et al.'s (2011), suggests that '*the time has come for the profession to care for its own in order to allow therapist, in turn, to care for (and about) the vulnerable other*'.

Given the complexity of suicide and suicide ideation, it was decided that the research question, 'how do counselling psychologists experience working with clients with suicidal ideation', would be phrased as an open question to give the freedom to participants to position themselves however they wanted. Suicidal ideation was left undefined to not limit or restrain participants' responses. It was anticipated that each participant would give their own meaning and would put emphasis on suicidal thoughts and/or suicide planning according to what best described their experiences.

Method

Overview

This chapter will focus on the methodology and methods that are used in this research project. More specifically, this chapter will consist of an exploration of how the methodology relates to the research question; a discussion of the underpinning epistemological position; a summary of research procedures, such as recruitment and sampling; ethical considerations; a description of the suggested analytic strategy, and methodological and researcher's reflexivity. The methodological chapter will be written in the first person to demonstrate the reflective nature of qualitative studies and to be more approachable for the reader.

Rationale for a qualitative approach

Qualitative studies complement quantitative studies, shed light on unexplored areas and provide rich findings. Qualitative methodology focuses on meaning and how people understand and perceive certain experiences in their lives (Willig, 2013). Smith et al. (2009) suggest that a qualitative study explores, describes and interprets the personal and social experiences of people from a comparatively small sample group. The complex and subjective nature of someone's experiences requires a qualitative methodology that recognises the uniqueness and meaning of each personal experience rather than a quantitative methodology that seeks to generalise and quantify findings (Silverman, 2005).

Most research questions that are formulated in order to answer a 'How' or 'What' instead of a 'Why' can guide the researcher to choose a qualitative research design (Creswell, 1998). The present research project employed a qualitative methodology because it was deemed the most suitable method to gain an in-depth understanding of the phenomenon of counselling psychologists' experiences of working with clients with suicide ideation. This study emphasised the experience of practitioners so as to gain a greater insight into counselling psychologists' perceptions and their emotional

world when delivering counselling to clients with suicidal ideation. It aimed to identify individuals' interpretations of themselves, their surroundings and their actions when working with clients with suicidal thoughts or ideation (Fleischer, 2000).

Most studies on suicide have used atheoretical empirical frameworks to identify aetiologies or risk factors (Rogers, 2001). Also, a large number of quantitative studies have explored pathological, psychological, biological or genetic risk factors of suicide (Beautrais et al., 2005; Hjelmeland & Knizek, 2011). However, Hjelmeland and Knizek, (2010, 2011) have highlighted the significance of exploring subjective experiences and the benefit of using qualitative methodologies in gaining an in-depth understanding of the challenges faced when working with this client population. Although findings regarding mental health practitioners' experiences and wellbeing while working with suicidal clients are growing, most studies regarding suicide have focused on exploring suicidal clients' and suicide survivors' experiences (Orri et al., 2014; Vatne & Nåden, 2013). This indicates that there are insufficient research studies that inform us about the nature of psychologists' experiences while working with clients who have expressed a level of suicide ideation. Qualitative accounts of counselling psychologists can be developed and complement current literature, and can help to achieve a more holistic understanding of a professional's personal experience of working with such a presenting issue. Qualitative methodologies are deemed to be more suitable than quantitative methodologies for eliciting and enhancing this knowledge (Silverman, 2005; Willig, 2008). Counselling psychologists' wellbeing and stance towards suicide play a significant role in supporting clients in overcoming suicidal thoughts, given their continuing exposure to this client population. Therefore, participating in this study will help counselling psychologists enhance their understanding of their internal processes regarding suicide and their reflections will enrich their skills in order to help their clients efficiently.

Counselling psychologists are attempting to explore the complexity of human experience with the use of qualitative methods, as these are more in line with the paradigms and methods that are used in their practice (Morrow & Smith, 2000, Ponterotto, 2005a). A qualitative methodology was not chosen only because I am interested in people's subjective experiences, but also because it is rewarding and stimulating to have an active role in the research. McLeod (2001) suggested that

conducting a qualitative study and engaging in therapy are related in terms of the knowledge that is developed and the skills that are applied, such as active listening, showing understanding and being empathetic. Therefore, as a counselling psychologist in training, I was instinctively drawn to a qualitative research project. As Ponterotto (2005b) foretold, '*our discipline will reach significant new heights through the incorporation of postmodern perspectives and associated qualitative research methods*' (p. 127).

Reliability and validity in qualitative research

Qualitative researchers, similar to quantitative researchers, have to examine and demonstrate the credibility of their research studies. In quantitative research, the choice and use of measurement device determines the credibility of the research study, whereas in qualitative studies the 'instrument' tends to be the researcher (Patton, 2002). Therefore, when quantitative researchers refer to validity and reliability, they refer to the credibility of the study. On the other hand, the credibility of a qualitative study is influenced by the work and determination of the researcher. Validity and reliability are relevant and important terms for quantitative research, but in qualitative research they have not been considered to be key to evaluating the quality of the study (Willig, 2001).

In the design and implementation of this study, the following guidelines and criteria suggested by Yardley (2000, 2008) and Smith et al. (2009) were taken into account to establish quality: Sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. In order to ensure sensitivity to context, I carried out a thorough literature review relevant to the research topic, which demonstrated my understanding and knowledge. Also, the participants' views and words were used throughout this study to support the findings and interpretations that were made. Since Yardley (2000, 2008) highlights the importance of showing sensitivity to the relationship between the researcher and the participant, a reflective journal was kept during the whole process of the study.

Furthermore, I dedicated a significant amount of time to this research project, which shows my commitment and rigour. My aim was to demonstrate rigour during both the

data collection and analysis, as I was attentive to participants' narratives (Yardley, 2000, 2008). An additional component of rigour is transparency. Transparency allows readers to understand and assess how the researcher was led to certain conclusions and interpretations (Smith & Osborn, 2004). In this study, participants' quotes were used to demonstrate the authenticity of my findings. Also, I was involved in peer discussions and supervision in order to identify any biases.

Moreover, the impact and importance of this research project demonstrated its actual validity (Yardley, 2000, 2008). This study focused on counselling psychologists' perceptions, which are often ignored, as most researchers are interested in clients' views. Also, the current study encouraged counselling psychologists to think about their practice and those personal experiences when working with clients with suicidal ideation that they might have not considered or reflected upon before. In addition, the findings of this study might influence counselling psychologists' practice and perceptions of working with this client population, which is an invaluable and original contribution to the field of Counselling Psychology.

Qualitative researchers are less concerned about generalising their findings, as their main aim is to explore rigorously specific cases and understand human experiences (Polit & Beck, 2010). The qualitative paradigm and idiographic methods, such as Interpretative Phenomenological Analysis, contribute to enhancing our knowledge about a specific phenomenon and complement actuarial findings stemming from quantitative research studies (Warnock, 1987). According to Smith (1999), '*from an idiographic perspective, it is important to find levels of analysis which enable us to see patterns across case studies while still recognising the particularities of the individual lives from which those patterns emerge*' (p. 424). The nature of IPA allows researchers to discuss their findings in relation to existing theories, models or approaches, which subsequently can lead to generalisations (Smith & Osborn, 2003).

Philosophical positioning

Willig (2008) has highlighted that it is important for researchers to state their epistemological positions to demonstrate that they are consistent with the selected methodology and to clarify what kind of knowledge they would like to attain from their

research study. This section presents my philosophical positioning, which appears to be in line with the theoretical underpinnings of IPA.

The aim of this qualitative study was to explore subjective experiences; however, I acknowledge that it is not possible to access someone's personal world directly. Therefore, I hold a critical realist position, which assumes that an individual's beliefs can affect how knowledge is perceived (Madill et al., 2000). Throughout this study, my goal was to engage thoroughly with the data and understand participants' views concerning the phenomenon investigated. I value the importance of trying to understand other people's experiences and trying to put myself into their shoes. Thus, I was drawn to IPA because it is a dyadic method, which involves the participant who is trying to make sense of their experience and the researcher who is trying to understand the participant's world (Smith & Osborn, 2008). Willig (2016) suggests that the research questions in IPA studies are themselves realist, as they are referring to a phenomenon (in this case, working with suicidal ideation, which is a shared experience) that exists.

I strongly believe that the way in which the researcher understands the participants' views and feelings is affected by her assumptions, experiences, and the way she thinks. This is not considered to be a bias but a necessity for understanding someone else's experience (Willig, 2013). It is assumed that to access the participant's world, the researcher has to interpret what the participant has expressed (Brooks & King, 2017). In line with what Smith et al. (2009) have suggested, I acknowledge the significance of language when interpreting and making sense of an individual's experiences. This research also draws on symbolic interactionism (Mead, 1934), as '*for IPA the lived life with its many vicissitudes is much more than historically situated linguistic interactions between people'* (Eatough & Smith, 2017, p. 184). In addition, I support the idea that '*even emotion words and emotional concepts must have individual resonance and personal meaning*' (Chodorow, 1999, p. 165).

As a researcher and as counselling psychologist trainee, I do not question whether other peoples' experiences are true, and I am not concerned with identifying an objective reality. My main aim is to attempt to understand and make sense of other peoples' experiences, which is in line with IPA's stance (Willig, 2008). Larkin et al.

(2006) suggested that the participant's experience is described and understood by both the participant and the researcher, therefore it cannot be accessed objectively. As Willig (2016) has suggested, IPA researchers are trying to make sense of different layers of reality. Therefore, throughout this study, my aim was to listen or read carefully other people's narratives to get as close as possible to how they experience their world.

I align myself with the critical realist ontological position, which suggests that there is an objective reality, which is independent of human perception (McEvoy & Richards, 2003). As Willig (2016) asserted, ontological realism is a core condition for carrying out research studies. Frazer and Lacey (1993, p. 182) stated that, '*Even if one is a realist at the ontological level, one could be an epistemological interpretivist . . . our knowledge of the real world is inevitably interpretive and provisional rather than straightforwardly representational*'.

Choosing Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was primarily developed for research studies in psychology, especially in health psychology (Breakwell, 2008). It was introduced in 1990 by Jonathan Smith, and according to Smith et al. (2009), it assists in understanding how individuals perceive and sense their personal experiences in life. The three most acknowledged theorists of the IPA approach, Smith, Flowers, and Larkin (2009), have asserted that IPA examines how individuals understand their most important experiences. Additionally, they suggested that IPA supports that people are sense-making creatures. Participants in this research study will therefore demonstrate how they are making sense of their experiences. What makes IPA distinct and admirable is its 'participant-oriented' nature and the respect and sensitivity that it shows to the participants (Alase, 2017).

IPA has phenomenological roots, and it aims to investigate in-depth subjective experiences and personal views. These phenomenological underpinnings are linked to Husserl's and Heidegger's idea of exploring people's experiences as they occur in their consciousness (Tuffour, 2017). Therefore, one of the main features of IPA is a

'*detailed and systematic analysis of consciousness*' (Tuffour, 2017, p. 3). Also, Creswell (2012, p. 76) stated that '*Phenomenologists focus on describing what all participants have in common as they experience a phenomenon*'.

IPA is the exploration of a lived experience with a personal and insightful interpretation (Reid et al., 2005). It allows novice researchers to examine and interpret the lived experiences of individuals that have experienced a common phenomenon in a detailed and flexible way (Alase, 2017). IPA relies on idiography, which means that the researcher focuses on analysing in detail each case before reaching to any general conclusions (Smith et al., 1995). As such, IPA focuses on specific and detailed accounts of personal experiences. Moreover, it underlines both the similarities and discrepancies between individuals (Smith et al., 2009). IPA is a dynamic process due to the vigorous and significant role of the researcher.

Another theoretical underpinning of IPA is hermeneutics. This suggests that the art of interpretation or meaning is fluid, therefore it is continuously growing and open to new insights (Friesen et al., 2012; Smith et al., 2009). Hermeneutic phenomenology embraces the poetic and literary use of language that derives from the research process (Friesen et al., 2012). Also, IPA is considered to be a double hermeneutic approach in which the researcher attempts to make sense of the participant's making sense of the phenomenon by analysing and interpreting thoroughly (Tuffour, 2017). The researcher plays a significant role in the analysis process, as they have to read between the lines and make meaning (Finlay, 2011). IPA acknowledges that researchers cannot put into 'brackets' their personal experiences and that the ways in which they interpret are influenced by their own schemas (Smith, 2004; Willig, 2001). This methodology aims to explore a participant's worldview; however, the researcher's outlook is inevitably colouring the methodological process.

In qualitative studies, there are several approaches that could be utilised for analysis. One of these approaches is Grounded Theory, which was also considered for use in this study. Willig (2008) suggests that IPA and the shortened version of Grounded Theory share some similarities. Both of these methods show interest in an individual's point of view, classify data into themes, and analyse each case individually and then combine it with other cases to gain a rich account of the experience being explored.

However, a distinct difference between the two methodologies is that Grounded Theory aims to elucidate the social processes that are related to the phenomenon, while IPA works to reveal the essence of the experience (Willig, 2008). Since the aim of this study was not to develop a theory but to understand the participant's world and unique experience, IPA was considered to be a more suitable option.

An alternative methodology used in qualitative studies is Discourse Analysis. This method is often used in research studies that explore socially constructed phenomena. Discourse Analysis pays attention to the language used and explores how participants use words and conversational features to talk about their experiences (Willig, 2008). However, the focal point of this study was not to explore the use of language but to gain access to participants' subjective worlds without disregarding the importance of language, which can influence the way participants make sense of their experiences. The objective of this study was to get a glimpse of counselling psychologists' perceptions and how they make sense of their responses towards their clients with suicidal ideation, therefore IPA was chosen over Discourse Analysis.

IPA was reckoned to be the most suitable method for this study due to its richness and suitability when examining areas that are sensitive, complicated or ambiguous (Smith & Osborn, 2015). IPA was applied to this research because the topic of suicide is a phenomenon that is difficult to explain and the focus on counselling psychologists' wellbeing is a sensitive matter that has been overlooked. Hence, an account of the experience of working with clients with suicidal thoughts could provide very rich findings of the phenomenon from a counselling psychologist's point of view. Also, it is important to highlight that the sensitive phenomenon of suicide is not solely about the individual who has suicidal thoughts or behaviours. This method has been previously used to explore the experience of emotions, which is relevant to this study (Eatough & Smith, 2006). Eatough and Smith (2006) supported the finding that IPA can aid in broadening '*psychological understanding of emotion experience*', as it '*brings to the fore the complexity of human meaning making'* (p. 486).

Smith et al. (2009) claimed that IPA attracts researchers who are interested in human experiences, such as counselling psychologists. Researchers and psychologists aspire to see the world through other people's eyes, which requires reflexivity (Willig,

2008). IPA analysis gives the freedom to the researcher to be creative and flexible while following clear guidelines (Smith & Osborn, 2004). IPA shed light on the counselling psychologists' experience of counselling clients with suicidal thoughts and opened novel avenues of exploration and opportunities to adjust counselling training, supervision and personal therapy to support counselling psychologists. The philosophical underpinnings, ethos and purpose of the IPA approach are in line with what the profession of Counselling Psychology stands for. It respects the uniqueness of each individual's experiences and relies on the relational aspect of a relationship. All in all, IPA is a valuable method of data analysis, which can provide useful information about the central issue of suicide ideation that commonly appears in counselling psychologists' work.

Criticisms of IPA

IPA privileges the participant and is a sensitive and dominant qualitative research method. However, it has potential limitations and has been criticised over the years. It has been suggested that IPA is lacking clarity and is not sufficiently interpretative (Giorgi, 2010; Hefferon & Gil-Rodriguez, 2011; Larkin et al., 2006). Hefferon and Gil-Rodriguez (2011) suggested that there is a misconception that IPA is similar to thematic analysis in that it does not require an in-depth interpretation and therefore is often selected as an easy option for analysis. This lack of understanding of IPA leads to simply descriptive results that include mainly descriptive super-ordinate and sub-ordinate themes with insufficient quotes to support them, which does not signify a good level of analysis (Smith, 2010). However, this issue was addressed in research supervision, as my supervisor is well-informed about IPA and encouraged me to raise the level of interpretation in my analysis.

Also, Hale et al. (2008) mentioned that small sample sizes have been considered to be a potential and common limitation of IPA, although its main aim is not to generalise findings but to obtain full personal accounts and identify common concepts and similarities between them. However, Smith et al. (2009) have claimed that a small number of participants can provide a more detailed analysis and richer findings that might not be possible with larger sample sizes. Also, Smith et al. (2009) have

encouraged researchers to ‘go beyond’ what is explicitly disclosed in interviews and develop their interpretative capacity.

Another potential limitation of IPA is that the importance of the use of language is not recognised in analysing data (Willig, 2008). However, this is not entirely true because in order to make sense of participants’ experiences language factors, for example, the use of metaphors, are affecting the analysis and are therefore part of the interpretation process (Smith et al., 2009).

It has also been questioned whether the researcher and the participants have the appropriate and necessary skills to effectively communicate the experiences. For that reason, it has been suggested that only eloquent people can participate in a phenomenological research study (Willig, 2008). Noon (2018) argued that IPA would be a challenging task if the participants were young children or people with speech or language difficulties. The researcher would experience difficulty accessing participants’ worlds or making sense of the interview transcripts. Although prompts could be helpful in such studies, an alternative method of analysis is considered to be a better option (Noon, 2018). In this study my sample consisted of well-educated professionals who were articulating themselves very thoroughly and were aware of the level of information that qualitative studies require. However, the language barrier is a criticism that all researchers have to consider, as each individual has their own way of expressing themselves. To address this criticism IPA researchers are required to be more attentive to what each participant is disclosing, ask relevant questions whenever they do not understand what has been said, and lastly collect exhaustive data.

The aim of IPA being solely to understand lived experience, rather than being explanatory, has also been debated. Willig (2008) has pointed out that IPA is not explaining why a particular phenomenon is being experienced the way it is; instead, it attempts to understand how that phenomenon is experienced. Smith et al. (2009) have claimed that IPA highlights the cultural standpoint of participants’ experiences by using ‘hermeneutic, idiographic, and contextual analysis’ (Tuffour, 2017, p. 4).

Finally, another limitation that has been levelled at IPA is its concern with cognition, which is not compatible with some phenomenological underpinnings, as the role of

cognition in phenomenology is not sufficiently recognised (Willig, 2008). However, Smith et al. (2009) rejected that criticism because the condition of making sense and understanding an individual's experiences in IPA requires constant reflection, which is in line with cognitive psychology (Tuffour, 2017).

In summary, despite the criticism and potential limitations of this methodological approach, IPA is a versatile approach that allows researchers to understand participants' experiences. IPA research studies have provided a valuable contribution and a different flavour to the growing research arena of Counselling Psychology.

Ethical considerations

Ethical approval was obtained from City University Ethics Committee (Department of Psychology) before recruitment of participants began. The BPS 'Code of Ethics and Conduct' (British Psychological Society, 2018) and 'Code of Human Research Ethics' (British Psychological Society, 2014) were followed and taken into account during the entire research process.

Before agreeing to participate in this study participants were given an information sheet that provided brief and clear information regarding the research study and their role in the research project (Appendix A). Moreover, participants were explicitly informed at the beginning of the study that their participation was voluntary and that they could withdraw at any time without giving a reason. Participants were asked whether they wanted to be contacted again in one week's time to arrange the interview date. This ensured they had sufficient time to thoroughly consider whether they wished to participate in this study. If the potential participant agreed to participate, they were asked to sign a consent form to confirm participation (Appendix B). By signing the consent form, they agreed to be audio-recorded during the interview and consented to the use of transcribed sections of the audio-recordings in publications. Participants were also ensured that their data would be stored anonymously in a password-protected computer.

The present research study involved human beings so anonymisation was of vital importance. I had to honour and protect the qualified counselling psychologists who volunteered to participate in my study by processing data in a courteous manner. My role was to make sure that my interpretations were in line with what the participants said and to be cautious of not misinterpreting the data. It is fundamental to interpret the transcripts with respect and report the findings with a neutral stance (Sanjari et al., 2014). All the participants were informed of the use of quotations from the interviews in my final write-up and gave their consent to it. Participants were reassured that quotes used would not reveal their personal details and that they would remain non-identifiable. The ethical principles were taken into account throughout the research process and my role as a researcher was explored reflectively.

Although participants were qualified counselling psychologists who had face-to-face contact with clients with suicidal thoughts on a daily basis, the chance of a minimal risk was not discarded. The possibility that the interview might remind them of upsetting information or distressing feelings was taken into account. Therefore, I was mindful throughout the interview process and was able to identify any signs of discomfort or distress. If a sign of distress was noticed, the participant was reminded that their participation was voluntary and that they could withdraw or have a break at any time. At the end of the study, all the participants were given a debrief letter in which the aim of the study was indicated (Appendix C). Participants had time to ask questions and raise any concerns regarding the research procedure. If the participants seemed distressed, they were encouraged to contact their personal therapist and supervisor. In addition, since the participants were qualified practitioners, it was anticipated that they would be cautious about their wellbeing and be familiar with routes to psychological support.

Although it was envisaged that I would not feel distressed, I used several networks of support. First of all, I found peer support very valuable, as sharing experiences about the research process with colleagues or classmates made me feel understood. Last but not least, a reflective diary and supervision supported me throughout this journey.

Evolution of methods

Sample

Turpin et al. (1997) suggested that most doctoral programmes in Britain consider six to eight participants to be suitable for an IPA study. Therefore, the present research study aimed to recruit eight participants, both males and females, who were purposefully selected to talk about a particular phenomenon and represent a closely defined group of mental health practitioners. IPA researchers rely on a homogeneous sample (Pietkiewicz & Smith, 2014). Therefore, the sample of this study sought to include only qualified counselling psychologists registered with the Health & Care Professions Council Standards of Proficiency (HCPC) who were fluent in English and had worked with one or more clients who had expressed having suicidal ideation. Due to the methodological nature of this study and the purposive sampling, it was decided to exclude psychologists from other divisions, such as clinical psychologists. Although counselling psychologists might have received training from different institutions, the ethos, core elements and learning in Counselling Psychology courses were expected to be broadly similar. Focusing exclusively on counselling psychologists' narratives will bring into light their unique experiences of working with clients with suicidal thoughts or ideation and will address the lack of research on the field of Counselling Psychology.

Participants with clients who had also engaged in self-harming behaviours and had a history of suicide attempts were equally eligible to participate. Initially, I thought that it would be best not to include participants with clients who had died because of suicide to avoid any additional distress to the participant. However, after receiving a response from a potential participant who expressed an interest in participating in this research study and had lost clients due to suicide, I decided to review my inclusion criteria and contact the City University Ethics Committee. I strongly believe that including participants who might have experienced the loss of client due to suicide will bring to light valuable information about counselling psychologists' wellbeing and experiences when working with clients with suicidal ideation. Also, I wanted to demonstrate that it is normal for highly experienced and competent practitioners to experience such a loss due to the complex and unpredictable nature of human beings. Any professional who was willing to participate and share their personal experiences of losing a client to

suicide would be welcome to participate; their personal experiences would help other psychologists to broaden their perspectives in terms of client suicide and suicidal ideation. A homogenous sample with a degree of heterogeneity was felt to be appropriate to gain access to diverse experiences that would enrich my findings. Excluding participants who had lost a client from suicide would also have diminished the representative nature of my sample, as many counselling psychologists have faced a client's suicide and continue to work with clients with suicidal ideation, which is part of their job.

Psychologists of any theoretical orientation were invited to participate. I did not want to include participants working in just one theoretical modality because this might play a crucial role in the way participants responded to clients with suicidal thoughts. On the contrary, I was interested in exploring counselling psychologists' perceptions using different psychological approaches.

There were no exclusion criteria in terms of gender, age, ethnicity or sexual identity, similar to other IPA research studies focusing on counselling psychologists (Rizq & Target, 2008). Also, since participation was voluntary, it was assumed that each participant was feeling comfortable and emotionally resilient to reflect on such a sensitive research topic.

Recruitment

Prior to the actual recruitment process, two counselling psychologist trainees volunteered to help me carry out the pilot study by acting as participants. The two pilot interviews were carried out remotely via Skype. Counselling psychologist trainees' feedback assisted me to become accustomed to the procedure and practice the interview questions. The preliminary interview schedule was piloted to identify any errors or ambiguities in case it needed to be modified accordingly. These interviews helped me rephrase some of the questions and allowed me to think of follow-up questions that could encourage a more in-depth reflection.

Participants were identified from my network of practitioners, counselling services, mental health charities and private practices. The Counselling Directory and a Google

search assisted in identifying qualified counselling psychologists. Both male and female counselling psychologists were identified and approached via email. Another recruitment strategy that was used was snowball sampling. Colleagues and classmates were asked to share the researcher's information sheet with a counselling psychologist friend or acquaintance with experience of working with clients with suicidal thoughts or ideation. Potential participants were able to contact me directly via email and were reassured that the counselling service, mental health charity or any colleague (e.g., psychologist or counsellor) would not be informed about their participation. This ensured that participants did not feel under pressure to participate in the project. Recruitment flyers (Appendix D) were also visible to counselling psychologists on Facebook groups for psychologists once permission had been given.

As soon as potential participants contacted me and expressed an interest in participating, copies of the consent form and information sheet were emailed to them to help them consider their participation. In my email I also asked them to indicate when they would be available for a screening phone call to assess their suitability for participation in this study. If they were still interested in volunteering, they would respond to my email to arrange a suitable day and time for our brief conversation. During the phone call, I ensured that each one of them was HCPC registered and had worked with at least one client with suicidal thoughts or ideation. The potential participants were asked whether or not they had had a client who had died because of suicide, to ensure that they were feeling comfortable referring to this sensitive matter. Participants' theoretical orientation was also noted for my personal records and demographic information. Lastly, participants were briefly informed about the research project and were encouraged to ask any questions or voice any concerns they had.

Throughout the challenging process of recruitment, two male and six females HCPC-registered counselling psychologists were recruited. All participants came from different cultural backgrounds and age groups. They had all completed a doctorate in Counselling Psychology and were working privately and/or in an NHS setting and/or a mental health service. Participants were putting into practice different theoretical approaches, including Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Psychoanalytic, Psychodynamic, Pluralistic, Existential, Systemic, and/or

Integrative approaches. Biographical details recorded in this research project are minimal to ensure anonymity and confidentiality and are shown in the table below.

Participant's Pseudonym	Gender	Completion of DPsych	Therapeutic Approach	Place of work	Clients' Suicides
Henry	Male	2014	CBT; Psychoanalytic	NHS, Private Practice	0
Zoe	Female	2018	Pluralistic; Existential	Private Practice	0
Olivia	Female	2010	Systemic	NHS, Private Practice	0
Peter	Male	2016	Integrative Approach (DBT, CBT, Psychodynamic)	NHS, Private Practice	3
Paige	Female	2011	CBT	Student's Psychological Service, Private Practice	0
Alice	Female	2014	Integrative Approach; Existential	Private Practice	0
Ivy	Female	2017	Integrative Approach	Private Practice	0
Fiona	Female	2016	Integrative Approach	Private Practice	0

Table 1: Table of Participants' Information

Data collection

Instrument

IPA requires a flexible data collection tool that will provide rich data and will allow participants to talk freely about aspects of their experience that best illustrate how it is for them working with clients with suicidal ideation. As Smith et al. (2009) have suggested, semi-structured interviews are considered to be one of the best tools to collect qualitative data, therefore the present study used this tool. Semi-structured interviews enabled me to engage in valuable conversations with participants. Also, with the use of a semi-structured interview, there is the flexibility to change initial questions according to how the participant has replied. According to Willig (2008), the order of the questions matters less in a semi-structured interview than in a structured interview, which can offer a natural flow. Additionally, semi-structured interviews allow the researcher to ask for clarification and explore important points that might surface (Smith & Osborn, 2008). In comparison to unstructured interviews, semi-structured interviews implement an ordered framework that allows the key topics to be addressed and the pertinent aspects of participants' experiences to come to the surface (Consider, 2017).

The semi-structured interview included open-ended questions that focused on answering the research question. An interview guide was developed to help me think about how to phrase questions in a clear and sensitive way (Smith & Osborn, 2008). Also, it allowed me to consider different areas that could be explored during the interview, which could elucidate the experiences of counselling psychologists. Additionally, prompts were included in the interview guide to be used when the question was more complex or unclear for the participant.

The final open-ended questions were chosen and verbalised carefully according to the pilot study and previous research studies (Appendix E). The interview questions endeavoured to cover the following areas: personal views on suicidal ideation; feelings before, during and after the sessions; sense of wellbeing; therapeutic relationship; thoughts about their work and impact of training and supervision; and self-care. In line

with Smith and Osborn's (2003) suggestions, I familiarised myself with the interview schedule prior to meeting the participants.

Procedure

Following or during the screening phone call, and depending on the readiness of the volunteer to participate, we agreed on a convenient date, time and venue for the interview to take place.

Most of the semi-structured interviews (five) occurred in participants' private counselling rooms or working areas; two of them took place at a booked room at City, University of London during business working hours; and one of them at the participant's home. The venue selected depended on the availability of each space on the selected date.

On the day of the interview, a hard copy of the information sheet was handed to each participant so we could talk through it and they would be able to ask any questions. Subsequently, I ensured I had obtained the participants' informed consent prior to the interview. As soon as the participants' consent was obtained, I assured them that their private data would be stored safely and securely. During these conversations with the participants, I attempted to build a rapport and make the participants feel comfortable before the interview (Smith & Osborn, 2003). Each interview lasted approximately one hour and was audio-recorded from two digital recording devices to ensure the best sound quality and avoid any malfunctions. At the end of each interview, I did an oral and written debriefing about the purpose and aims of the study and I asked participants again if they had any questions about the research study.

Transcription and analysis

Before transcribing and analysing the data, Creswell (2013) recommends that researchers reflect on how they are experiencing the phenomenon under study to avoid interjecting their personal experiences and views of working with clients with suicidal ideation with participants' experiences or stories. Therefore, I decided to

record my reflections before and throughout the transcription and analysis to illustrate the journey of this research project.

First of all, the recordings were deleted from the digital recording devices as soon they were transferred to an encrypted and password-protected laptop. I listened to all of the recordings a few times before I transcribed them verbatim and typed them up electronically. This helped me engage fully, recall the environment and atmosphere of the actual interview and put myself into participants' shoes. Every time I read or listened to the interview, I understood the data more (Pietkiewicz & Smith, 2012).

A verbatim transcription encompassed all utterances that occurred during the interview, including grammatical errors, pauses or non-verbal communication of both interviewee and interviewer. Smith et al. (2009) have suggested that transcription can be part of the interpretative process, hence it is unnecessary to correct any grammatical errors because they might alter the meaning (Langdridge, 2007). Personal details and identifying information of the participants were omitted from the verbatim transcript to ensure confidentiality and anonymity (Smith & Osborn, 2004). Special attention was given to participants' experiences and psychological themes, which is in line with the aim of this research study. The transcript of each was read three times while listening to the corresponding audio-recording. This allowed me to relive the interview and take into account the speech and tone of the participant, which were both vital for my understanding. Although each participant had a different accent, every effort was made to transcribe each interview word for word. Whenever I was not sure if I had heard correctly, I would highlight the word and then revisit it to finalise each transcript and make sure that it represented what they said as faithfully as possible.

For the purpose of the research study, a random pseudonym was assigned to each participant to protect their identity (Alice, Fiona, Henry, Ivy, Olivia, Paige, Peter and Zoe). The data were analysed using IPA, which is a method that promotes a 'healthy flexibility' throughout the process (Smith et al., 2009). I chose to conduct the analysis manually rather than using computer software because it felt methodical and rewarding. It allowed me to engage fully with my data, have an active role and enhance

my skills of qualitative analysis. Examining my data manually kept me mentally alert and creative, which was the most inspiring and exciting part of the process.

Once each interview was transcribed thoroughly, it was formatted to sit in the centre of two lined columns (margins) to facilitate the coding procedure. This procedure can be both strenuous and frustrating, as it can be time-consuming and demanding (Smith et al., 2009). Researchers are advised to read the transcripts several times before starting the coding process 'to get to get a better feel of the participants' "state of mind" vis-à-vis how the subject-matter has affected their lived experiences' (Alase, 2017, p. 16). Therefore, I made some notes in my reflective journal and wrote down key words or phrases to encapsulate the core essence of each interview.

I made extensive notes in the left margin about the content, language used and context. Preliminary interpretative comments were also made (Pietkiewicz & Smith, 2012; Smith et al., 2009). I was trying to understand the phenomena explored and used an emic in conjunction with an etic perspective. The latter means that the data were explored through a '*psychological lens*' and I was interpreting data based on psychological concepts and theories in order to understand the research question. This was achieved by looking at the data as an outsider, which provided new information and insights that even the respondents might not have been aware of. By contrast, '*[a]n emic perspective attempts to capture participants' indigenous meanings of real-world events*' (Yin, 2010, p. 11) and '*looks at things through the eyes of members of the culture being studied*' (Willis, 2007, p. 100). Therefore, with the use of an emic perspective psychological reductionism was avoided, as the focus was on the insider's perspective (Pietkiewicz & Smith, 2012).

After making the initial notes, each transcript was read again, and in the right margin, emergent theme headings were noted by taking into account the initial annotations (Appendix F). Those theme headings were then written on post-it notes, which facilitated in clustering themes, as they were spread out on a large round table and were moved around to create groups with similar or related material (Appendix G). This method helped me identify super-ordinate themes and sub-ordinate themes for each interview (Appendix H), which aimed to represent as accurately as possible each participant's experience of working with clients with suicidal ideation.

As soon as all eight transcripts were analysed to this level, the emergent themes that were similar were arranged into clusters. Lastly, a table was compiled that summarised the themes created in order to detect the final super-ordinate and sub-ordinate themes that best represented the findings. According to Smith (2009), super-ordinate themes are identified through abstraction (*putting together similar items and giving a new super-ordinate heading*), polarisation (*finding the differences within the themes*), contextualisation (*identifying the contextual features within an analysis*), subsumption (*identifying a clear super-ordinate heading and then trying to find similar themes to put under this heading*), function (*grouping themes together according to their function*) and numeration (*evaluating the significance of a theme according to its frequency*) (Leight et al., 2015). For each super-ordinate theme, two to four sub-ordinate themes were created, which were supported with relevant quotations from the participant's narrative (Appendix I). These are presented in the Analysis chapter.

Methodological reflexivity

Initially, I thought that recruiting counselling psychologists would be an easy task; however, the recruitment and completion of interviews took six months overall (from June 2019 until November 2019). The data collection process was very interesting and thought-provoking, and I found myself being drawn into participants' stories. Due to counselling psychologists' busy working schedules, most of the participants could offer 50 minutes of participation. Some of them were seeing clients before and after our interview, which made me become more alert and attentive to any signs of discomfort during the interview process. At first, the time-limited participation made me conscious of time and less able to engage in an open dialogue with them. I had in mind that I wanted to ask several questions that were considered to be important for encouraging an in-depth reflection and seeing suicidal ideation from different viewpoints. However, refocusing on the purpose of semi-structured interviews and IPA, which is to allow participants to share their personal experiences and allow new insights and themes to emerge, I was depending less on my interview guide. As I familiarised myself with the data collection process, I was more natural, and I was more able to immerse myself in each unique narrative. During the interview, I also realised that counselling psychologists do not have enough space and time to reflect

on their experiences apart from supervision and personal therapy. Therefore, I felt that it was essential to allow each participant to 'lead' the interview and focus on feelings and aspects of their work that coloured more vividly their experiences of working with this client population.

Although transcription was sometimes frustrating and time-consuming, I found it to be an integral part of making sense of participants' experiences. When I first started listening to the recordings, I felt that I wanted to know more about participants' experiences and wellbeing. I was apprehensive about the length of some of the interviews and the data collected. However, upon more detailed examination I noticed that there was great depth to the material and content shared by all participants. Once I had listened to all the recording several times, I realised that I could still hear each participant's voice, which enabled me to truly 'intrude' into their experiences.

During the analysis, I tried to put aside my personal experiences and feelings. However, Smith (2007) underscored the significance of the double hermeneutic within IPA. Therefore, my personal views helped me in making sense of the participants' experiences. Being a counselling psychologist trainee can be advantageous when interviewing participants because we can naturally be active and empathetic listeners and feel comfortable talking about sensitive issues. However, I realised that analysing data with IPA can be challenging for a counselling psychologist trainee and I could sometimes feel a tension between the two roles of being a researcher and a psychologist trainee. I had to be cautious of not making interpretations as a psychologist, but rather as a researcher.

I can still remember that my first participant responded to my questions differently to how I expected, and I remember that I felt that he was not responding to what I had asked. However, when this was discussed in research supervision, I realised that I had collected rich and meaningful data which would require a lot of work and interpretation. Moreover, some views and feelings that were expressed by participants were not similar to my personal emotional responses, and therefore I thought that this would be something that would challenge me or affect my interpretations. On the contrary, it was the most intriguing part, and one which made coding and clustering more enjoyable. Additionally, because of my enthusiasm, I had the temptation to

progress and identify super-ordinate themes and sub-ordinate themes quickly, which resulted in top-down analysis, instead of bottom-up. This was discussed in research supervision and was revised.

Throughout the analysis, I was reminding myself that the aim of the research study was to honour each counselling psychologist's experience and not let my beliefs affect the process. Exploring the findings of this study on a deeper level made me look at this topic from different angles and acknowledge the complexity and multidimensionality of suicidal ideation.

Identifying super-ordinate and sub-ordinate themes was both a daunting and exciting process because knowing that there was no right or wrong answer made me doubt my findings, but at the same time allowed me to be more flexible. During the whole process, I was feeling excited and I was appreciating the uniqueness of each participant's experience.

Personal reflexivity

The journey embarked upon when studying for a doctorate in Counselling Psychology is an empowering process, and the research component is an integral part. Through reflexivity, researchers acknowledge their involvement in the research process and how it has impacted them. Reflexivity is an important feature of a qualitative research study and it can aid readers to enhance their understanding of the aims, procedures and interpretations of the study (Willig 2008, 2013; Yardley 2000, 2008).

My interest in the global issue of suicide stemmed from my desire to understand the internal world of someone who was led to this behaviour. Initially, after researching the current literature, I was interested in conducting a research study on middle-aged men who have attempted suicide in the past. However, as this population was difficult to reach, I decided to change my research question.

My primary goal of conducting a study on suicide was to learn and understand how I could support clients with suicidal thoughts or behaviours as a professional counselling psychologist. This led me to consider that in order to help a client with suicidal ideation

effectively, we need to understand how counselling psychologists experience this client population and what are their emotional responses and thoughts about suicide. As I immersed myself fully in the research process and the profession of Counselling Psychology, I understood that I was more fascinated to explore counselling psychologists' perspectives and experiences of working with clients with suicidal ideation.

As a counselling psychologist trainee, I have worked with several clients who have expressed suicidal thoughts. As my training was progressing and my clinical experience was growing, I realised that working with suicidal ideation is a central and common aspect of the therapeutic work, which confirmed the importance of my research topic. Throughout my training, I acknowledged that clients' suicidal thoughts were not leaving me untouched, as I felt my anxiety increase during the sessions. I can still remember the first time that a client disclosed to me that she had suicidal thoughts, which made me feel powerless and numbed. Also, I was feeling a strong desire to banish these thoughts, and I was struggling to put aside my emotional reaction. I strongly believe that having hope for my client helped me stay with these unpleasant thoughts and walk beside her and support her effectively. Reading some of the existing literature about how mental health professionals experience working with clients with suicidal thoughts led me to reflect on my personal experiences as a counselling psychologist trainee. Looking back, I can recall that earlier in my life I was naïve, and I believed that a psychologist would have the power and responsibility to prevent a suicide. In order to work effectively with this client population, I used the space of supervision to reflect on how I was feeling during the sessions with this client population, and what were my beliefs and presumptions of suicide. Throughout the research process, I endeavoured to separate my own feelings and views from those of my participants, by way of a reflective diary.

Analysis

Overview

The semi-structured interviews that were conducted brought to light the experiences of eight qualified counselling psychologists of working with clients with suicidal ideation. Each interview was insightful and unique, like each participant, and facilitated in understanding and acknowledging the experiences and emotional journey of practitioners. All transcripts were analysed thoroughly by following the steps that Smith et al. (2009) have suggested, which were described in detail in the methodology chapter.

The present chapter will focus on the super-ordinate and sub-ordinate themes that emerged from the analysis of each interview. Extracts from the transcripts and my analytic interpretations of each one will be included to support my findings and offer an intelligible account to the reader. The quotations that are included in this chapter will not be modified and any grammatical or syntax errors will not be corrected, as my aim is to portray the natural and idiosyncratic expression of each participant.

Throughout the analysis, my role was to listen to what the participant had genuinely communicated to me, internalise it and allow their inner reality to be heard, as each participant's world can be different (Willig, 2012). Although it is impossible to include in my findings all of the valuable points of each narrative, my aim was to capture the gist of each interview and highlight the themes that best illuminated the experiences of each participant. I felt strongly that each participant decided to participate in my research study to communicate to me particular matters, therefore I tried to remain grounded in the data while at the same time bringing to life the words and essence of each interview. It is worth mentioning that the emergent themes would have been different with a different researcher. I believe that the magic of qualitative studies is the flexibility and freedom of researchers to make their personal contribution to the field. The positioning of each sub-ordinate theme within each super-ordinate theme is subjective and crossovers between and within them were unavoidable due to the multidimensionality and complexity of suicide and method of analysis, which was IPA.

Despite the richness and volume of data, similarities and parallels between participants' experiences were conspicuous.

Analysing the plethora of data from each interview allowed five super-ordinate themes to emerge that attempt to summarise in a few words the journey of each participant in working with clients with suicidal ideation. The first super-ordinate theme, Therapeutic Relationship, refers to how the relationship between the counselling psychologist and the client is affected once the client has disclosed suicidal thoughts or ideation. The second super-ordinate theme, The Overriding Feeling of Trepidation, refers to the emotional experiences of practitioners and how suicidal thoughts/ideation can affect them in their personal space or in the counselling room. The third super-ordinate theme, Sense of Urgency, describes how counselling psychologists get into a different mode during the therapeutic sessions with this client population. The fourth super-ordinate theme, Raison d'Etre, reflects the nature of being a psychologist and what it entangles in relation to working with such a presenting issue. Lastly, the fifth super-ordinate theme, Feeling Vulnerable, signifies how fragile practitioners feel personally and professionally when working with suicide risk.

The table below shows the super-ordinate themes that were outlined above along with the corresponding sub-ordinate themes.

Super-ordinate Themes	**Therapeutic Relationship**	**The Overriding Feeling of Trepidation**	**Sense of Urgency**	**Raison d'Etre**	**Feeling Vulnerable**
Sub-ordinate Themes	Chess Game or Dance	Taking the Client Home	Put a Different Hat on	Feeling Constrained	The Law Is in the Room
	Withdrawal	Sitting with the Uncertainty	Self-preservation	We Can All Be in that Chair	Not Prepared
	Sense of Privilege		It Is Live	Not a Deity	Feeling Alone
					Sense of Responsibility

Table 2: Table of themes

Super-ordinate Theme One: Therapeutic Relationship

The therapeutic relationship between the practitioner and the client who has suicidal thoughts can play a crucial role in treatment (Samra & Monk, 2007). Therefore, special attention was given to how the therapeutic relationship can be affected after the client has disclosed their suicidal thoughts. Therapeutic Relationship, which is the first super-ordinate theme, can be a strong determinant of how the therapy is progressing and can indicate how strongly the psychologist can be 'touched' by such disclosures. This theme highlights important aspects of counselling psychologists' experiences, which gives us information about their personal and professional identity and indicates that conversations about suicide do not remain neutral. According to participants' disclosures, the therapeutic relationship can be symbolised as a Chess Game or

Dance that entails rules, boundaries and a level of closeness. Also, participants have expressed a sense of Withdrawal and a Sense of Privilege working with this client population, which were classified as two additional sub-ordinate themes.

Sub-ordinate Theme One: Chess Game or Dance

Due to the interpersonal nature of suicidality, participants' disclosures indicated that the presence of suicidal thoughts or ideation can leave a mark on the therapeutic relationship. This sub-ordinate theme refers to a therapeutic relationship that is experienced as a dance, which involves coming closer to the client but at the same honouring boundaries and allowing the client to maintain their personal space and to respond respectively. Additionally, the therapeutic relationship is symbolised as a chess game, which indicates that working with suicidal ideation is a two-way process that requires a move from each player (the therapist and the client), which can affect the therapeutic process and progress. This game has certain rules, and it can be experienced as fair or unfair.

According to Alice, the relationship is like a chess game or a dance. When we are referring to dancing and relationships, we can visualise at least two people dancing. It is an easy metaphor to picture, and it shows the complexity of the therapeutic relationship, which has its own rules of engagement. Below Alice is describing a client who comes close, steps aside, and then pulls away:

I give an intervention and then he tries to step aside from the intervention and tries to distract me and then we will touch to something painful and then he pushes me away. And it has always been like a chess game or a dance, as much as I am trying to help, he gets uncomfortable and pulls away. (Alice)

Alice's disclosure indicates that although she is trying to approach the client and provide support, the client sets up walls and does not accept the helping hand that she is offering. This demonstrates her effort and the challenges in making a move to get closer to the client, which sometimes appears to be experienced as uncomfortable or alien to the client. A chess game can be similar to a therapeutic relationship; you can get close to certain pawns but at the same time you have to follow the rules, like in

therapy, and maintain the boundaries. A chess game can be complex and has unlimited possibilities and moves, similar to a client, who can be unpredictable. A chess game is a game of strategy in which each person's move is a response to the opponent's move. The metaphor of the chess game is very powerful, as it shows the commitment, attentiveness and investment of time that are essential components when working with clients with suicidal ideation.

Similarly, Paige highlights the importance of boundaries:

…feeling whatever emotions, you feel with the client in the room there are also boundaries that are there. So you want to make sure that there is nothing there that is going to hinder the work you are doing but of course once the person leaves the room, as long as you know they are ok, they leave the room, you might just shake it off a bit and you then have to go on to do something else. So, it is about being able to let go and so on as well. (Paige)

Paige suggests that although there might be an emotional impact, it is important to remain present with the client and focus on the therapeutic work. From Paige's disclosures, it seems that the client comes first and once they leave the room, she focuses on her internal processes. This indicates that she prioritises the needs of the client by setting boundaries to protect the client and the therapeutic process. It is evident from the above quotation that she is making an effort to remain focused, although she might be experiencing several emotions. Once the 'dance' of the therapeutic session is over, she recognises the value of letting go of the client once they leave the room. Therefore, Paige underlines the importance of boundaries within the therapeutic relationship to protect her personal and professional identity.

Fiona noticed a deep connection with a vulnerable client who was experiencing recurrent suicidal ideation:

…interestingly it also made me feel closer to her when we did resume working, because I was actually sitting with the vulnerability and the reconnection which was quite significant probably for both of us. (Fiona)

Fiona's personal grief of losing two people from natural causes placed her in a challenging position, as it was unbearable and painful to explore suicidal ideation in therapy. However, she might have possibly felt a reconnection with the client because metaphorically speaking it was as if she was reconnecting with life and a person who had overcome the absoluteness of death. Being beside the client who is in such a vulnerable state helps make her feel closer to the client, as she opens her arms, dances with the client and contains the despair.

Moreover, Henry said,

At some point she said, 'I don't know if life is worth living' and it made absolute sense in that moment. My relationship didn't change at all, if anything, well, if you were to say it changed, it kind of deepened. (Henry)

Henry felt that the relationship between him and the client had grown because the client's suicidal despair and suicidal ideation were making sense to him. Therefore, he was able to empathise with the client, as the 'game' was experienced as honest and straightforward, which enforced the fair-play principle between the therapist and the client. Henry was invited into the client's world and he was allowed to understand the client's existential statement. This might indicate the importance for Henry of having clarity and a clear picture of a client's suicidal ideation, which can positively influence the therapeutic relationship.

On the other hand, throughout Henry's account, a predominant feeling was irritation towards some clients who do not take seriously the significance of expressing suicidal ideation:

So then I had to always monitor and ask the same questions and then I was like 'fuck me'. Wanna play that game? (Henry)

Henry describes that with certain clients the presence of suicidal ideation can affect the therapeutic relationship, as it places him in a defensive position, ready to respond and react to the client. Henry feels that he has to become repetitive by assessing the risk, and the words '*fuck me*' signify his frustration. Although he might take a neutral

starting position whenever he meets a client, he can identify the nature of each game and is prepared to join in.

Sub-ordinate Theme Two: Withdrawal

Counselling psychologists who participated in the current study expressed a dormant sense of withdrawal working with some clients with suicidal ideation.

According to Henry, if the client has a negative attitude towards life from the beginning and there is a tone of pugnaciousness, he experiences a difficulty empathising with the client and there might be a level of detachment.

And there was another client who, you know, from the moment she stepped in she was like yeah life is shit, I want to, I don't know, stab people in the back and kill myself. And that became a point of detachment, a point of creating distance between us now and again. (…) There is no deepening. There is nothing. It becomes meaningless. So, it depends on the other stuff as well. (Henry)

Making sense of why the client has developed suicidal thoughts can affect the therapeutic relationship. Henry's tone is sarcastic and his words '*stab people in the back*' convey a sense of betrayal. I am wondering if he meant that he feels betrayed by some of his clients who have expressed suicidal thoughts. It seems that Henry experiences an emptiness within this relationship, where he potentially feels that he has nothing to offer, and what the client brings is not serious enough for his attention and care. The above excerpt indicates that the therapeutic relationship is not affected solely by the expression of suicidal ideation, but can also be influenced by the overall presentation and personality of the client.

On the other hand, Alice feels frustrated and exhausted when a client discloses suicidal ideation:

I get a bit flashed, this sounds so awful, but it is almost, not another one, not another person that needs a lot from me. (Alice)

Alice has noticed some physical sensations when she is having clients who have expressed suicidal ideation, such as feeling flashed. This can be a physical reaction that cannot remain invisible. She feels taken aback when clients express suicidal ideation. However, from her account, it is apparent that she is well versed in reflecting how she is experiencing working with this client population. She acknowledges her responses and feels that this client population requires extra attention and more work from her side. Alice's discourse hints at a desire to push those clients away, as they can be experienced as a burden and a huge weight on her shoulders.

It appears that Alice sometimes experiences those clients as demanding and there is a level of withdrawal, as she clearly states in the following quotation.

So, when I have clients like that presenting with suicidal ideation I just, to be honest with you I get quite withdrawn. (Alice)

Alice is open to sharing her experiences but from the way she expresses herself, it is apparent that it is hard for her to share her negative reactions, which hint at a possible burnout or emotional exhaustion.

Contrary to Alice's experience, Peter reported the following:

At this moment in time I might have to be your parent, I might have to be the person that is there for you, that is accepting you despite everything that is going on and then I need to learn, I need to almost withdraw from that step by step because you have become stronger. (Peter)

Peter seems to feel an obligation to become a significant person that is missing from the client's life. He becomes the one to rely on, who holds a non-judgmental stance and accepts the client the way they are. This does not only describe the core conditions of developing a good therapeutic alliance with a client, but it also demonstrates the investment and effort that he makes to bracket his own values and beliefs in order to apply unconditional positive regard. Peter's quotation shows that he is beside the client, accompanying him on his challenging therapeutic journey and that he is prepared to slowly let go of the client once they are ready to become

independent. In other words, there is a gradual withdrawal from the therapeutic relationship, as soon as he feels that the client is safe. It appears that Peter uses his self to be fully present and helpful for his clients but at the same time he acknowledges the boundaries and that he cannot remain that significant person for the client. Therefore, he is prepared to gradually detach from them. Peter seems to make a distinction between personal and professional relationships, as he acknowledges that therapeutic relationships are conditional upon clients' needs and are not static or fixed.

Fiona expresses a difficulty connecting with clients who want to end their own lives, while other people die from natural causes:

…it is hard to sit with that struggle, you know, when obviously if you have lost somebody, you would just give one more day, you would love to have one more day with them but for those who feel suicidal one more day feels unbearable. (Fiona)

Due to personal losses that Fiona had experienced, it was painful for her to listen to clients with suicidal ideation because people in her own life, who had wanted to fight for their lives, did not survive. Fiona's words show the paradox of life that some people do not have the choice to live or die, while others might have. It seems that Fiona as a bereaved individual experienced a resentment at the unfairness of that paradox and her tone of voice indicates a grievance. However, it seems that Fiona is trying to bracket her own experiences and reactions and understand how a client with suicidal ideation might feel. As someone who is experiencing a loss and is grieving, it could potentially be more challenging for Fiona to empathise with the client who wants to end their own life.

Fiona described a distancing between her and the client, as she stated:

I felt very awful for her and really concerned and then I went straight to feeling really angry. [...] He was literally fighting for his life and she was fighting to end her life, and this was difficult to sit with those complete polarities and I felt very angry caught in the middle of that. (Fiona)

Fiona reported being overwhelmed by different emotions when working with a client with suicidal ideation while she was experiencing her own grief. The participant is describing an emotional rollercoaster, as she felt sad, worried, but above all angry. Fiona appears to be tightrope walking, as she is trying to keep her balance on a tensioned wire, while attempting to bracket her personal life and remain present with the client who is contemplating suicide.

Sub-ordinate Theme Three: Sense of Privilege

Participants working with clients who have expressed suicidal thoughts or ideation described feeling a sense of privilege and honour. That sense of privilege was rooted in feeling entrusted with an individual's innermost despair, which was sometimes counterbalanced by anxiety and feelings of burden or worry.

I need to see you, you are the person that, you are my psychologist I cannot go to someone else. Um, and there was something within me that I do not like to reject someone when they, it felt wrong and so I thought ok I will see you. (Alice)

Alice's report indicates that she can be regarded as a special person to the client, which can be experienced as a privilege. It can be an honour to listen to words such as those uttered by the client above, as it shows that the client appreciates and highly respects Alice. However, she experiences the client as someone who needs her, which leaves her unable to decide unreservedly whether she would like to work with him. It appears that Alice feels inclined to accept the request of the client due to the previous therapeutic work and relationship that they had developed. She feels that it is her duty to continue with a client that she has worked with in the past, which can add an additional pressure. This indicates that Alice feels that it is her duty of care to support the vulnerable one and prioritise clients' needs over her own.

Alice continues by saying:

I think it is very hard when you have been working with someone for so long, as well, you know because the therapeutic relationship is such that you see them through all sorts of different ways and obviously it is a little bit more unique when you

see someone at the hospital, because obviously they are an inpatient at times and they are in a gown in bed, so you are seating at their bedside. (Alice)

Alice suggests that working with clients for a long period of time can affect the way she experiences them. This is because working long term with this client has allowed her to see him at different points in his life, when he was more or less vulnerable, which possibly deepened the relationship. Working in a hospital and seeing the client in a gown and in bed appears to be experienced as more intimate. A sense of privilege is hinted at as Alice considers her experience to be '*unique*'. Sitting at her client's bedside has allowed her to witness his personal world in the here-and-now, which can be very intense and moving. She can see with her own eyes the pain and struggles of each client and enter their tangible storylines rather than their narratives or stories following an event or after leaving the hospital.

Zoe seems to be feeling powerful that she is capable of providing a safe space for the client:

So I think it, in some senses it may be the case of slight hope or slight motivation in therapy that you've disclosed it to somebody, you want somebody to step in and I think the power of hearing somebody in that and being able to hear somebody and be able to withstand that and then work with what is going in on, it can be something really powerful to offer. (Zoe)

The participant appears to feel a sense of privilege that she is able to contain and endure listening to suicidal ideation. She refers to an internal strength and a unique ability that she has. Zoe seems to respect the power of therapy and what a psychologist has to offer. Additionally, she feels hopeful for the client who has expressed suicidal ideation because they are seeking support. Her words '*you want somebody to step in*' indicate that she believes that she is given the permission and chance to have an impact on the client's worldview and wellbeing. This can show the sense of responsibility that she feels working with this client population and the expectations that she might have of herself for intervening in client's suicidal thinking.

Furthermore, many participants, including Olivia, acknowledge the courage of the client to open up to a stranger:

…it is very brave to sit down with an absolute stranger who asks you all these really intrusive questions about your life and mental state and your emotional world and then you answer honestly. That is weird, that is a really strange relationship, hi nice to meet you so tell me about your suicidal thoughts, it is odd. (Olivia)

Olivia characterises the therapeutic relationship as bizarre, as often from the first session mental health practitioners ask personal questions and assess risk. Although she seems surprised by the clients' bravery, from her tone of voice it seems that she is amused and intrigued by this relationship. Olivia puts herself into the clients' shoes and recognises their courage and authenticity. The above quotation shows that she is pleased that clients trust her and respond honestly to her, which suggests a sense of privilege.

For Peter, the sense of privilege takes a different dimension:

I am less concerned about my own mortality now and I am just thinking oh when my time comes, my time comes and that will be the end of that. Actually, I am hearing in front of me somebody who hasn't got that yet, hasn't got that confidence and I think that for me to be able to think like that feels like quite a privilege. It feels like a privilege of education, like a privilege of I suppose of status, all of those things that allow me to feel safe enough to think ok I have lived a reasonable life. (Peter)

Peter feels confident that he is in a better position than the client. The participant does not feel the same stuckness or hopelessness that a client with suicidal thoughts might experience. From the participant's disclosures, it seems that throughout his life he has enhanced his self-awareness and feels secure. On the other hand, the word '*reasonable*' was used, which highlights the subjectivity of Peter's worldview, as what is reasonable for one person is self-justified and might have a different meaning for another person. Nevertheless, he considers his education and status to be a privilege, which shows that he acknowledges these things are not given. Although there is a sense of pride and honour, it seems that he respects his clients and believes in

change, as he says that the client '*hasn't got that yet'*, which indicates that he is hopeful for the client.

Peter in the following passage expands and says:

So I think that we are best placed as psychologists to be able to sit and contain a lot of that distress, we are able to sit and manage a lot of that distress that we hear and to help people find that life worth living, and we've got so many therapies now that can help people to recover and not just recover but to manage their own recovery and to build on that layer by layer and if we can help people go through that process and eventually exit our service, we have done a good job. (Peter)

Peter in the above excerpt demonstrates his belief in the profession of psychology and the usefulness of psychologists. It is evident that Peter feels proud of himself being a psychologist and uses the word '*we*', which shows that he does not only believe in his self but in all qualified psychologists who can contribute to the care of each individual. He trusts that psychologists are in a good place to support clients with suicidal ideation effectively and admires that they are able to sit, contain and manage the distress of each individual seeking support. From the above excerpt it seems that he feels that he belongs to a community which offers a good quality of support to clients for a better future. Peter highlights the duty of care and responsibilities that he has as a counselling psychologist, which places him in a determinant position for the client's recovery, which seems to be motivating him.

Peter also says:

Working in mental health is abnormal, it is not normal, never normalise it. People behave like that because they are distressed, and they are dysfunctional. All I can do is make sure that outside my life is calm enough to be able to manage that and be able to go back in. (Peter)

The above phrase might illustrate that Peter feels that psychologists have certain abilities and responsibilities that are beyond what is considered to be 'normal'. He highlights that in order to do his job he has to be calm and take care of himself, which

shows the contradictory nature of personal and professional life, as working in a mental health setting is not experienced as something ordinary. Peter is describing a different world that he has to enter and to do that effectively he has to prepare himself emotionally. This shows that he has a responsibility as a professional to make use of his 'privileged life' to support clients efficiently.

Ivy's account points at an important element of the therapeutic relationship, which is trust:

I feel that the trust, she trusts me, for her to trust enough, she hasn't even told her husband, so for her to be able to come into that space and share this information, which feels shameful and to feel able to share the despair around that for me that is a really positive thing. (Ivy)

Ivy feels a sense of privilege in being the person to whom the client has chosen to disclose something so personal like suicidal ideation. She sounds amazed and honoured that she was let in to the client's hidden world, which cannot be easily accessible. The repetition of the word '*trust*' is noticeable, and signifies how important it is for Ivy to feel trustworthy. The above excerpt shows that Ivy is glad that she can offer a safe space for the client to share her suicidal ideation because she recognises the shame that the participant is experiencing. Ivy's words indicate that she is experiencing her client's disclosures as secretive due to the covert nature of suicidal ideation, which could potentially make her feel inclined to protect that 'secret'.

Super-ordinate Theme Two: The Overriding Feeling of Trepidation

Findings from this study indicated that counselling psychologists, no matter their experience, are not immune when confronted with the suicidal ideation and despair of their clients. On the contrary, they are the ones who witness and listen to the raw truth of suicidal ideation and all the different aspects of it. What was poignant in participants' responses was that the predominant feeling when working with this client population was anxiety and fear, therefore the second super-ordinate theme is named The Overriding Feeling of Trepidation. Participants have expressed significant concerns

and worries about clients which result in thinking of them in their personal space. Therefore, the first sub-ordinate theme is Taking the Client Home. Also, counselling psychologists appeared fearful and anxious about a potential suicide or suicide attempt due to the vagueness of clients' statements around their suicidal thoughts or ideation. The second sub-ordinate theme is Sitting with the Uncertainty, which suggests that practitioners cannot be certain whether or not a client will end their own life. They are inclined to endure the ambiguity of the prospect of a suicide and clients' elusive reports about their intention and thoughts around suicide.

Sub-ordinate Theme One: Taking the Client Home

Counselling psychologists who participated in this study described their concerns and worries about clients who have expressed a level of suicide ideation. Some of them have noticed that their wellbeing is impacted, which affects the way they interact with other people or react to situations in their personal life. Others have noticed that they are thinking of clients who have expressed suicidal thoughts or ideation at home, while others have shared their need to think of them in their personal space and then allow themselves to let go of them there.

Paige reported the following:

Yeah, I guess occasionally, very occasionally quite rarely I need to sort of go home and say oh I had this sort of situation today and I just need to speak about it and say oh it was worrying and so on and then I am like ok that's it and I can leave it. Sometimes you need to take it at home with you and then have to let it go there.
(Paige)

Paige says that she occasionally carries her worries and concerns home, and she has the need to share these with someone and say:

Oh gosh I can't believe what I heard today, someone was suicidal, and I was worried.
(Paige)

It seems that Paige wants to share with someone else the weight of what she has heard. This denotes that sometimes it might be unbearable keeping something so significant and critical to herself. Paige has the need to externalise her feelings and concerns to someone from her personal life as a way to discharge herself and feel off duty and safer.

On the contrary, Henry draws a line between his professional and personal life and does not let the clients come close to his 'doorstep'.

It matters to them, it matters to me, if I have suicidal thoughts, If I am in love. Of course, it matters but this is the most important thing, and it is the most important thing for them, but I will not take it home with me because I have my own shit. (Henry)

Henry is saying that although he understands that clients' suicidal thoughts are important for them, he removes himself from what matters to them without implying that these things are not valid. He says firmly that in his personal space he has to deal with his own '*shit*', which might indicate that he believes that each person has to own their own '*shit*' and take responsibility. He uses the word '*shit*', which conveys something that is messy and which he possibly wants to avoid. Henry appears to be aware of his personal limits as a professional and holds the belief that each person has to take responsibility for their feelings, decisions and actions. The contradiction between love and suicidal thoughts caught my attention and it sounds as if Henry is trying to convey that having suicidal thoughts can be something immensely personal, such as feeling in love. Being in love, although it might entail its own challenges, is regarded as being something positive that might change form and shape throughout time. A main difference between being in love and death is that love transcends the boundaries of life, while death is something definite and irreversible.

In contrast to Henry's account, Zoe describes the criticality of a potential suicide:

I know people fundamentally make their own choices, but it is the criticality of it, which weighs particularly heavily on me. There is no going back from death, so the absoluteness is very difficult. So, with the other clients' issues, one might have a

difficult session and there might be a kind of tension so you know you might end a session with an issue in the air or with the client feeling angry about something, but you can pick it up next week, whereas with suicidality ultimately you couldn't. [...]So I think I hold the client more in mind from week to week, than I might another client. (Zoe)

Zoe says that she holds clients in mind between sessions because she is worried about their safety and the absoluteness of a potential suicide. She knows that suicide and death are irreversible, and she cannot do anything to repair them at a following session. This makes her feel more alarmed and anxious working with this client population. Her report is indicative of a huge expectation that she has on herself to prevent a suicide and save the individual.

Alice reflects on an internal battle between her own needs and her professional liability that she is experiencing:

I go home to my partner, and I am thinking, you know it is confidential I cannot say anything, I wouldn't say anything anyway. (Alice)

According to the above quotation, it seems that Alice has the temptation and need to share with her partner that a client expressed suicidal ideation, but she withholds and feels constrained, possibly due to confidentiality and the nature of her work. Although it seems that she needs comfort from her partner, she resists and suppresses her worries. This results in Alice feeling alone with it, while at the same time feeling tempted to share it with her loved one and express her emotions. Her statement suggests that there is a part of her that wants to break confidentiality and emancipate herself from her worries and frustration.

Additionally, from the excerpt below it appears that she subdues her anxieties regarding clients' suicidal ideation when at home:

I get quite tearful, you know, which I think is actually good, you can get it out, which is sometimes confusing [laughter], having people around me, especially when I am

home and watching a heavy movie or something, I do find it comes out like that, yeah. (Alice)

Alice is significantly moved by clients' disclosures and she tends to withhold a lot of clients' pain. She has noticed that she expresses her emotional reactions in her personal space whenever there is a trigger. From the quotation above it seems that it is confusing for her when she is tearful or emotional, but she experiences it as something positive because it is a way for her to unload the emotional baggage. Her tears might be prompted because she might feel hurt and worried about her clients, which hints at emotional exhaustion.

Fiona clearly states that she thinks of clients with suicidal ideation in her personal space and spends a lot of time reflecting on such client cases:

…those are the clients that I sort of take home with me and I do reflect on them quite a lot. I find myself wondering you know are they ok and sometimes there is a feeling like oh should I send them a message and check in on them, but I don't. But there is that feeling of responsibility that I want to check in and see if they are okay and again hoping that they will make it to the next session. Or should I contact their doctor, or it is kind of sitting with the weight of that responsibility. (Fiona)

Fiona feels the urge to text clients who have expressed suicidal thoughts or ideation to check if they are safe, but it seems that she resists her urge. From the above excerpt it seems that she feels responsible and obliged to take action to protect the client. This demonstrates that following her clients' disclosures about suicidal ideation she is experiencing an internal battle and is apprehensive about what she is expected to do. The weight of responsibility makes her want to enter into her client's world and check in with them to see how they are feeling and coping in their daily lives. Fiona is speculating about whether she can do something to protect the client or whether she has to withstand her worries and remain passive after the client has left the counselling room.

Sub-ordinate Theme Two: Sitting with the Uncertainty

Sitting with the uncertainty of a client's intention has been a common and recurrent theme in all eight interviews. Counselling psychologists have felt anxious and fearful of a potential suicide. Clients' uncertainty about their purpose in life or unclear statements about their suicidal ideation can emotionally affect counselling psychologists, as they are obliged to remain present and endure any ambiguity.

Alice voiced the following:

The challenge is that you can never know for sure, if that person is going to do it or not and I think that being able to sit with that can sometimes be very uncomfortable. (Alice)

Alice expressed that it is hard to sit with the uncertainty and not be sure whether the client is going to end their own life. Her statement implies that she has to tolerate that uncertainty, which can make her feel uneasy.

Alice also describes that sometimes you might not be able to predict who might try to end their life:

…you know ironically, he was the one that I was not worried about in terms of suicide. (Alice)

It is ironic for Alice the fact that she might be taken by surprise by a client's suicide attempt, while she might be worrying about other clients. However, with her statement she highlights the unpredictability and elusiveness of the human mind and that she can never be certain about another person's intentions or behaviours.

In the following statement, Henry suggests that for him clients' uncertain and vague responses following a risk assessment might make him question the motivation behind their expression of suicidal ideation:

Oh, I would kill myself but I don't know when and I don't know why... Whatever... They did their own bit

(…)

Maybe they want to score more points and they found that question and oh if I put it from a zero to one they will pay more attention to me or I will be more eligible for help. (Henry)

Henry appears to be feeling deceived by the client and he experiences some doubts about the authenticity of clients' suicidal thoughts, as it seems that he believes that they might have a different function. There is a sense of disbelief when the client provides vague answers, and it is experienced as the client is putting on an act. In the above quotation it seems that Henry is trying to understand why on paper some clients might express something different from what they have said during the session. Moreover, it seems that Henry disregards that this might be due to his clients' hesitation of disclosing openly suicidal ideation to him, and instead suggests that he is being misled. Although he assumes that some clients express suicidal ideation in an attempt to seek further attention or support, it seems that it has the opposite effect on him. Henry's difficulty in understanding whether the client is at risk and whether the client has thought of ways of ending his life can create irritation and anxiety.

Similarly, Paige shared that she is anxious when a client's statements about their suicidal ideation are equivocal:

…it is like ouf so what do we do here, can we get this person help, if they have not been clear either, I suppose the anxiety is still there. (Paige)

In the above quotation Paige shows her thought processes and how her anxiety might escalate. She appears to feel lost and unsure about the next steps that she has to follow, especially because she is uncertain of whether or not there is an immediate risk.

Peter touches upon a significant point that often men do not have the language to describe their pain and communicate their despair, which makes him particularly concerned:

So, I get very concerned when men with poor communication skills talk to me about suicide because I think actually if you haven't got the words, then how are you going to let us know that you are safe or that you are not feeling safe. (Peter)

It seems that Peter has noticed from his experience that men have difficulty sharing what they are experiencing, which leaves him unsure about their safety. Peter appears to feel frustrated that he is not able to access the client's world, and he feels excluded from that world. His words indicate that he is experiencing a disconnection from some male clients because he does not have clarity or enough information to know how to support the individual in question.

Ivy describes how she has no control over clients' actions once they leave the counselling room:

Actually, you have got no idea if you are going to see that person again, and it is quite difficult to let that go because once she has left you just don't know. (Ivy)

Sitting with the possibility of a potential suicide and the fact that she cannot be certain about whether she is going to see the client again can leave Ivy feeling overwhelmed by her apprehensions. It is apparent that she is struggling to release herself from her worries after the client has left the session and she acknowledges that she has to withstand that sense of uncertainty and trepidation.

I mean luckily no one has, touch wood ever gone on to do it and please God, I hope to God I don't, but you never know in this career. (Ivy)

Ivy has not had a client who ended their life and this is something that she is worried about. She uses the phrase '*touch wood*', which is often used to avoid bad luck, and which demonstrates the complex and unpredictable nature of suicide where some things might happen that are out of her control. She also says '*please God*' to express her strong hope or wish not to experience a client loss due to suicide. However, she is aware that it is part of her job and that it is a possibility to experience such a loss.

Relying on whether a client is going to follow the safety plan is particularly difficult for Fiona:

So she was very knowledgeable in how to do it but it was always sitting with the delicacy of that and the uncertainty. (…..) I was always sitting with sort of when will she actually say something to somebody, I guess, I took it to supervision a lot and we did kind of set a bit of a support plan for her in place, who to call and in what circumstance. (Fiona)

Fiona is referring to a client who expressed suicidal ideation and knew what to do in case of a crisis. However, Fiona shares that she has to sit with the uncertainty of whether the client is going to follow the safety plan, which is out of her control. She has done what is required of her to keep the client safe, but it seems that she struggles not to take on the client's responsibilities, which exacerbates her anxiety.

Super-ordinate Theme Three: Sense of Urgency

The third super-ordinate theme involves the sense of urgency that many practitioners experience when dealing with suicidal ideation. Since urgency is a time-based concept it signifies practitioners' inclination to act quickly and often automatically and spontaneously. The sub-ordinate themes within this super-ordinate theme are: Put a Different Hat On, Self-Preservation, and It Is Live. 'Put a Different Hat On' refers to how psychologists change the way they work and get into a different mode once suicidal ideation is disclosed. They prioritise risk assessment and ensure that they follow protocols and ethical guidelines. Practitioners have also indicated an urgency to protect themselves both emotionally and legally (Self-Preservation). Additionally, findings demonstrate that working with suicidal ideation makes counselling psychologists more alert, as suicidal ideation is experienced as a serious issue that 'is live' in the room, which means that it needs an immediate response and full attention (It is Live).

Sub-ordinate Theme One: Put a Different Hat On

From the participants' reports, it was hinted that they were putting a different hat on as soon as a client expressed some suicidal ideation. Some practitioners felt inclined to interrupt the therapeutic process and focus on suicidal thoughts or ideation by following specific steps in a robotic way, which demonstrates their drive to work in line with protocols and ethical guidelines.

As Henry suggested:

During the session, I try to focus on risk assessment but also on the material of the session because it is not just the risk assessment, you have to do your job, you know the other part of the job as well and after I make sure that I record everything that is needed of me. I assess the risk but also make some real thinking around whether the person will actually commit suicide. (Henry)

From the above excerpt, Henry suggests that the risk assessment is a distinct part of the job, which is not the actual therapeutic work. The psychologist switches to a different mode, where he has to make his notes thoroughly, which he is entitled to do. He prioritises the risk assessment and then he considers the severity of the intention, which is based on the assessment and his subjective understanding and previous experiences. It is noticeable that Henry is focusing on the practical procedures during the assessment, instead of focusing on his emotional experiences, which highlights his determination to ensure that he follows protocols.

Similarly, Alice gets instinctively into risk assessment mode by following protocol, such as by having a checklist:

During the session, is almost like a kind of checklist in some ways, so it is more like what happened, describe it to me, was there an intention, is there a plan, you know, I start to go through more of the checklist protocol really. And then once I realise, if there is no intention or plan, then I kinda want to explore the deeper elements to it. (Alice)

Once she realises that the client does not have a specific plan to end their life, she changes hat and puts on the hat with the exploratory capacity.

Similarly, Zoe states:

So with that client I stopped, did a risk assessment, made a quite structured plan if you have these thoughts again what would you do, so in that sense, I do normally work in a more structured way, so yeah it changes the process of the work, I go into risk assessment. (Zoe)

Like the others, Zoe discontinues the therapeutic work and switches to a more structured way of working, which is the risk assessment.

In the same way, as is clear from her words below, Paige immediately considers what the protocol's steps are and acts accordingly in order to feel safe that she has done all that is required of her:

Ok, we need to get you in contact with your GP, (...) with a service that can actually manage that risk. (...) so I guess that there is this sense of urgency to make sure that you have done all you can. (Paige)

Paige gets into a different mode and detaches herself from her emotional reactions or experiences. She says '*ok*' as if what the client has disclosed has notified her to switch mode and proceed to the risk assessment and management plan.

Olivia suggests:

I have a guiding light in my mind if that makes sense of continuously assessing for risk, especially when working with parents because the risk that I am assessing for is in the family. (Olivia)

Olivia feels that it is necessary and her duty of care to continuously assess risk, to protect not only the client but their whole family, which can perhaps increase the sense of responsibility. The guiding light that she is referring to is something external, which

acts as a distractor from her personal experiences or reactions. Olivia trusts that guiding light, as it can offer her a sense of support and security in times of uncertainty.

Peter underlines the importance of wearing the appropriate hat as soon as possible, which will allow him to follow the protocol and inform his colleagues about the risk:

We want to make sure that we are informing the rest of the MDT as quickly as possible, we are making sure that we have a risk management plan in place and that may mean restricting leave. (Peter)

Peter suggests that it is crucial to do everything that he is required to do, which shows not only his urgency to support the individual but his determination to follow ethical guidelines. The participant might also feel an urgency to do everything in advance to avoid having any second thoughts or regrets about his actions.

Ivy appears to agree with the above practitioners, as it is discernible that she changes the way she works and directs the focus of the work on suicidal ideation, and makes sure to follow the protocol:

I have to support them in a different way, because they might be really vulnerable and have other things but actually, this is the protocol that I need to follow with these suicidal people and I need to, it is just ways of developing coping strategies and making sure that they have support beyond the therapy room. (Ivy)

It is worth noting that she uses the phrase '*I need to'*, which shows the anxiety and urgency not to deviate from the ethical guidelines and protocols. Ivy seems to categorise this client population as a group that requires more actions from her to ensure that they have adequate support in case of crisis.

Sub-ordinate Theme Two: Self-preservation

Counselling psychologists' disclosures indicated that while working with clients with suicidal ideation they are more alarmed and feel a sense of urgency to protect themselves both personally and emotionally. Their narratives emphasised the

importance of considering the law, protocols and ethical guidelines to protect their professional identity.

Henry reported:

I would dread to think that one of my patients would commit suicide and I didn't do the paperwork. (Henry)

Henry is sharing his fear and anxiety that is related to the danger of litigation and accusation of malpractice. Henry's instant thought and reaction following a client's suicide is to think of the resulting risks for his professional status. This illustrates how strongly his fears about his career and the potential consequences for his professional identity overpower the therapeutic relationship and his loss.

Zoe finds it hard to find a balance between what is best for her and what is best for her clients:

My supervisor very strongly encouraged me to contact the client's GP [...], I could if I wanted to, I have the client's GP number, so I could do it but it is not something that I regularly do and also, in all honesty, I think it does feel like something to protect the therapist rather than the client because you know GPs are very busy and if I were to talk to the GP, what would they do, probably they would do a note about it, unless the client goes to see them, we are not going to section this particular client so it almost felt like it is going to be something for me rather than something for the client. (Zoe)

Zoe is experiencing an internal conflict, as she feels that she has to protect herself but at the same time this feels as if she is putting herself above the client for legal protection. Zoe is referring to an ethical dilemma that she experienced when her supervisor encouraged her to break confidentiality and contact the client's GP. Zoe felt that breaking confidentiality would not be helpful for the client and its only function would be to protect herself and her supervisor legally. It seems that Zoe uses not only supervision but also her own professional judgment to make decisions by evaluating different scenarios and trying to distinguish her own needs from those of her clients.

Moreover, Olivia stated the following:

> *So, I think that I have to be careful of myself and protect myself ethically and psychologically, as you said at the* beginning this is an emotive area. (Olivia)

The above excerpt signifies Olivia's cautiousness with regard to protecting herself both psychologically and legally. This can make her feel more alarmed while working with this client presentation, which seems to have an emotional effect on her.

Additionally, Peter emphasised:

So that is the unpleasant side of what we do and I always from the first time this happened I always thought okay I am gonna make sure that I have done everything so that I can actually look them in the eye. (Peter)

Peter is a practitioner who has lost clients to suicide; therefore, he knows from his experience the importance of having a clear conscience and ensuring that he has done everything that was in his hands. His report hints that losing a client can make you feel guilty, which can be a very difficult place to be. Peter's previous losses were a learning experience for him, and motivated to do everything in his power to help clients and be able to feel confident about his actions without having any doubts about his work.

Ivy suggested that a form of self-preservation is seeking support from her supervisor.

I think it is the reassurance. You know I think you can feel quite vulnerable, so being able to communicate with my supervisor and knowing, you know did I do it, do you feel that I could have done more, do you think that this is right, you know what I mean, I think that is helpful. (Ivy)

As Ivy shared, it is invaluable to communicate with your supervisor whenever a client has expressed a degree of suicidality and let her or him know how you handled it. Sharing the responsibility and disclosures with her supervisor was reassuring for Ivy and a way of protecting herself as a practitioner.

Sub-ordinate Theme Three: It Is Live

This sub-ordinate theme highlights the urgency for counselling psychologists to pay attention to a client's disclosures around suicidality and respond to it. This theme highlights the importance of listening to the client, as suicidal thoughts or ideation is an urgent and immediate issue that they ought not to overlook.

Oh my goodness, this is live, it is in the room, life or death is in the room, it is realistic, isn't it? (Olivia)

The above quotation captures in a few words the core points of this sub-ordinate theme. Olivia shows how surprised, shocked and alerted she becomes once she listens to her client's suicidal ideation. When the client discloses their suicidal thoughts out loud it makes it real and immediate. Olivia normalises and validates the existence of suicidal ideation and understands that she has to be attentive.

Paige stated:

And if anyone indicated at any point that there was any kind of suicidal thoughts, I was oh you know oh what is going on here, I have to make sure that I focus on this. (Paige)

As Paige explains, she becomes vigilant and makes sure that she pays extra attention to it. It is noticeable that there is an internal dialogue with herself in order to keep her focused on what the client has disclosed.

Similarly, Peter says:

I think the other thing that I would never say to somebody, would be…well I would never ever say to somebody I don't believe you, you will never say that. […] No, actually if you have come and expressed that desperation to me, I am going to respond to that and make sure that you know that I've listened to you. (Peter)

Peter describes how he has to respond to what the client has shared, even if he might not believe the credibility of his client's narrative. He highlights the importance of

communicating to the client that they were heard no matter his personal response or reaction. Peter suggests that he has to remain present and relational.

Fiona, as a result of her clients' disclosures, becomes more measured and cautious about how she is expressing herself, as is evident below:

I am quite careful with the words that I am using. I try to be quite clear and express my concern rather than leave anything up to interpretation. (Fiona)

She is cautious with regard to the questions and words she is using, in order to make herself clear and avoid any misunderstandings. This indicates that she is more self-conscious during the sessions and expresses her concerns to the client openly and directly. Fiona suggests that when she is working with this client population, she wears her professional hat at all times and does not express herself unreservedly.

Super-ordinate Theme Four: Raison d'Etre

This theme illustrates how counselling psychologists perceive the nature of their work and how the profession of being a practitioner psychologist is interweaved with working with suicidal ideation. The sub-themes within this main theme encapsulate feeling constrained by the law, ideology and protocols within an organisation (Feeling Constrained), the normalisation of suicidal ideation (We Can All Be in that Chair), and not having superpowers to change clients' worldviews or save them (Not a Deity).

Sub-ordinate Theme One: Feeling Constrained

Most of the participants viewed the experience of working with clients' suicidal ideation as a distinct part of the therapeutic process once this is disclosed during a session. It appears that the therapeutic work takes a different turn and focuses on suicide risk assessment. The findings of this study demonstrated that counselling psychologists do not feel free during the therapeutic sessions when exploring suicidal ideation. Their capacity to work with suicide risk is strictly bound to protocols and ethical guidelines, which do not allow them to use themselves fully. Although safeguarding and ethical guidelines are put into place to protect clients and practitioners, it seems that these

are affecting their work as they become more self-conscious because they have to rely primarily on protocols. Participants describe a feeling of constraint, which requires assimilation and adjustment to their preferred way of working and personal ideologies.

Henry asserts the following:

It depends on the system. In the NHS, IAPT, all that, all these systems... it falls on you to monitor it as best as you can so you can avoid litigation. That's it. That is the end of it. (…) If there is space of worrying about somebody's wellbeing it will not happen because of tick boxes, I will feel it. (Henry)

Henry criticises the systems and says that there is a protocol that you need to rigidly follow, such as ticking all the boxes to ensure that the person is safe. However, he suggests that a tick-box exercise cannot be sufficient to indicate whether the person is safe or not. Henry stresses that his gut feeling might be a stronger indicator that could aid the risk assessment process.

Hmmm in a setting such as the NHS because I do not work psychoanalytically. I allow myself free rein to say whatever bullshit comes to mind. So, I take the master position as opposed to the analytic position and I go with hope. There is hope, of course, let me tell you all about hope. The only thing that I haven't done yet is do the genie dance sequence from Aladdin. Yes of course. I am gonna say there is hope, there is point in trying because that is the ideology of the NHS being alive is ok.[…] At the end of the day we bring ideology and my ideology is not there is always hope. Sometimes there is no hope. We have to accept that. (Henry)

Henry suggests that when he works in an NHS setting, he '*goes with hope*', which hints that it is not his preference and it is what he is required to do. He implies that he says things that are not in line with his beliefs and personal ideology. Henry feels constrained to act in specific ways and sometimes feels compelled to infuse clients with hope, although he himself believes that there is not always hope. Henry can easily put on a professional facade and become like a genie. The participant was acting like the genie from the film, as I was feeling that he was trying to entertain me in an animated way. I got the sense that he was trying to appear distant from all the

emotional effects that a potential suicide could have on him and this was apparent from the overuse of sarcasm and the strong language. The character of the genie in the animated film Aladdin is a comedic one who acts as a servant to the person who holds the magic lamp. Similarly, Henry has to remain bound to the systems' protocols, although his ultimate wish is to be set free like the character of the genie. The participant stated that in the NHS there is the conviction that we have to prevent the client from taking their own life and that being alive is the best and only option. He implies that the NHS is encouraging employees to stop the client from ending their life from a societal perspective and not therapeutically. Henry cynically talks about how he is following the protocols of the NHS, although his own ideology and ethos are not in line with what the NHS stands for.

Alice shared how upset she was feeling after a client tried to kill himself:

I really struggled with that, I cried a lot, I sent my poor supervisor an email to her on a Friday night saying, you know, this patient just tried to kill himself and his case was not with a GP, he just moved house, so all the standard things that we would do, I couldn't do right away. I had to wait for him to register with a new GP, I couldn't you know write the letter to the GP right away and I had to sit with it for the weekend obviously and in hope that he signs up. (Alice)

Due to practical difficulties, such as paperwork, Alice was feeling frustrated because the system's procedures tied her hands. Alice reported that she was not able to support the client immediately, as there were steps that she and her client had to follow. Further, she appears to experience a stuckness during the waiting period and hopes that the client will cooperate with the whole process. Alice seems to feel constrained to act on time and has to compromise because of the ethical guidelines and conventions.

Similarly, Peter highlights the following:

A lot of senior managers within the NHS would tell you that we need to lower suicide rates and you know that we can never have another preventable death, then I will just go take my magic wand [sarcastic tone]. (Peter)

Peter acknowledges that the NHS's ethical guidelines and foundations are to preserve life and prevent suicides, but he suggests that this is not feasible. He describes how he cannot prevent all suicides and uses 'magic wand' as a figurative device to suggest that preventing all suicide deaths is unrealistic and requires magic or superpowers. Peter suggests that the NHS and senior managers have set unachievable expectations of professionals, which can place him in a defensive and challenging position.

Zoe is referring to feeling constrained in terms of the way she approaches suicidal ideation whenever it is disclosed in therapy:

I guess there is a kind of restriction or tightening and I lose the exploratory capacity, so I find it quite difficult I think in my work when I feel I have to be very pragmatic and very, you know I have to ask certain questions. (Zoe)

She changes the way she approaches the therapeutic work, as she feels inclined to ask specific questions, which makes the work more structured. She feels that she loses the exploratory capacity and cannot explore suicidal ideation with the client in a phenomenological way, possibly due to her fears and the legal parameters that are restricting her, as she clearly states below.

I think the question of suicide is a really interesting one and I think what it brings up for me, in particular, is the difference between how you might approach it from a psychological point of view and the kind of legal parameters or restrictions. For me, there is kind of entrenchment between these which are difficult to balance them against each other. (Zoe)

Zoe suggests that her concerns about the legal parameters have become so firmly established that she is experiencing a difficulty allowing herself to explore suicide ideation in depth and balance the weight of the psychological perspective with the legal parameters.

Zoe is feeling constrained by the law, as there are things that she is not allowed to do because she has to follow the ethical guidelines:

Ehm and yes, the idea of the law coming into the therapy room, I find that very difficult, so the idea that I have to do certain things, there are certain things that I can't do because of the law. But I then become aware of myself and keeping myself safe and what am I doing. Could what I am saying be seen to condone suicide, it is difficult because I think people have the right to kill themselves. (Zoe)

While Zoe is working with a suicidal client, she does not feel free to be herself and explore the notion of suicide unreservedly because she has to take the law into consideration, as well as her and her client's safety. In the room, she is not just with the client, but she is attentive to what the law says and that the default is to prevent an individual from killing themselves. Her ideology about suicide might cause dissonance with systems ideology, as she does not strongly subscribe to the idea of suicide prevention; rather, she believes that an individual has the right to choose to end their own life.

Sub-ordinate Theme Two: We Can All Be in that Chair

Suicidal thoughts or ideation are experienced as something common and typical to be shared in a therapeutic session. Participants recognise that they cannot shy away from working with existential issues or suicide risk, as it is part of the job. Existential questions and suicidal ideation are normalised by professionals, as they can understand and make sense of why they might exist.

Olivia suggested that with a lack of purpose, she could just as well be in her client's shoes:

I understand that without that sense of purpose I might lose myself actually. Without that sense of purpose, I might lose that passion that vitality for life, so then that enables me to think that well without this I might be that person in that chair. (Olivia)

Olivia normalises the despair that might lead to thoughts of ending your own life. This allows her to empathise with the client and realise that she could be sitting in the client's chair.

Olivia continues her reflections by saying:

I always think that when we train as psychologists there is this view that we are somehow different because we have this lofty training, you know we do these doctorates, we get these letters after and before our names, almost like that separates us from others. Actually, no we are just sitting in a different chair. (Olivia)

Olivia illustrates the idea that people perceive counselling psychologists as different individuals, who have acquired advanced knowledge which places them in a more advanced position than individuals who struggle. On the contrary, she says that '*we are the same*' as clients with suicidal ideation because we are all human beings living a life, which can be difficult and disappointing at times.

However, an important message from Olivia is the following:

…if you connect to what makes you strive, what connects you to your own sense of purpose, you can connect to that within clients as well or the absence of it that they might feel. (Olivia)

Her statement above indicates the importance of enhancing self-awareness and identifying her personal sense of purpose, which helps her connect with the client.

Likewise, Henry said:

…how little sense reality makes and of course suicide will be the fantasy of pressing the escape button again and again and again. (Henry)

Henry suggests that reality might be difficult to understand, therefore having thoughts of ending your life can occur naturally.

And that creates a debate, is life worth living? And everybody is happy to say 'yes it is!' [exaggeration]. These clients have the strength of a despair, but now you see it actually begs the question. Is it? Is it worth living? (Henry)

Henry seems to be questioning the purpose of life and clients' suicidal ideation might raise thoughts for him regarding the meaning of life. He also notes that most people support that there is a meaning to life and it seems as if he is irritated by the buoyant and optimistic worldview of those individuals. He also highlights that there is a strength within the despair.

Peter demonstrates his understanding of the presence of suicidal ideation with the following:

The routine, the monotony, the lack of future orientation can be enough to kind of think you know what, escape would be a great thing to do. (Peter)

Peter rationalises that the lack of future orientation might lead to suicidal ideation. He empathises with the client and understands that suicide might seem like an option for a client who cannot see a light beyond his difficulties.

Fiona says the following:

I think from that early experience of thinking that I will never work with death [laughter] or suicidal thoughts, which is crazy because it manifests in some shape or form through this work and to where I am now. (Fiona)

Fiona believes that it is ironic that she thought that she would never work with clients who present with issues such as feelings around death or suicidal thoughts. She has realised throughout her personal and professional journey of life that death and existential issues are central parts of our life cycle, which will inevitably appear as a point of discussion in therapy.

Sub-ordinate Theme Three: Not a Deity

The respondents who participated in this study acknowledged their limits as counselling psychologists. They acknowledged that they have to settle with the idea of a potential suicide and accept that it is out of their power and control to prevent all

suicides. Although it is their duty of care to try to help an individual in despair, there are some boundaries that cannot be crossed.

If the person is going to do it, they are going to do it, I kind of come to that place. (Alice)

Alice's disclosure indicates that she is coming to terms with the fact that she cannot prevent someone from ending their own life, as it is a personal decision. Her statement indicates that she was struggling to accept it but now with the benefit of experience she is trying to reconcile with it.

Similarly, Henry said:

I let go of my desire to have the power to change their minds, to save them. (Henry)

Henry sounded disappointed as he said that he has given up on his desire to change clients' mindsets and prevent them from a potential suicide. He no longer believes that it is part of his job to '*save them*' and his words hint that he has lost hope. It sounds as if he is trying to ground himself and become more pragmatic by eliminating his own desires.

It can be suicidality of patients who actually have nothing to live for, very sadly they have absolutely nothing to live for. At that point, I cannot tell them anything, especially in the IAPT service that I used to work. I couldn't but join in the hopelessness. In my head I was thinking yes you have nothing to live for, sorry. There is no amount of CBT that will fix that. (Henry)

For Henry, a client's wish to end their life can make sense and it seems as if he can be convinced by the rationale of the client or their presentation. In that case, he feels unable to change the client's mind because he believes that it is out of his power or control to change the worldview of the client. In addition, it seems as if he is doubting the effectiveness of the CBT model. Henry appears to have lost hope for some clients and some therapeutic approaches in regard to helping an individual overcome suicidal

ideation. The phrase '*yes you have nothing to live for, sorry'* signifies his cynical way of approaching this matter and possible numbness that he experiences.

Imagine being thrown in a football game and before you go in, they cut your arms and your legs and you are expected to play well and not complain about it. What's the fucking point? And then you assign me to that crippled person that crippled football player and you say make them feel good about themselves while playing the football game. The best that I can do 'see the ball, touch the ball, feel the ball, be mindful about the ball', bollocks. (Henry)

Henry at this point in the interview was referring to the co-occurrence of suicidal thoughts and chronic fatigue syndrome, which underlines the multidimensional nature of suicide. He refers to this and similar conditions as '*crippling conditions'*. His description of the football player evokes vivid and distressing images, and from his words, it seems that he does not feel hopeful for this individual, as he feels that as a practitioner his powers are limited and do not allow him to change the condition of the individual. The participant seems to be feeling irritated that he was assigned to such a client because he doesn't feel that he has enough support to offer, and that possibly if he was in his client's shoes, he would feel hopeless too. His quotation signifies that working with some suicidal clients might be experienced as a lost game from the beginning. The cynical description and wording are remarkable, and mask his anger or sadness.

Similarly, Peter shared his dissatisfaction and disagreement with the idea that all suicides can be preventable:

…this nonsensical idea that we have that we can prevent all suicides, how is that possible? I am not a deity, I do not have supernatural powers, if somebody leaves my consulting room or leaves my service and goes and kills himself, I have no power to prevent that. (Peter)

It is evident that Peter is annoyed by this idea that many systems and organisations hold. He strengthens his point by saying that it is beyond our powers as human beings or as counselling psychologists to protect individuals after they leave the service or

the therapy room. He raises the question of whether it is possible to prevent all suicides, which opens up a big area of debate in our field.

From a similar standpoint, Ivy rejects the role of being a superhuman, as being able to stop someone from ending their own life after they leave the room exceeds her personal assessment of what is feasible or possible to do as a psychologist.

…if someone is going to do something, they are going to do it and you know as a therapist we are not superhumans. (Ivy)

Fiona echoes a similar feeling:

So, I guess on a personal level that is something that I need to wrestle a bit with sometimes in supervision of not taking on that feeling that you need to be an all-powerful therapist and fix everyone. (Fiona)

Fiona is trying to reconcile with a potential suicide and accept that as a therapist she cannot 'save' everyone, which is something that she is willing to explore further in supervision. This demonstrates that Fiona is still having many expectations of herself as a professional, which can lead to many responsibilities resting on her shoulders.

Super-ordinate Theme Five: Feeling Vulnerable

The idea of suicide has evoked several emotions in the present participants, as it seems to place them in a challenging and vulnerable position. Feeling anxious, fearful or angry are some common emotions that counselling psychologists experienced working with this client population. Participants' responses have indicated that the threat of litigation of malpractice plays a significant role in how they respond to working with suicide risk. The first sub-ordinate theme in this section is therefore, The Law Is in the Room, whereby participants feel that they are in a difficult position because of potential legal implications. Additionally, some counselling psychologists demonstrated that they are sometimes questioning their abilities and readiness to deal with this issue. Participants have disclosed that they do not feel prepared emotionally

or professionally, which is linked with the second sub-ordinate theme, Not Prepared. Counselling psychologists in the current study reported that working with death and suicide can be a solitary endeavour. Therefore, Feeling Alone is another sub-ordinate theme, which demonstrates the vulnerability that practitioners feel in managing the risk, particularly in private practice. Last but not least, counselling psychologists experience an enormous and inevitable sense of responsibility, as illustrated by many excerpts. Hence, Sense of Responsibility was identified as a key and recurrent sub-ordinate theme, which describes how responsible counselling psychologists feel for their duty of care or sometimes for a client's life itself.

Sub-ordinate Theme One: The Law Is in the Room

This theme represents the vulnerability that counselling psychologists feel due legal obligations and the related consequences and procedures following a suicide. Participants indicate that they are concerned about legal implications that could threaten their professional identity.

Henry, as is evident below, has predominantly expressed his worries about the possible consequences that might arise after someone has ended their life:

> *I always thought that I would be fired because I didn't tick the right boxes, or that I didn't ask the right questions or didn't get the right answers or was not specific enough. (Henry)*

Henry has expressed in many ways both implicitly and explicitly his fear of legal consequences from working with this client population and how much a client's suicide could potentially affect his career and professional status. His account emphasises the importance of the practical work that needs to be done, such as completing the appropriate paperwork, ticking all the boxes, and asking relevant questions. Henry's vulnerability is clear from his disclosures, and it seems that his confidence can be shaken when he considers that his career '*may rest upon the shoulders of the suicidal clients*' or upon paperwork. It seems that he does not feel secure in his job and he is questioning his skills and ability to follow protocols or assess risk.

Henry continues by saying:

Of course, it is not their fault, these are the means of communication and they are communicating something to me, it just so happens that what they are doing in my own silly fantasy also risks my career because if they then go and kill themselves, a crafty lawyer somewhere, a very pissed off parent and a very hurtful family member might say yes but they scored this on the questionnaire and then everything collapses and people can just roll you up in a piece of paper and I hate that, it sucks. (Henry)

Henry is aware that suicidal thoughts can be used as a metaphor and that clients might have different intentions when they are sharing them with their therapist. However, he cannot avoid thinking of the potential danger of litigation and accusation of malpractice following a client's suicide. His words '*silly fantasy*' reflect his understanding that his fears might not be real. However, he suggests that if there were signs or evidence of suicide risk prior to a client's suicide, then he could undoubtedly be criticised for his work and have to deal with any legal consequences. He feels fragile, as he suddenly feels that his professional identity is under threat and that circumstances could put him in a position where he might feel trapped or exposed. It appears that he feels annoyed and irritated by the harm that a suicide could do to his career, which is hinted at from the expression '*it sucks'*. As he is expressing his thoughts it seems that his fears and anxieties are escalating. His tone of voice becomes more dramatic and intense when he describes how other people might get involved in the case. It is apparent from Henry's report that his instant reaction is to distance himself from the client by thinking about his career.

Zoe is also preoccupied by the fear of legal consequences, which makes the work with clients with suicidal ideation a scary territory:

And then as a practitioner, I think it brings up feelings of, I think it is a situation, which I feel particularly vulnerable as a practitioner because I am very aware of potentially being drawn into you know a kind of a coroner court or some legal kind of wranglings. (Zoe)

Being vulnerable is part of the human condition and refers to the effects that a person or a situation could have on another person. Here the participant refers to the vulnerability that she feels as a professional and how her work could come under the spotlight should a client decide to end their life. The use of the idiom '*being drawn into'* shows how unpleasant and difficult it would be for Zoe to be involved in investigations due to a client's suicide. Zoe has a knowledge about the process following a suicide, which makes her self-conscious and scared when working with suicide risk.

Additionally, Zoe becomes more vigilant and cautious:

I am suddenly very in the room, my needs are in the room, the law is in the room and all of these things are in the room and can become very pragmatic. Yeah, so I hate that, what it does to the work, there is a loss of that exploratory capacity but maybe that's coming from my own fears and why can't I just explore it, yeah, interesting. (Zoe)

The law is present in the room, which makes Zoe feel paralysed and vulnerable. She feels that the therapeutic work is affected, which annoys her. It sounds as if she loses her professional identity and she freezes, as she is feeling observed and possibly assessed. Zoe has repeatedly mentioned that her reflection around this topic feels limited and that the legal precautions and parameters reappear in her mind.

Similarly, Peter says that if somebody ended their life, he would feel personally and professionally affected:

…so not only there is a personal impact if somebody completes, so you kind have to question well ok did I do everything okay, were there things that I have left out, you know with the things that I didn't spot, then you have to think that there is somebody external alongside with the police investigation, there will be external people, senior in your organisation that would then lay eyes on your work and kind of think about well ok did Peter do everything that he could, that we would expect of him, which is reasonable and if not well that I would become accountable for them, so why I may have done that. (Peter)

Peter said that following a client's suicide it is natural for him to question his work with the client and to wonder whether he has missed anything. Despite his own doubts and insecurities, he has to deal with other people's investigations, which might put him in a difficult position as his work might be questioned or assessed. If errors are identified, then he would be considered responsible for them. Peter throws the spotlight on to the aftermath, in which he would have to deal with legal procedures or consequences.

Sub-ordinate Theme Two: Not Prepared

This theme refers to the start of the journey of becoming a counselling psychologist and the training, which was not considered to be adequate for the preparation of working with clients with suicidal ideation. Psychologists claimed that they did not feel sufficiently ready emotionally or professionally to work with this sensitive issue. Participants have suggested that they question their skills and experiences in the presence of a suicide or the possibility of a suicide.

Alice states:

I didn't feel like I had as many tools or knowing what to do with all the emotions that it evoked. (Alice)

Alice suggests that the emotional impact is huge, which leaves her unprepared to cope with it. This indicates that Alice is significantly moved by clients' disclosures and is overwhelmed by several emotions.

Zoe is feeling scared and fearful of a potential suicide and questions her abilities:

So, I definitely have a sense I suppose of an imposter syndrome, which is more like a sense of I can quite even unqualify, so if somebody is telling me that they are planning to kill themselves this is so what can I do with this. I feel so, not to say deskilled but definitely, it makes me feel less I suppose because of the enormity of what the client is bringing. (Zoe)

The enormity and absoluteness of suicide make her feel numb and powerless. She is experiencing difficulty self-affirming her abilities and competencies. Zoe feels 'young' as a practitioner in the presence of clients who express suicidal plans. Her inner narrative is that she cannot support the client and that she does not have the required skills to work with suicidal ideation. Her inner dialogue could perhaps limit her courage and exploratory capacity working with these clients.

According to Peter:

…it often causes us to feel inadequate, it often causes a crisis of confidence if people go into completion. (Peter)

From Peter's experience, a successful suicide can make him feel less confident and a personal and professional crisis might be experienced. This indicates that as a professional he was not feeling prepared to deal with the loss of a client due to suicide.

Ivy stated the following:

No one trained you to deal with the emotional impact of this or whether you carry it when you leave the room or dealing with that sense of responsibility, and I think that is probably what you take to the supervision and so there is no particular training around that. (Ivy)

Ivy emphasises that although she has received advanced training and she knows the steps that are required to be followed, she was not trained in managing and regulating her emotions when working with such distressing difficulties. It seems that Ivy feels disappointed that she did not receive relevant training to deal with the emotions evoked and particularly her sense of responsibility. This indicates her desire to be able to acknowledge, process and bracket her personal reactions and feelings in response to clients' disclosures.

Ivy suggests that it is a myth that with experience the emotional impact lessens:

My thoughts as a practitioner are that [pause] I don't think it gets easier, you know the more, there might be an assumption that the more people that you get exposed to that have that you know have these ideas that in some sense you know you could manage it. (Ivy)

She suggests that each individual and each case is unique, and therefore it might be as if you are working with suicidal ideation for the first time. Ivy suggests that she has not been desensitised by working with suicide risk, as each case is different.

For Fiona, working with death and suicide was overlooked in her training:

I mean in my actual training we touched on things like risk assessment and suicidal thoughts, but not in too much depth about how to actually work with that. So, when I was confronted with that as a trainee for the first time, I felt completely out of my depth and very unskilled [laughter] and a bit clueless about what I was really doing. The learning really came from talking about that in supervision as opposed to being given a great deal of direction in my training. Even though it was a great training, it was very thorough, but I feel that was an area that was a bit glossed over. (Fiona)

Although topics such as risk assessment and suicidal thoughts were mentioned throughout the training, there was not enough emphasis on it and how to work with it in real life and in real time, which seems to have made her less confident or secure in working with such an issue. She said that once she became exposed to clients with suicidal ideation, she learned how to deal with these challenging issues. This hints that her knowledge and skills were developed with actual practical experience. From her accounts, it is implied that she would have benefited from further training in this area.

Sub-ordinate Theme Three: Feeling Alone

This theme underlines how lonely an experience it can be for counselling psychologists to work with clients' suicidal ideation. Psychologists consider private practice more challenging when working with this client population because there is no system or organisation around them to contain the risk and support them. Also,

doubts about their choice of career come to the fore, as is evident from Alice's words below:

I have always felt very alone with the work so, I don't know if it is because everyone is working so hard in giving so much to the patients or clients, however you want to describe it, that they do not have anything to give to each other but I just feel and it makes me a bit angry sometimes that you know I have chosen an industry and this is all my choice and think it is more feeling angry with myself than anything else because I chose an isolating industry and I am isolated with the responsibility of this. (Alice)

Managing risk and exploring suicidal ideation can be driven by several emotions that can leave Alice feeling alone. She suggests that being a psychologist is an isolating job and that sometimes carrying the responsibility of a potential suicide or attempt can be distressing. She states that she feels angry with herself that she has chosen this career because often she feels alone with the responsibilities. She is disappointed that other professionals do not provide her with adequate support and she is trying to make sense of it.

Furthermore, Zoe is feeling alone when she is thinking of a potential suicide:

So, I think if clients were to kill themselves then it would be essentially, well, they would be dead so they couldn't say anything about, it would be my word and that's it. (Zoe)

From the above quote, it seems that Zoe would feel alone in the occurrence of a client's suicide. Although working with clients is a relational process, following a suicide, she is really the only person who can protect and defend herself. This indicates that she might feel exposed, which might make her feel more vulnerable working with suicide risk.

I think it is important for us to know what the law is and to think about how that links with HCPC and BPS guidelines but not to the extent that we are so scared and

paralysed. I am not sure if this is just my reaction or if other people feel the same way. (Zoe)

From the above segment, it seems that Zoe is not sure whether her response is common and questions whether or not she is the only one who has such a strong reaction to suicidal ideation. She is scared and paralysed by the possible legal implications and is unsure how the law is linked to the HCPC or BPS guidelines. She suggests that it would be beneficial if psychologists received further education and guidance in working with suicidal ideation.

Similarly, Olivia suggests that when you are working in private practice you do not have a system around you like in an NHS setting, where you work alongside other professionals, such as GPs or psychiatrists:

..in the NHS now we have this big system around us (..) In private practice I don't have that, it is me in a room, sometimes in a house on my own (…) I was doing some trainee evaluations and one of the questions is about working within the limits of your competence, you know, thinking about working safely. (Olivia)

Olivia reports that as a lone psychologist, she has to take into consideration more parameters to ensure ethical practice and that she is working within her competence.

Fiona says that she feels worried and upset working with clients with suicidal ideation in private practice:

I do feel quite sad and concerned and especially working in private practice where often you know there is, you don't have that kind of web of care around you so you actually have to create it by making contact with doctors, psychiatrists, just to make sure that there is enough support in place because obviously in private practice you only see the person once a week and not really having much clinical contact. (Fiona)

Working alone requires extra preparation and more precautions to be put into place. According to Fiona, every practitioner has to make sure that there is enough support to protect themselves and the client.

Sub-ordinate Theme Four: Sense of Responsibility

Participants experience a sense of responsibility due to the nature of fulfilling their professional role as counselling psychologists. Participants acknowledge that they have to be responsible to the client and listen to their distress and act appropriately. They cannot avoid feeling responsible for the client's life, although they have come to the philosophical conclusion that each individual is autonomous, and a suicide is a personal decision. Counselling psychologists are demonstrating an attempt and effort to reject the grandiose position of being responsible for a client's life and actions.

Alice stated the following:

I do have a sense of responsibility even though I know that I am not responsible for that person and their life in a lot of ways. (Alice)

Alice views the sense of responsibility, as something that is present and inevitable, although she is aware that it is not reasonable or necessary.

…he was really alone and the weight of responsibility of him not having a sort of support network, it really hurt me actually. (Alice)

Alice expresses an internal pain that she feels when she feels that the client does not have another person in his life that cares about him. This increases the weight of responsibility on her shoulders.

Zoe, in attempting to articulate how she is experiencing working with this client population, states:

Ehm I think the sense of criticality, I think the ultimate fear is that if I do something wrong, whatever that might be then this person could die. (Zoe)

Zoe expresses a fear of doing something wrong, especially because of the seriousness and absoluteness of suicide. This implies a huge sense of responsibility that she feels in terms of the role she might play in the client's decision.

The phrase below grabbed my attention and acted as a key for understanding the experience of Henry, as it illuminated interpretations.

I cannot obsess over sugar when I am making a cake but if I spill sugar all over me, yes, I have to somehow clean it. (Henry).

Henry's somewhat puzzling phrase proved highly revealing, as it gets to the heart of his whole interview. This statement shows how Henry normalises suicidal thoughts and separates himself from the client's difficulties. According to his remarks, he is not affected by their suicidal thoughts, as they do not involve him, and they are not personal for him. Yet if the client's suicidal thoughts in some way make him feel involved, then it can have an emotional effect on him. The anxiety and sense of responsibility experienced are due to the fear for his career and possible legal problems, which is also evident in the quotation below:

So there is the sense of responsibility but it is very cynical for me, it points towards covering your own ass. (Henry)

He feels a sense of responsibility to protect himself from subsequent legal penalties or criticism. The way he expresses himself is coloured with cynicism and frustration, which underlines his fear of losing his professional identity.

Paige indicates that if a client refuses to disclose their plans for ending their life, she feels a huge sense of responsibility:

I just thought I can't let you go,[frustration] I don't know what you plan, I can't, I felt it was my responsibility and of course you know as a counselling psychologist you know we are taught to, you know it is not about trying to persuade people to do things that you think they should do, it is all about what does the person want and so on, but in that situation, it is like no I can't just let you go off and perhaps kill yourself and you know then I would feel that I didn't do anything to help. (Paige)

Although she honours the humanistic nature and ethos of Counselling Psychology, to encourage client's agency and independence, working with this issue makes her want

to derail from that path. It seems that the dread of feeling guilty of someone's suicide increases her sense of responsibility to take action.

Olivia acknowledges that she is responsible to the client and not for the client:

They are responsible for themselves, so I will work with them, but they have to meet me halfway or maybe even further halfway, right? They have to kind of bring 70% and I have to bring 30%. (Olivia)

She highlights the importance of sharing the responsibility with the clients, as therapeutic work is relational and a two-way process and interaction.

Peter suggests that he is accountable to his profession, traditions, rules, and the engagement of psychology:

Well, I think we do have a responsibility to listen and to respond appropriately and to ensure that you know we have done everything that we can to ensure our client's safety, that's my responsibility. (Peter)

He acknowledges that he has a duty of care, where he has to follow a particular protocol, take a client's suicidal thoughts seriously, and respond accordingly.

Ivy stated:

I feel a sense of responsibility when I am in the room but once they have left, I have no control over how their behaviours are going to be. So, I also have responsibilities outside of work and I have a life and I feel that if you don't have boundaries in terms of between your professional and your personal life then it can really have a negative impact on your wellbeing. (Ivy)

Ivy is capable of leaving the responsibility in the room, as she recognises that after the therapeutic session, she does not have any control over the actions of the individual. She has set some boundaries between her work and personal life; therefore, she closes the door whenever she leaves her practice and returns home.

I have to take it very seriously and I have a responsibility for this client's welfare, and I have to sort of make a judgment. (Ivy)

Ivy continues by saying that she experiences a sense of responsibility to make a judgment call, which can be challenging. Making a judgment itself requires a degree of responsibility to make a decision and rely on your instincts, as there might not be sufficient evidence or firm rules to help you, as each case is different.

Fiona's emotional experience is like a roller coaster with its ups and downs:

So, for me, it is a bit of a journey as well, the sense of hopefulness and then relief and again when they leave if they do not feel safe then it is again sitting with that kind of responsibility and just being mindful of them. (Fiona)

Here the sense of responsibility has a different flavour. It emphasises the responsibility to be attentive and caring for the clients.

Summary

Working with clients with suicidal ideation appears to be a sufficiently complex and multidimensional phenomenon that can emotionally affect both clients and counselling psychologists. Participants' accounts show that working with clients' suicidal ideation can be delicate, challenging and demanding. Also, suicidal ideation is considered to be a natural response, as the tendency to want to escape is inherent in all human beings. Although working with this client population is viewed to be 'part and parcel' of a counselling psychologist's job, inevitably clients' disclosures about a potential suicide do not leave professionals untouched and it is evident that there is also a level of tension in the therapeutic relationship. The overriding feeling of trepidation about the client's safety was noticeable, as well as participants' sense of urgency to follow protocols, protect themselves and respond to the client. Many participants shared that protocols, different ideologies and the law can make them feel constrained in their exploratory capacity but also affect their concept of professional identity and put their career at risk. Counselling psychologists are attempting to reconcile with a potential

suicide and accept that they do not have superpowers, and are not responsible for their clients after they leave the counselling room. Last but not least, an important point was that working with this client population can feel like lone working. This can be because the practitioner is working privately but also because of the sense of responsibility and the number of tasks that a practitioner has to handle by themselves. Maintaining confidentially about such a serious issue can make practitioners feel like lone psychologists who are shouldering a lot of pain.

Discussion

Overview

The final chapter of this research project aims to summarise the findings of this study to enhance our understanding regarding counselling psychologists' experiences of working with suicidal ideation. Responses and attitudes towards suicide risk are complex and multidimensional; therefore, the findings of this study ought not to be explored from a simplistic viewpoint. The current chapter commences with a discussion of the key findings in light of previous research studies and existing theories. Then the strengths and limitations of the research study will be outlined. A section suggesting areas for future research and implications for training and practice will follow. A reflection section focusing on my latest personal experiences of working with such a sensitive issue will also address some additional suggestions and considerations for future training needs. Finally, in my conclusion, I will reiterate the aims and goals of this study.

Exploration of Themes in Light of Existing Findings

Therapeutic Relationship

The therapeutic relationship, which was a super-ordinate theme identified in this study, has received great attention in research studies in relation to working with suicide risk. Findings of this study demonstrated that psychologists' emotional reactions can affect the way they experience their clients, which consequently does not allow the therapeutic relationship to remain unchanged. Similar to all kinds of relationships, which require the involvement and engagement of two people, the therapeutic relationship can be affected by what the client has disclosed. Findings of this study highlight that the therapeutic relationship cannot be developed solely with the efforts and good intentions of the therapist because it is a two-way interaction.

According to participants' narratives, developing and maintaining a secure bond with clients with suicidal ideation appears to be a challenging task. However, irrespective

of the therapeutic approach used, the therapeutic relationship is central to the therapeutic work. As Thomas and Leitner (2005) stated, the relationship might be a key factor and more critical when mental health professionals are working with suicide risk. Gooding et al. (2013) have suggested that the strongest determinant of an intervention is the therapeutic relationship. Additionally, the working alliance has been found to decrease suicidal thoughts and attempts (Dunster-Page et al., 2017). Therefore, bringing to light counselling psychologists' perceptions of the therapeutic relationship while working with clients with suicidal ideation can not only help us understand their experiences but also help us consider how best to support these individuals. The present findings indicate that clients' disclosures about suicidal thoughts or ideation can make counselling psychologists experience the therapeutic relationship as a chess game or a dance. This demonstrates the difficulties that psychologists encounter while they are trying to get 'closer' to clients with suicidal ideation in order to provide support. A sense of withdrawal was also evident from participants' narratives, which shows how strongly clients' presenting difficulties could impact the therapeutic relationship. Despite the delicate issues of working with clients who have expressed suicidal thoughts or ideation, this study recognised a sense of privilege that counselling psychologists experience.

Chess Game or Dance

Counselling psychologists in this study reported that sitting with the vulnerability of clients can bring them closer to them while they are trying to contain their despair. Participants highlighted the importance of prioritising clients' needs by bracketing their personal reactions and letting go of the client after they leave the therapeutic space. This finding illustrates their efforts to respect the boundaries within the therapeutic relationship and to protect themselves with regard to any additional emotional involvement.

Participants in this study experienced their work with suicidal clients as a dance, which highlights the closeness and awareness of therapeutic boundaries to honour their 'partner's' space and personal emotional wellbeing. This finding is supported by how Rasmussen (2005) described the therapeutic relationship as like a dyadic dance that includes reciprocal responses. The dance that was described by the current

participants is not characterised by harmony, as it consists of pushes and pulls of closeness and distance. Although practitioners might try to build a good therapeutic relationship with clients by offering a helping hand, the clients might want to pull away. As Aherne et al. (2018) suggested, this might be because clients might want to end relationships in their lives, including their relationship with their therapist. Therefore, counselling psychologists' duty of care is to remain attentive, not give up on the client and keep trying to find the optimal way to approach the client, which will allow the client to trust them and accept the support offered. In other words, findings of this study indicated that psychologists might have to adapt to a more demanding role when working with suicidal clients, which requires good 'dance' moves to approach and accompany clients to a 'dance' (therapeutic journey) that might not have been previously 'choreographed'.

As noted above, counselling psychologists who participated in the present study reported feelings of closeness that were outweighed by boundaries, which was not only described in the context of a dance but also of a game, such as a chess game. A chess game can be a complex game in which each paw has a specific function. Therefore, each player has to follow specific rules like in therapy maintain boundaries.

According to participants' disclosures, psychologists during therapy with suicidal clients might be invited to play a game with rules that sometimes might be experienced as fair or unfair, which can affect the relationship between them. The nature of the game is recognised by the way in which clients express suicidal ideation and how clear and unambiguous or not their disclosures are. According to the findings, making sense of and understanding the reasons behind a client's suicidal ideation can be important for maintaining a good therapeutic alliance. This finding was also evident from psychiatrists' disclosures regarding experiences of assessing suicide risk (Waern et al., 2016). Similar to this study's findings, participants suggested that making sense of the credibility of what the client was sharing regarding suicide ideation was considered to be an integral part of the assessment process. Having a clear understanding of why suicidal thoughts are present seems to alleviate ambiguities around the client's suicidality and might make the therapist hold a more empathetic stance, show unconditional positive regard, and be warm with the client, which could counter the client's negative feelings, such as shame as described by Jobes and Ballard (2011).

Piper et al. (1991) suggested that if the practitioner has a clear explanation for why the client is behaving in certain ways, they will not experience compassion fatigue but, on the contrary, will experience the pleasure of taking care of another individual and the privilege of being a psychotherapist.

Conversely, if the psychologist experiences clients as dishonest or ambiguous the 'game' might be experienced as unfair. Consequently, as Jobes and Ballard (2011) proposed, the therapeutic relationship might include power differences, feelings of betrayal and feelings of personal vulnerability (Jobes & Ballard, 2011). This demonstrates the potential lack of congruence and moments of rupture in the therapeutic relationship, which could hinder the therapeutic work. However, Safran et al. (2001) have shown that repairing the therapeutic alliance from ruptures can play a significant role in the effectiveness of therapy. It has been suggested that although maintaining a meaningful relationship with suicidal clients can be challenging, it can also be lifesaving (Schechter et al., 2013). An individual who expresses the thought of ending their own life can evoke several emotions for therapists and can change the dynamic of the therapeutic relationship, as the practitioner is trying to keep the individual safe and prevent a suicide (Jobes & Ballard, 2011).

Although the findings of this study emphasised the importance of respecting participants' readiness to engage with therapy by maintaining boundaries to protect themselves and their clients, there is evidence from other studies which supports that crossing boundaries can be therapeutic for a suicidal client. Roman and Whiteman (2012) described crossing boundaries as the deviation from normal therapeutic practice without harming the client. Roman and Whiteman (2012) suggested that in order to enter the world of clients with suicidal ideation, additional and innovative efforts are required that are beyond the usual therapeutic practice. In addition, Bergmans et al. (2009) suggested that boundary crossings, such as personal disclosures, can result in stronger bonds between therapists and clients and consequently lead to a more effective therapeutic outcome. Additionally, it has been predicted that a boundary-crossing might be effective for clients with suicidal ideation as it has been for clients with addictions (Gutheil & Brodsky, 2008, pp. xii, 340). However, the concern here is that counselling psychologists might become more emotionally involved with their clients and the stakes for practitioners might get higher.

The therapeutic connection between a client and a therapist is particularly significant throughout the work with a client who has disclosed suicidality, therefore the lack of it could be a predictor of suicide (Joiner et al., 2009). As Wiseman and Atzil-Slonim (2018, p. 99) suggested, '*When clinicians are caught in complementary interactions, instead of having to choose between closeness and distance, they may try to open up the space to explore the internal battle that is taking place within themselves as well as within their clients. Exploring the longing and dread of closeness and distance may lead to a greater ability to bear conflict in these painful matters and to allow new ways of being together.*' Practitioners ought to be aware of their internal processes in order to maintain a good therapeutic relationship with their clients that will facilitate the therapeutic process. Remaining present with the client by bracketing their own responses and reactions by prioritising the needs of the client can be beneficial for the client and the therapist, who ought to protect their personal and professional identity.

Withdrawal

Counselling psychologists who participated in the current study have expressed a level of withdrawal and distancing when working with clients who have expressed suicidal ideation. Levy et al. (2019) found that if negative emotions are associated with working with clients with suicidal ideation, then the therapeutic relationship can be affected and this could potentially harm clients. Hayes et al. (2011) indicated that not only extreme emotions, such as hate, but also common emotions, including feeling uncomfortable, could harm clients. In their study, a counselling psychologist stated that she was feeling withdrawn from clients, who were experienced as more demanding, which indicates that suicidal clients might require extra support. Pieper (1999) found that therapists feel discouraged, drained or irritable when clients demand more than what is on offer. Moreover, the findings of this study suggested that the therapist might take the role of a significant person in the client's life and then withdraw from the relationship once the client's needs have changed. This is compatible with the view that the therapist's inclination to take care of the client is homologous with the pleasure experienced by a parent, who does not act due to personal motives or out of guilt but due to caregiving motives (Pieper, 1999).

Some counselling psychologists shared that they felt withdrawn from the therapeutic relationship and noticed an urge to 'push away' clients with suicidal ideation. This is a reaction that was also identified by Nicholl et al. (2016), who suggested that the therapist wants to flee from the hopelessness of the client. This could affect the therapeutic work, as the topic of suicide might be avoided and not explored adequately. This response could also be described as a 'flight' response, where the therapist experiences a fear of working with suicide risk and detaches from the client. This detachment could be translated as disinterest to the client in despair, which confirms that people do not care about them (Thomas & Leitner, 2005). This finding adds to the existing literature and suggests that countertransference can be experienced as withdrawal. Countertransferential responses to clients' disclosures about suicide could cause vicarious trauma and 'infect' the process of therapy, making the therapist feel impotent (Pearlman & Saakvitne 1995). On the other hand, vicarious resilience could counterbalance vicarious trauma, as the practitioner can witness the progress of a client who overcomes their hopelessness (Hernández et al., 2010). The present study showed that personal grief and losing a significant person from natural causes while working with a client's suicidal ideation can produce feelings of anger. Personal grief can make the professional withdraw from the relationship, but this study has also suggested that it can be experienced as a significant reconnection with the client who is still alive. As Moore and Donohue (2016) suggested, working with this issue could wound and heal both the clinician and the client. Clients with suicidal ideation can easily identify projected negative feelings in their therapists (Maltsberger & Buie, 1974). The present study also found that spontaneous physical sensations are experienced in response to a client's suicidal ideation, which were similarly identified by Booth et al. (2010). Therefore, counselling psychologists should be aware of their own feelings and experiences and explore them openly in supervision and personal therapy.

Moreover, counselling psychologists who participated in this study shared that they might feel over-concerned about clients with suicidal ideation, therefore detachment could be beneficial for therapists who have found themselves getting more involved than necessary with their clients. This was supported by Galloway and Brodsky (2003), who also claimed that caring less might be more productive when working with certain client populations. They proposed that it is important for psychotherapists in their early

years of practice to acknowledge the effectiveness of therapeutic detachment in working with specific client populations, such as individuals with personality disorders. Galloway and Brodsky (2003) demonstrated that a distant and detached interpersonal style might be helpful when working with a challenging client, as it can help the therapist focus on the therapeutic goals.

Privilege

An important finding of this study is that the therapeutic relationship is coloured with a sense of privilege and honour while working with clients with suicidal ideation. Although the sense of privilege is not a common or recurrent theme in the literature regarding working with suicide risk, it has been also identified by other researchers (Moore & Donohue, 2016; Nicholl et al., 2016). Participants in the current study felt honoured that clients were trusting them with something undoubtedly deep and personal. They also suggested that being able to endure and contain clients' helplessness and hopelessness is a unique power. As Michel et al. (2002, p. 430) proposed, it is a '*shared experience in which narrator and listener learn together about a life of pain and failure, ... [which is] instrumental in re-establishing the teller's broken sense of self*'. This highlights the importance of recognising and accepting the pain of the client and offering them a safe space by listening without judgment.

The sense of privilege that counselling psychologists experienced was also psychological and academic, which indicated that they felt resilient and secure in terms of their existence in the world and their professional status. Participants in this study conveyed that they felt a sense of privilege and honour from being part of this field and part of a community that can offer significant care to individuals in need. This is in line with Moore and Donohue's (2016) findings highlighting the ethos of clinicians who acknowledged the value of being part of a larger resilient and specialised community.

The Overriding Feeling of Trepidation

Counselling psychologists in this study have been found to be invaded by intense feelings of anxiety, worry and fear, which is in line with existing findings. Clients' suicidality can provoke basic and natural human feelings in the therapists (Grad &

Mitchel, 2004). Working with suicide risk is undeniably difficult and a recurrent issue in the field of Counselling Psychology. As has been suggested, it has been a constant matter of discussion and concern since 1965 (Litman, 1965).

Ellis and Patel (2012) have found that practitioners who work with clients with suicidal ideation experience increased levels of stress and anxiety. However, in the literature, it is well established that anxiety-related feelings can affect practitioners' clinical effectiveness (Beeson, 2014; Whitfield 2011). Taking into account the significant negative emotions that are often experienced when working with clients with suicidal ideation, such as anxiety and fear, is crucial, as the projection of therapists' feelings towards clients is inevitable (Richards, 2000). These responses can have unintentional negative effects on the individual who is experiencing suicidal ideation. In line with the present findings, there is a growing literature that suggests that practitioners experience different emotions, such as fear, panic, anxiety and feelings of incompetence, when working with suicidal clients (Pompili et al., 2002a; 2002b; Reeves & Mintz, 2001; Richards, 2000). Similarly, Panove (1994) found that counsellors' responses to suicidal clients were coloured with anxiety, depression and anger.

According to the present findings, counselling psychologists' overriding feeling working with this client population was trepidation. As described in more detail below, they felt uneasy and apprehensive working with clients with suicidal ideation because of the inevitable sense of uncertainty that they experienced about clients' safety, intentions, risk and their own duty of care. Due to their intense emotional reactions, it was evident that they could not always shake off what the client had disclosed to them, which resulted in taking clients' problems home with them.

Sitting with the Uncertainty

Participants in this study reported that their anxiety was heightened because of the worry and uncertainty about whether the client would be alive to attend the next session. This is in line with what Schechter et al. (2013) have suggested, who highlighted the uncertainty that is experienced once the client leaves the counselling room. As they suggested, there is a risk that the increased anxiety experienced could

make practitioners become less attuned to clients' needs. Moreover, Spielberger (1966) has made a distinction between state anxiety and trait anxiety. He said that state anxiety is a temporary emotion when an individual is experiencing physical arousals and is consciously aware of feelings of tension and uneasiness, while trait anxiety is mostly stable over time and is characterised by the predisposition of each individual to respond. Brown and Range (2005) suggested that if someone with high trait anxiety shows increased vigilance in comparison to those with low trait anxiety, then that form of anxiety could facilitate discussions with clients with suicidal ideation. This suggestion does not propose that trainees' and psychologists' felt anxiety is beneficial when working with suicide risk. On the contrary, findings of this study and previous studies recommend that extra practical and emotional support is crucial for practitioners who work with this client population, as they have to learn how to soothe themselves cognitively, physically and emotionally.

This study has found that counselling psychologists struggle to sit with the uncertainty regarding clients' ambiguous disclosures and statements about their suicidal ideation or intention to end their lives. Participants expressed a persistent anxiety and frustration when they could not be sure about the next moves of their clients. Similarly, Nicholl (2016), who conducted a narrative analysis and analysed the stories of five psychotherapists, identified the sense of uncertainty that practitioners experience while working with clients with suicidal ideation. The suggested sense of uncertainty was specifically about the reported feelings of indecision and doubts with regard to referring clients to other professionals or breaking confidentiality. However, participants in this study put greater emphasis on the uncertainty regarding suicidal clients' actions or intentions and the uncomfortable and overwhelming feeling of having no control over what might happen once the client leaves the therapy room. According to the present findings, it seems that the sense of uncertainty experienced while assessing risk is an ordinary part of counselling psychologists' jobs, which is similar to what psychiatrists reported in Waern et al.'s (2016) qualitative study.

Taking the Client Home

Many counselling psychologists who participated in this study shared that they were worried and concerned about clients' suicidality, which led them to think of their clients

when in their personal space. Participants' narratives demonstrated that they carried their clients home due to the regressed transferences and the uncertainty of a potential suicide, as has been suggested by Paris (2017). This was attributed to clients' ability to get under the therapist's skin (Moore & Donohue 2016; Paris, 2017). A novel and interesting finding of this study is that some counselling psychologists have the need to talk about clients' suicidal disclosures with a close person in their life, which hints that they feel alone. It indicates how unbearable it is for them to hold that weight of responsibility and worry about somebody's life. This finding highlights the importance of developing a buffer between a counselling psychologist's personal and professional life. Although it was noticeable from participants' narratives that they are well aware that they cannot control whether or not the client will end their life, as it is considered to be a personal decision, anxiety is possibly inevitable in such a high-stakes uncertain situation (Bongar & Sullivan, 2013). Findings of this study, which is in line with what other researchers have suggested, indicate that practitioners are fearful of losing a client to suicide and worried about whether or not the clients are going to protect themselves and follow the safety plan after they leave the counselling room (Ellis et al., 2018).

It is significant that participants were able to recognise their feelings, thoughts and behaviours in response to clients' suicidality. Having negative responses to clients could affect the therapeutic relationship and prevent working in a constructive way. Systematic self-reflection can help practitioners notice signs before becoming overly affected by clients' disclosures (Ellis et al., 2018). As Brems and Johnson (2009) suggested, if the therapist engages in a continuous self-exploration while working with suicide risk, it is equally beneficial for both the therapist and the client. Recognising and accepting thoughts and feelings can be effective for the whole process. I would like to note that it is important to cultivate acceptance for things that professionals cannot control or cannot predict. Also, coming to terms with the sense of uncertainty might aid this. As Sommers-Flanagan and Sommers-Flanagan (1995) argued, '*clinical objectivity and effectiveness is enhanced when practitioners have a high level of self-awareness about their underlying personal biases and vulnerabilities*' (p. 41). The findings of this study concerning the overriding feeling of trepidation emphasise the need for self-care and the option of personal therapy for managing negative emotional reactions or responses to clients' suicidal ideation. Last but not least, as Bongar (1992)

stated, it is imperative for practitioners to be aware of their emotional tolerance when they work with this client population.

Sense of Urgency

A heightened feeling of urgency was sensed while working with clients' suicidal ideation. All participants throughout their narratives paid special attention to show that they were complying with ethical practice, were listening to clients' disclosures, were assessing the risk and were following protocols and guidelines on time to protect themselves and their clients. Evident was their urgency to 'put a different hat on' and turn their attention and focus of the therapeutic session to clients' suicidal thoughts or ideation. Counselling psychologists felt a sense of urgency to do what they were required to do to protect themselves personally and professionally. They suggested that it feels as if life or death is in the room, which requires an immediate response from them that makes them more alert during their sessions with suicidal clients. All these findings (sub-themes) add to the existing literature; however, the sense of urgency was not explicitly named as a recurrent theme of how professionals experience working with this client population.

Put a Different Hat On

Counselling psychologists who participated in this study reported that in the wake of the presence of suicidal thoughts they became more vigilant and focused on assessing suicide risk. In this study a change of mode was apparent, which is described with the sub-theme 'putting a different hat on', which is similar to the 'fight' response identified by Thomas and Leitner (2005). They suggested that therapists respond in an active and aggressive way that takes agency and control from the individual with suicidal ideation. The pressure to follow the protocol, assess the risk and complete paperwork adequately was evident in this study. Risk assessment and note-taking appeared to become practitioners' priority when they faced a client who expressed a level of suicidal ideation. This was also echoed by Macleod (2013), who suggested that this pressure could fuel professionals' anxiety due to the concerns about a client's safety, fear of potential death, and disruption of therapeutic work. However, the paradox is

that a therapist's anxiety about a client's safety can weaken empathetic attunement (Schechter et al., 2019).

Practitioners in the current study described that there were disruptions to the therapeutic work and process, as the focus of the work was directed towards suicidal ideation. It has been suggested that in person-centred approach the importance of sharing power with the clients might be hindered if a formal risk assessment is carried out (Merry, 2002). Moreover, several risk assessment tools that are commonly used by social workers, psychiatrists and psychologists might not be compatible with the usual counselling process (Reeves et al., 2004). Previous research findings that explored counsellors' experiences of working with suicidal clients found that a few of them named or talked about suicide or asked explicit questions to assess the risk. In a video training resource from Manchester University (2002), it was suggested that mental health practitioners, due to their fear, avoided asking questions about suicide because they believed that it would make clients think of it and possibly consider it for the first time, which could intensify the risk. Counselling psychologists in the current study reported strong reactions towards clients' disclosures about suicide, including fear. However, they appeared to be comfortable assessing the risk and naming suicide. This is contrary to what Leenaars (2004) and Trimble et al. (2000) have found, who suggested that counsellors do not ask questions about suicide because they feel angry, scared, incompetent or anxious in case a client expresses suicidal ideation.

Self-preservation

In this study counselling psychologists expressed both implicitly and explicitly their urgency to '*cover their own ass'*, as quoted by one participant, to protect themselves from any legal implications in case a client ended their own life. The practitioners inevitably were getting into a mode of self-preservation to protect themselves emotionally and professionally. Although this is an important consideration, it seems that some counselling psychologists felt that they were placed in a difficult position to make decisions that were not always for the benefit of the client and the therapeutic relationship. They felt inclined to respond in ways to protect themselves, supervisors or institutions legally and not deviate from any protocols or guidelines. Findings of this study showed that psychologists experienced an urgency to follow ethical guidelines

and make sure that they got the support they needed from supervisors. Additionally, they highlighted that a requirement for them is to inform colleagues during MDT meetings about clients' suicidal ideation and put into place a risk management plan to keep themselves and clients safe. Participants in this study appeared to adopt an '*objectifying spectator attitude*' towards their clients and were trying to make sense of the risk of suicide in a robotic, structured and automatic way, as Rossouw et al. (2011) have also described. In Rossouw et al.'s (2011) research study, it was described how Rossouw was surprised and shaken by the way in which the institution he was working at was reacting to suicide risk and suicide cases. He said that there was great emphasis on the administrative aspects, including the documented evidence regarding clients who completed suicide. According to his reports, he did not feel an interest from the institution or colleagues about how he was feeling and experiencing his clients' suicides. Also, they did not pay special attention to how and why the client had ended their own life. Rossouw realised that the priority of the institution was to ensure that they were protected legally and had adequate evidence for defence against potential culpability. This demonstrates that the priority for some institutions or colleagues might be to protect themselves and their professional status rather than supporting the professional who has lost a client due to suicide. This might leave the professional wounded, as emotional support, supervision and debriefing are required for processing such a loss.

It Is Live

Once suicidal thoughts or ideation were revealed in a session, counselling psychologists felt that the risk was 'live', therefore they felt inclined to respond to it urgently, as a duty of care. A valuable response referred to by psychologists was communicating and showing to the client that they had been heard. This finding is consistent with what Waern et al. (2016) found when analysing psychiatrists' narratives about assessing suicidal clients. They proposed that interpersonal skills and active listening are skills that professionals have to acquire throughout their training. The importance of this suggestion is also strengthened by what suicidal clients have disclosed (Idenfors et al., 2015), as they highlighted the importance of having a non-judgmental clinician who invites them to share their stories and listen to them. Moreover, what was evident from the findings was that an immediate response and

taking into account what the client had shared was deemed to be pressing for psychologists for legal and ethical reasons. Nicholl et al.'s (2016) study is in line with the present finding regarding protecting oneself professionally. It is evident that practitioners – both supervisors and psychologists – feel an urgency to focus on how to protect themselves from potential litigation, which can be triggered by feelings such as anxiety and fear. As Nicholl et al. (2016) proposed, the experienced fear is due to the culture and mentality that someone has to be blamed for a client's suicide.

Raison d'Etre

It is recognisable from counselling psychologists' narratives that working with clients who express suicidal thoughts or ideation is inevitable in the profession of Counselling Psychology. The raison d'etre of this profession is to work within competence and ensure safe and ethical practice, which is often determined by organisations' protocols and ethical guidelines. Counselling psychologists are expected to work within these limits, which help them keep themselves and clients safe. However, findings indicated that protocols, legal implications and ethical guidelines can make them feel constrained because they do not allow them to use themselves to the fullest or shape their professional identities as they wish. Working with suicidal ideation or existential issues is part of the job of a counselling psychologist and, as was stated by one of the participants, it is '*part and parcel of this career*'. Findings have demonstrated that psychologists normalise the existence of suicidal ideation as part of humans' despair and emotional journey. However, they underlined that suicide is a personal decision and that sometimes they might not have the power to intervene and protect the client because they are not deities. Counselling psychologists have a unique identity, and their speciality serves a unique and significant role within the broader field of psychology. However, like all professionals, they have their own limits of duty of care. Participants in this study acknowledged that although they had been armed with a rigorous training, they were human beings and not deities with the power to prevent all suicides.

Feeling Constrained

Counselling psychologists reported that they felt a tension between their personal and organisation's ideology. They felt constrained because their professional responsibilities were incompatible with their personal beliefs. This finding is compatible with what Scupham and Goss (2020) have found. It is also suggested that some routine methods of assessing and responding to clients with significant suicidality can have undesirable impacts due to specific organisational policies. These should be continually reviewed, as Reeves (2017) recommended. Protocols should be used cautiously and with one's informed professional judgment to ensure safe practice.

Practitioners felt thrown into psychology's and systems' protocols and ethical guideless and felt pressure to comply. The present findings were mirrored by what Rossouw et al. (2011) found. Participants often felt obliged to assess the risk with the use of standardised measures and procedures as expected, which resulted in losing their personal identity and exploratory capacity within a professional persona that has rigid limits due to the systems' ideologies. Counselling psychologists suggested that specific questionnaires and tick-box responses are not adequate in ensuring clients' safety and that sometimes clinical impressions can elicit a gut feeling which could inform the risk assessment. This was also a recurrent theme in psychiatrists' narratives in Waern et al.'s (2016) study. Although participants in the current study demonstrated their willingness to explore suicidal ideation in a non-reserved way, they felt inhibited due to their own fears of suicide or legal implications and their urgency to follow protocols. Similarly, psychiatrists said that the discourse between the doctor and the patient is dominated by safety concerns (Waern et al., 2016).

We Can All Be in that Chair

Furthermore, counselling psychologists normalised the presence of suicidal thoughts and were able to put themselves into clients' shoes. They validated clients' existential questions and said that they could be sitting in the client's chair. Participants normalised the presence of suicidal ideation and acknowledged the importance of making sense of clients' pain and despair. As Wrathall (2005) suggested, a world should be understood if we can find a way to enter it and comprehend it the way it is. Although the scientific paradigm suggests that there is only one world (Willig, 2001), if

professionals struggle to ascertain the existence of different worlds and worldviews, they might experience only barriers in addressing the phenomenon of suicide efficiently. Findings indicated that this was not the case for the participants, as they appeared motivated and keen to access clients' worlds and make sense of them.

Not a Deity

Counselling psychologists who participated in this study argued that institutions or certain people expect them to save lives and prevent all suicides, although this is not something that is in their power. This is experienced because each counselling psychologist develops a professional persona, which is bound by certain professional and ethical guidelines. Although professionals attempt to conceal their human nature and personal vulnerabilities, they should regularly remind themselves that they are ordinary humans without superpowers. As Gorkin (1985) suggested, the level of perceived omnipotence that each therapist has could impact their capability to work with this matter. The psychologists in the present study did not resonate with the idea of Counselling Psychology being perceived as a *'medical discipline'* because they did not see *'human life as a vegetating biological organism',* which is in line with what Rossouw et al. (2011) have suggested. This is therefore a source of anxiety for them because they are placed in a challenging position, where they have to predict through assessments and risk factors whether or not an individual is going to end their own life. This cannot be possible at all times because it would mean that human beings' behaviours were consistent and persistent. It appears that counselling psychologists in this study have a clear understanding of their duty of care, which helps them accept that they do not have superpowers. Although it was apparent from their disclosures that they acknowledged that they are not omnipotent, the anxiety and increased sense of responsibility experienced were equally evident. Unambiguous protocols can minimise the sense of responsibility that practitioners feel, as they can immerse themselves in that mode and culture of working with suicide risk, which is limited to a mechanistic way of working. The expectation of the mental health care system to prevent all suicides, apart from increasing the anxiety of clinicians, could lead to maladaptive responses, such as unnecessary hospitalisations (Waern, 2016). And yet, Huber et al.'s (2016) observational study indicated that suicides are not prevented if patients are in locked wards, which underlines the importance for clinicians to feel

comfortable and accept that a less restrictive treatment plan might be a suitable option. Therefore, professionals, including counselling psychologists, have to accept that they are not deities, which will help them protect themselves emotionally and manage their expectations of saving all clients.

Feeling Vulnerable

Counselling psychologists revealed that the existence of a client's suicidal ideation left them feeling both emotionally and professionally vulnerable. Similar to the study conducted by Scupham and Goss (2020), who included several mental health professionals as participants in their study, it appears that an inner conflict is experienced between the professional self and the vulnerable human being that exist within the practitioner. Working with clients with suicidal ideation brings to the surface psychologists' vulnerability and fragility. Malterud and Hollnagel (2005) have suggested that if patients sense the vulnerability of the doctor, it might be appreciated and might have a positive influence on the therapeutic relationship, which can be significant for suicidal clients. Counselling psychologists who participated in this study shared their vulnerability to possible legal implications that might make them feel exposed. Respondents indicated that they were feeling alone and not adequately prepared to work with this client population, possibly because they were aware that they could not prevent all suicides or keep clients safe at all times. Last but not least, the sense of responsibility that they experienced appeared to be inevitable, although they knew that their professional responsibilities were limited and that they could not prevent the actions of someone who has taken the decision to end their own life.

The Law Is in the Room

Participants expressed feeling vulnerable because they were worried about the weight that their decisions about a client's treatment might have, which could result in errors or lawsuits. Counselling psychologists expressed that working with suicidal clients can feel as if their career is at risk. If psychologists are feeling that their professional identity is under threat, it could be intolerable for them, as they can become defensive, the therapeutic relationship can be affected, and they might be lacking empathy or unconditional positive regard for their clients.

The findings of this study have shown that professionals feel more alarmed and constrained working with suicidal clients because it feels as if the 'law is in the counselling room' to spectate and restrict their job. A potential successful suicide could put their work under the spotlight and be assessed and questioned by family members or a coroner, which appears to be a scary procedure to be involved in, and one which might not leave them intact personally or professionally. Counsellors' concerns about legal implications, such as complaints or lawsuits from family members, were also evident in other studies (Hendin et al., 2000; Moerman, 2012). Fear and anxiety regarding the risk of litigation can be draining for professionals and can affect the therapeutic progress and outcome (Hendin et al., 2000; Moerman, 2012; Whittinghill et al., 2008). As Reeves (2010, p. 43) has suggested, '*fear of litigation and blame*' could result in breaking confidentiality as a defence mechanism. When therapists are considering the law and legal implications when working with clients with suicidal ideation barriers could be created between psychologist and client, which could be damaging. These findings underscore the importance of exploring in supervision overpowering feelings and any concerns about ethical or legal aspects of the work. Additionally, open discussions about the consequences and process following a potential suicide could normalise the aftermath of a potential suicide and might alleviate the fear of professionals.

Feeling Alone

The findings of this study illustrated that counselling psychologists who work with clients with suicidal ideation feel alone and isolated, despite that fact that they might share similar experiences of working with such clients. Being a psychologist might suggest that you are an individual who cares about other people's mental health; however, a counselling psychologist pointed out that sometimes support for each other is lacking. This suggests that often psychologists do not have the opportunity to reflect on their experiences with other professionals and might not have the space or time to provide emotional support to colleagues, as they focus mostly on their client work.

The sense of feeling alone during counselling sessions suggests that the therapeutic relationship and process can be affected. From this finding, it appears that sometimes

counselling psychologists experience the therapeutic relationship as a ‘solo dance’ and not as a ‘dyadic dance’. It seems that they feel alone in the room with the disclosures of their clients, as if clients are not present. This can make psychologists experience a lack of control and feel disconnected from the client, which could diminish their attention and emphasis on clients’ needs and underlining issues of suicidal ideation, which might require extra focus and exploration. Experiencing similar feelings of loneliness as clients with suicidal ideation could lead to a ‘stuckness’ in the therapeutic process. Also, there is the risk of clients’ disengagement and rupture in the therapeutic alliance, which could negatively influence clients’ suicidal ideation. Despite the challenges of recognising feelings of loneliness or aloneness, when working on a daily basis with other people, participants of this study were able to recognise them through the lens of self-awareness.

Moreover, participants shared that they feel alone not only literally but also metaphorically, as they feel isolated with the despair of their clients. They described that working privately could enhance the sense of responsibility, as private practitioners do not feel that they have a support system around them, which suggests that they feel more alone with the work that they have to do. Counselling psychologists who work privately reported that they have to be more cautious and make sure that they work within their competence, building a support system around them to keep themselves and their clients safe. This is line with the loneliness issues and deep sense of responsibility that psychiatrists experience during a suicide assessment (Waern et al., 2016).

Current findings are relevant to what Vogel (2018) has suggested with regard to medicine being a lonely profession, as doctors spend many hours of the day alone. Medical students share similar feelings of isolation and, as a student stated, ‘medicine is a lonely road and one which we all travel by ourselves’ (Vogel, 2018). Similarly, one of the participants in this study expressed her anger about her choice of career because being a counselling psychologist is an isolating job, as she has to hold the responsibilities of her role by herself. The sense of feeling alone when working with suicide risk is an original contribution to the literature regarding working with suicide risk, which highlights the importance of addressing it. Professional bodies should connect practitioners and encourage them to openly discuss their experiences of

working with suicide risk. This study supports that sharing experiences with other professionals, including supervisors, will help participants validate and normalise their feelings, which may counteract the sense of loneliness. Also, having a support system around them and openly reflecting on their experiences, will help them feel more the presence of their clients in the therapy room and find a way to reconnect with them by recognising their dual role in the therapeutic process and relationship.

Not Prepared

The current study extends existing findings of not feeling adequately prepared to work with clients' suicidal thoughts or ideation. Even though counselling psychologists are exposed to this client population from their early years of practice, it appeared that they still do not feel adequately prepared to work with suicidal clients. This raises a question regarding the effectiveness of the training that psychologists receive because they have not been trained in how to respond when clients' behaviours and choices are not in line with the therapeutic goals (Dundas et al., 2020). Also, the findings of this study indicated that working on clients' suicidal thoughts or ideation might not be experienced as something that gets easier over time because each case and person is unique. In contrast, Dundas et al. (2020) have found a significant and negative association between frequency of contact with suicidal clients and perceived difficulty of working with these clients, indicating that frequent contact with clients with suicidal ideation might reduce the experienced difficulty, as professionals might feel more confident. Longer professional experience might allow professionals to feel more self-assured, as they might have seen positive therapeutic outcomes or have accepted that it is not always possible to prevent suicide. However, no evidence was found that psychologists or psychiatrists with advanced experience are more capable of working with suicidal clients than less experienced practitioners. Moreover, Richards and Range (2001) found that psychologists did not respond better than advanced psychology students to an individual with suicidal ideation. This indicates that working with suicide is perceived to be challenging no matter the training, professional status or years of experience.

Participants' disclosures indicated the lack of confidence in their skills. A reference to imposter syndrome was also made. Imposter syndrome usually affects high-achieving

people, who have objective accomplishments. Despite their successes, they experience a difficulty internalising these and attributing them to their actual competencies. They doubt themselves and are afraid that they will be exposed because of their subjective beliefs of being an imposter or a fraud (Kolligian & Sternberg, 1991). Thériault and Grazzola (2010), who explored novice therapists' experiences, found that working with deeply depressed or suicidal clients can elicit feelings of incompetence. Feelings of incompetence have been associated with burnout (Hannigan et al., 2004) and feelings of disengagement and withdrawal in therapists (Thériault & Grazzola, 2006). Furthermore, a study conducted by Murphy and Mortimore (2020) recruited advanced clinical practitioners and found that role transition can lead to developing imposter syndrome, and that trainees can experience a sense of de-skilling, while they might feel anxious about meeting the expectations of being a qualified professional. They suggested that apart from clinical supervision, a separate mentor could contribute to supporting the professionals and helping them become more confident and develop their competence. Similarly, counselling psychologists could benefit from having a mentor who would help them overcome their self-doubts and assist them in developing a strong professional identity. Cooper et al. (2019) have also suggested that frequent meetings with a mentor can reduce the sense of loneliness and strengthen the sense of belonging. Addressing feelings of not feeling sufficiently prepared or competent to work with suicidal clients can also reduce feelings of withdrawal or loneliness, which were also evident in this study. Apart from the proposed mentorship, self-care should be taught and modelled as a professional practice for improving counselling psychologists' wellbeing and client work.

In addition, the criticality of suicide has left counselling psychologists feeling unprepared, ill-equipped and out of their depth when working with suicidal clients. These findings are compatible with Scupham and Goss (2020), who found that professionals were questioning their skills and abilities to effectively support an individual. This finding, along with the present findings, does not only highlight the need for further and specialised training but also shows the gravity of the phenomenon that could be experienced as traumatic for any mental health professional, including counselling psychologists who have received advanced training.

Despite the anxiety-provoking nature of working with suicide risk, not feeling prepared can also be an ethical issue. This heightens the importance for counselling psychologists to receive appropriate training in working with suicide risk. As suggested by Dundas et al. (2020), it is important for trainees and practitioners to be able to put their skills into practice in real-life scenarios. Silverman and Berman (2014b) have shown how deliberate practice has been included in training programmes for psychiatrists, which has helped them learn how to assess risk. Therefore, this deliberate practice could also be incorporated into Counselling Psychology doctorate programmes, where trainees could learn how to assess risk and become emotionally resilient through frequent emotional exposure in a caring training environment (Dundas et al., 2020).

An important finding of this study, which is consistent with findings from the existing literature, is that professionals did not feel emotionally prepared when working with this client population, which suggests that working with suicide risk can affect the personal life and wellbeing of practitioners (Ellis & Patel, 2012; Scupham and Goss, 2020; Veilleux, 2011). This highlights the importance of receiving relevant training and supervision, which will help professionals normalise their feelings, accept them and learn how to cope with them. This study, similar to Reeves and Mintz (2001) and Whitfield (2011), found that focused training on working with suicide risk is lacking. It appears that professionals have to seek additional and external training to enhance their knowledge and skills of working with the phenomenon of suicide or death.

Sense of Responsibility

Although the counselling psychologists who participated in this study were attempting to reconcile with a potential suicide and accept that they were not responsible for the client's life, an emotional turmoil was apparent due to the inevitable sense of responsibility. The strong sense of responsibility was a recurrent theme, and is a very pressing issue that needs to be addressed. Working as a counselling psychologist is undoubtedly an extraordinarily responsible job, however, it is important that counselling psychologists are able to make the distinction between their own professional responsibilities, the supervisor's responsibilities, and the client's responsibilities.

Most of the participants expressed a sense of responsibility focused on protocols of the institution and the profession of Counselling Psychology rather than on the clients' lives (Rossouw et al., 2011). Through their narratives, participants in this study were trying to draw a line and clarify what was expected from them. The findings of this study support what Rossouw et al. (2011) have stated, that '*[t]he guilt therapists feel towards the profession and its institutions conceals the guilt and responsibility that appropriately belongs to their vulnerability towards the needs of the client in despair*'.

Additionally, most of the counselling psychologists who participated in this study highlighted the importance of acknowledging that they were responsible *to* their clients and not *for* their clients. Counselling psychologists have a professional and ethical responsibility to keep clients safe and provide adequate support. However, professionals acknowledge that once the clients leave the counselling room, they do not have responsibility for or control over what the client will do.

An Australian study conducted by Trimble et al. (2000) surveyed clinical and counselling psychologists to explore the impacts of working with suicidal behaviour. An interesting finding was that counselling psychologists believed more firmly than clinical psychologists that '*it is the client, and not the therapist, who is ultimately responsible if a client commits suicide*'. The researchers suggested that this was due to the more complex clinical cases that clinical psychologists were exposed to, such as clinically depressed or psychotic individuals. However, as they suggested, it is crucial for all psychologists to believe that they can support suicidal clients effectively and accept that they cannot prevent a client's suicide if this is what they have decided to do.

Reeves and Mintz (2001) have found that the sense of sole responsibility that a therapist can feel for the survival of the client with suicidal ideation might be exacerbated due to their fear and panic, which could make them feel not ready to work with such a challenging and critical matter. Nicholl et al. (2016) have suggested that following a client's suicide a therapist can feel responsible and guilty for the client's death. This might suggest that the sense of responsibility would be intensified if therapists' fears are confirmed. This illustrates the importance for professionals of

normalising the probability of suicide and being mindful of their wellbeing while working with this client population.

Strengths, Limitations and Suggestions for Future Research and Training

The existing literature reveals the absence of focus on counselling psychologists' experiences; thus, this research project gives voice to a specific group of practitioners who have received similar training at doctorate level. A strength of the current study is that it enabled participants to express their feelings and encouraged them to think of some aspects of their experiences of working with clients with suicidal ideation for the first time. All participants appeared excited to participate in such a research project and they reported that it was thought-provoking and enlightening. They said that during the interview they had the opportunity to reflect at a deeper level about their experiences of working with clients with suicidal ideation and the idea of suicide in general. This indicates that participants do not feel that they normally have enough space to reflect on their experiences and emotional responses when working with suicide risk.

This study has the potential to enhance understanding of the complexities and challenges that professionals face throughout their therapeutic journey with clients who have expressed a level of suicidal ideation. Additionally, the findings of this study are not only supported by previous literature but have also identified further significant themes, which demonstrates the value of this study. A further strength of this study is that it recognises the ‘elephant in the room’, with the aim of encouraging course directors to consider the professional and emotional implications of working with suicide risk, something that needs to be addressed and profoundly explored in the mandatory training of counselling psychologists.

I hope that this study will open conversations about working with suicide risk and will stimulate professionals to reflect further on their experiences of working with such a delicate issue. This study has brought to light experiences of counselling psychologists

that could lead to the implementation of a better support system for practitioners and consequently for the service users.

Eight psychologists participated in this research project, and this is considered to be sufficient for a study that uses IPA as a method of analysis. I believe that the decision to recruit participants that use different therapeutic approaches was a strength, as findings of this study might apply and be generalised to a broader population of counselling psychologists, which itself can be considered as a theoretically eclectic population.

Throughout each interview, I sought to treat each participant equally and was using the interview guide to make sure that similar questions were asked, without however preventing any new themes or questions from arising that would help the study evolve. This helped me have a natural flow of conversation with participants without having to think of how to phrase each question to make it sufficiently open-ended or clear. Thinking of prompts prior to the interviews was convenient and helped participants during those times when the initial question was too general.

Employing IPA is an advantage of this study because data were analysed in depth and allowed hidden emotions and thoughts to come to the surface, such as the fear for their careers and the potential legal implications. The goal of exploring the personal experiences of counselling psychologists, including thoughts, and emotional and physical reactions, was met. Conducting a qualitative study with the use of IPA has successfully captured the nuances of psychologists' experiences through their rich and authentic accounts, which might not have been generated with the use of other qualitative methods of analysis or quantitative studies.

Despite all of the strengths of this study, there are some limitations that need to be considered and evaluated. The interchangeable use of the terms 'suicidal ideation' and 'suicidal thoughts' is likely to have affected participants' accounts. If the study had focused solely on suicidal thoughts or suicidal plans, the experiences reported might have been coloured by different emotions. Although I wanted to allow professionals to focus on whatever best described their personal experiences, a future study could explore either suicidal thoughts or planning or intention.

This study did not identify any strong themes about religious and moral beliefs with regard to the idea of suicide, therefore, it would be interesting for another researcher to focus on that. I suspect that the findings would be different and new aspects of counselling psychologists' experiences would be identified.

Although the sample of this study is considered to be homogenous, it included both female and male psychologists, which might have affected the findings. Perhaps a more homogenous sample that included only male or female psychologists would have recognised some poignant differences in their experiences, as in the data there were some indications of gender differences. Grad et al. (1997) found that females demonstrated more guilt, shame and self-doubt in comparison to men. Therefore, future studies could bring to light gender differences regarding the experience of working with clients with suicidal ideation.

The current findings indicates that the context of work can affect psychologists' experiences and points to differences between working privately and in an organisation. A similar study could recruit people who worked in similar settings, which might give a new perspective to the phenomenon. Last but not least, although this study demonstrates that even qualified psychologists are affected by clients' suicidal disclosures, it might also be revealing to investigate trainee counselling psychologists' experiences, as nowadays they are equally exposed to suicidal clients. Trainees are mostly exposed to low-to-moderate-risk clients, however, according to my literature review, even clients who are considered to be at a low risk of suicide might end their own lives (Large & Ryan, 2014). This highlights the importance of preparing trainees emotionally and professionally to work with this client population and become more aware of their limits as professionals.

Implications for Training and Practice

The current study has suggested that counselling psychologists are significantly affected both personally and professionally when they are working with clients' suicidal ideation. Hence it is crucial for counselling psychologists to gain more focused training in this area. Beginning to work with suicide risk without receiving any formal training can be distressing and stressful for professionals, especially trainees. Not having adequate knowledge about how to assess risk effectively or explore in depth the presence of suicidal thoughts or ideation can leave qualified and trainee psychologists feeling lost, less confident, and not equipped with sufficient skills. According to data collected in this study it seems that suicide is not a topic that is formally discussed or explored in all Counselling Psychology training programmes, and therefore graduates may be left feeling emotionally and professionally unprepared working with suicide risk. If students have not discussed suicide openly during their training this might leave them feeling contaminated with their own beliefs about suicide. This could have an effect on how they work with this client population and consequently affect their therapeutic relationships with clients, as was clearly demonstrated in this study. Counselling psychologists who do not receive focused training on working with suicide ideation might react and respond to clients without having clear boundaries, which could be harmful to the clients and to their own personal and professional identities. It would be beneficial for practitioners in this field to attend lectures or specialised training to enhance their knowledge in this area and learn how to explore and manage suicide risk and protect themselves emotionally.

Additionally, in light of current findings about Counselling Psychology being a solitary industry, it would be worth considering how counselling psychologists could feel safer and less alone working in an organisation or privately. It would be invaluable and liberating for professionals to have a reflective space and a support group to discuss their experiences with colleagues. More discussion about this subject should be promoted through peer support groups, as working with suicidal ideation is an integral part of our work and on which cannot be avoided. A mental health service or an organisation could set up support services exclusively for mental health professionals, such as 24-hour helplines, textlines or support groups, where practitioners could discuss ethical and personal dilemmas regarding suicide risk and feel heard with

regard to their concerns and feelings, without having the fear of being judged or facing any disciplinary consequences. Mental health services for professionals could also offer suicide workshops and chat rooms that could minimise the sense of feeling alone and not prepared. Online platforms and websites could include information, including policies and guidance of working with suicide risk that professionals could easily access when in doubt. Also, including up-to-date research studies and practice guidance regarding this topic could act as a valuable psycho-educational source.

Part of the job for many psychologists is to supervise the work of colleagues, therefore it is equally important to receive appropriate training for offering high-quality supervision to professionals that work with suicide risk. Supervisors should develop their skills and learn how to ask the right questions to help the supervisee conduct an in-depth risk assessment and become aware of internal processes. Supervisors are regarded to be the first point of contact when counselling psychologists are experiencing any difficulties, hence their role plays a critical part in how professionals experience their work.

In terms of practice guidance, I would like to emphasise the importance of self-care and regular supervision while working with this client population. Being aware of personal reactions to clients' disclosures and finding ways to overcome them, can be a strong determinant of the therapeutic outcome. Putting to the fore the therapeutic relationship and being emotionally resilient to work openly on any challenge can benefit clients. Also, viewing suicide as a multifaced matter and exploring collaboratively each aspect of it with the client without any judgment is key. Putting a unique hat on for each client, who expresses suicidal ideation can act as a reminder for professionals to treat each client as a distinct individual, not make assumptions about their experiences, and shape and colour this hat based on the needs of each client.

Last but not least, considering that psychologists feel fearful and constrained due to potential legal consequences, having a firm understanding of the legal parameters and implications of working with suicide risk might allow professionals to feel more secure. It could be reassuring and containing for counselling psychologists to know the legal procedures before and following a client's suicide. This is something crucial to address

in training and supervision, as the fear and worries about potential consequences that were evident in this study could not only impact the decisions that professionals make while working with suicide risk, but could also harm practitioners both personally and professionally.

Suggestions for training needs in relation to my personal experiences

[redacted]

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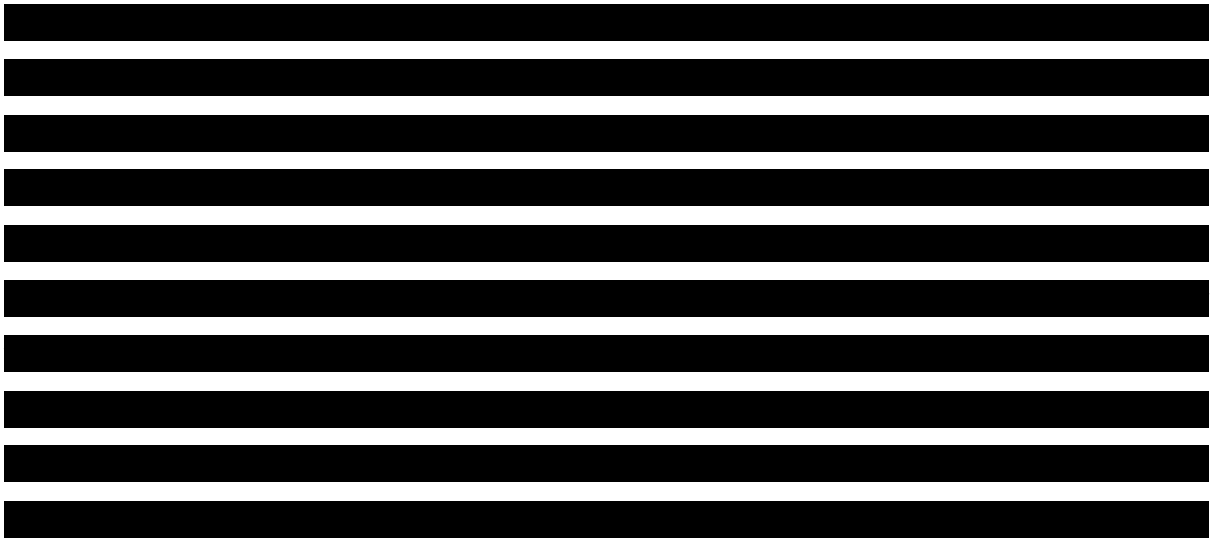

Conclusion

This research study sought to understand counselling psychologists' experiences, including thoughts and feelings around working with clients who have expressed suicidal thoughts or ideation. Although there is increasing literature around suicide, and valuable attempts at raising awareness on the subject, it is still a 'taboo' area of exploration and discussion. Many researchers have focused on how professionals could support clients with suicidal ideation efficiently. But how are professionals feeling about working with this presenting issue? Do their feelings affect their work? Is there enough support for them? These are important questions that I would like to raise and encourage training programmes and practitioners to consider. These questions are also relevant to effectively support clients who present suicidal thoughts or ideation. If psychologists are feeling out of their depth, it might be difficult for them to effectively handle suicide risk or deal and cope with a successful suicide.

The current research study adds to the existing literature by clearly demonstrating the need for counselling psychologists to feel emotionally and professionally supported and prepared. Many professionals conveyed that they did not receive relevant training during their doctorates and only familiarised themselves with the matter when they had to deal with it in practice. Therefore, through this research study, I would like to emphasise the importance of including a module or a series of lectures in training to enhance therapists' knowledge and understanding of suicidal ideation. Counselling

psychologists might know how to assess the risk, but the exploratory capacity is often lacking due to the emotional effects and potential legal implications. I would like to encourage trainees, qualified professionals and supervisors to reflect on how they are experiencing working with suicide risk. Professionals have to be equipped to know how to work with suicidal ideation and be aware of the aftermath of a client's suicide. Psychologists are constantly shaping their professional identities and growing, however, losing a client can deform and alter that identity. I strongly believe that recognising the limits of this profession and accepting these is of utmost importance.

To conclude, I would like to quote one of the most exemplary and recognisable Greek philosophers:

'*The only true wisdom is in knowing you know nothing*.' Socrates

Counselling psychologists, similarly to all human beings, have their limits and vulnerabilities. Being aware of their difficulties and how much they truly know can encourage them to commit to new learning experiences and their own continuous development. Participants who participated in this study by expressing their vulnerabilities and challenges were encouraged to go one step further, to acknowledge and accept them. Counselling psychologists are not deities; therefore, they cannot know everything, but that does not mean that they do not need to try to engage in the process of learning and unlearning, which is infinite.

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Appendices

Appendix A - Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of study

How do counselling psychologists experience working with clients with suicidal ideation.

Name of principal investigator

Researcher: Rafaela-Iro Schiza, Supervisor: Dr Jacqui Farrants

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This study is being carried out as part of the educational programme of the Professional Doctorate in Counselling Psychology at City, University of London. The purpose of this study is to enhance our understanding of counselling psychologists' experiences of working with clients with suicidal thoughts. Research findings have demonstrated that the therapeutic relationship and the stance that the therapist holds towards suicidal thoughts and suicide in general play a major role in the clinical outcomes and client's progress in therapy. However, little is known about counselling psychologists' personal experiences, wellbeing and emotional reactions working with this client population. This study aims to identify areas for improvement in training, education, and supervision.

Why have I been invited?

We are looking for qualified counselling psychologists who have experience working with one or more clients with suicidal ideation and/or previous suicide attempts. Counselling psychologists who had clients that died because of suicide are also eligible to participate in this research project. Psychologists of any theoretical orientation are eligible to participate in this study. We believe that you may fit these criteria and that is why we have invited you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do choose to take part, you will be asked to sign a consent form. If you decide that you no longer want to participate in this study, you are free to withdraw at any time and without giving a reason.

What will happen if I take part?

You will take part in a semi-structured interview that will last 60 minutes. The interview will take place in a comfortable, private room at City University or at your private office. The interview will be like an informal discussion about your experience of working with clients with suicidal thoughts. You do not need to answer all the questions if you do not feel comfortable and you can take a break whenever you want. The interview will be audio-recorded so that the researcher can listen to it carefully and identify any important themes that emerge that might be helpful for understanding more about counselling psychologists' experiences.

What do I have to do?

If you would like to take part in this study, please contact the researcher via email to arrange a phone call so that she can tell you more about the research study and give you the opportunity to ask any questions. If you decide you would like to take part, a convenient time and place for the interview will be arranged. At the interview, you will be asked to talk about your experience working with clients with suicidal thoughts.

What are the possible disadvantages and risks of taking part?

Talking about suicide is a sensitive issue that might cause distress, however, the participation is voluntary, and you can withdraw from the study at any point if you wish.

What are the possible benefits of taking part?

The interview is a safe space to talk about your experiences of counselling clients with suicidal thoughts. Your participation will contribute to research that enhances understanding of psychologists' perceptions and thoughts about suicide and how it affects yourself and your work. Findings of this study will help us to improve training programmes, supervision, and education for psychologists.

What will happen when the research study stops?

If for any reason the research is stopped before completion, the data will be kept anonymised, but all personal details will be destroyed. On completion of the study and after the required period of time that data has to be kept, all data will be destroyed using an appropriate method such as cross shredding for any paper records and permanent file deletion if held electronically. In accordance with City University policy, records will be retained securely for 10 years in paper or electronic form.

Will my taking part in the study be kept confidential?

Your data will be anonymised and your participation will be kept confidential. All data will be stored on an encrypted, password-protected computer. Consent may be revisited in the future if plans for data reuse change and re-consent is required.

What should I do if I want to take part?

If you wish to take part please contact the researcher via email (Rafaela-Iro Schiza, [redacted]

What will happen to results of the research study?

Since I am a doctoral student, the results will be used for my thesis that will be made available on the City Research Online Repository. However, your data will be anonymous and none of the participants will be identifiable.

What will happen if I do not want to carry on with the study?

You can withdraw from the study without any explanation or penalty at any time.

Who has reviewed the study?

The Research Ethics Committee of the Psychology Department of City, University of London, has approved this study.

Further information and contact details

Supervisor: [redacted]

Data Protection Privacy Notice: What are my rights under the data protection legislation?

City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

The rights you have under the data protection legislation are listed below, but not all of the rights will be apply to the personal data collected in each research project.

- right to be informed
- right of access
- right to rectification
- right to erasure
- right to restrict processing

- right to object to data processing
- right to data portability
- right to object
- rights in relation to automated decision making and profiling

For more information, please visit www.city.ac.uk/about/city-information/legal

What if I have concerns about how my personal data will be used after I have participated in the research?

In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone [redacted] who will liaise with City's Data Protection Officer [redacted] to answer your query. If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?

If the research is undertaken in the UK if you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted] You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: How do counselling psychologists experience working with clients with suicidal ideation

You could also write to the Secretary at:

[redacted]
Research Governance & Integrity Manager
Research& Enterprise
City, University of London
Northampton Square
London
EC1V 0HB
[redacted]

City holds insurance policies, which apply to this study. If you feel you have been harmed or injured by taking part in this study, you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Appendix B - Consent Form

CONSENT FORM

Title of Study: How do counselling psychologists experience working with clients with suicidal ideation?

Please initial box

1	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve:	
	• Being interviewed by the researcher	
	• Allowing the interview to be audiotaped	
2	This information will be held by City as data controller and processed for the following purpose: Preparing reports addressing the research question Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.	
3	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	

	I consent to the use of transcribed sections of the audio-recordings in publications.	
	I understand that the thesis will be made available in the City Research Online repository.	
4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in publication.	
8	I agree to take part in the above study.	

_____ _____ _____

Name of Participant Signature Date

_____ _____ _____

Name of Researcher Signature Date

Appendix C - Debrief Information

DEBRIEF INFORMATION

How do counselling psychologists experience working with clients with suicidal ideation?

Thank you for your time in taking part in this study. Now that the study has concluded, we would like to offer you a bit more information about it.

Counselling is considered to be useful for people, who suffer from a range of complex mental health problems and one of the most challenging areas is working with clients with suicide ideation. In order to effectively alleviate suicide ideation and support clients we need to enhance our understanding of psychologists' internal processes and stance towards clients with suicidal ideation. Exploring the issue from the point of view of counselling psychologists can offer an in-depth insight into psychologists' perceptions of suicide and their emotional responses to their clients' expression of suicidal thoughts. Finally, the findings of this study will improve the efficacy of supervision, education, and training in this area.

The information gathered from this study will shed light upon the counselling psychologists' experiences working with clients who have suicidal ideation. The findings of this study will be valuable for researchers, counselling psychologists and other professionals.

We hope you found the study interesting. Should you have any questions please do not hesitate to contact us by email as per below:

Rafaela-Iro Schiza
[redacted]

Jacqui Farrants
[redacted]

Should you feel that this study has raised any mental health concerns for you, please contact your personal therapist or supervisor.

Ethics approval code: ETH1819-0754

Appendix D – Research Flyer

Department of Psychology

City, University of London

PARTICIPANTS NEEDED FOR

RESEARCH IN COUNSELLING PSYCHOLOGY

We are looking for volunteers to take part in a study of

The Experience of Counselling Psychologists working with Clients with Suicidal Ideation

We are looking for qualified counselling psychologists who have experience of working with one or more clients with suicidal ideation. Psychologists of any theoretical orientation are eligible to participate in this study.

As a participant in this study, you would be asked to:

Participate in a semi-structured interview.

Your participation would involve a brief telephone conversation and one face to face interview that lasts approximately 60 minutes.

Your time will be greatly appreciated.

For more information or to volunteer for this study,
please contact:
Rafaela-Iro Schiza [redacted]

This study has been reviewed by, and received ethics clearance through the Psychology Department, City University of London.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on [redacted] via email: [redacted]

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk.

Appendix E – Interview Guide

Semi-Structured Interview
Topic Guide

Title of Study: How do counselling psychologists experience working with clients with suicidal ideation

Thank you very much for supporting this research project with your participation.

I am aware that client's suicidal ideation is a very sensitive issue to talk about. It might produce several emotions; however, talking about it might be useful for your own personal and professional development.

Settling in question about their motivation of taking part in this research study:
Can you tell me why you chose to participate in this study?

Questions

1. What is your experience of working with clients with suicidal thoughts/ideation?
    - What is your understanding of suicidal ideation?
    - How often do you have clients with suicidal thoughts/ideation?

2. How do you feel before, during and after the counselling sessions with clients with suicidal ideation?

3. How is it for you working with clients who have suicidal thoughts/ideation?
    - How does your experience of working with clients who have suicidal thoughts compare to your experience of working with clients who do not have suicidal thoughts?
    - What do you find challenging?
    - Are there any positive aspects when you are working with this client population?
    - Does anything remain 'unsaid' to client?
    - How does your religion or your own beliefs about suicide in general affect the way you respond to clients who express having suicidal thoughts?

4. What is your sense of your own wellbeing, when working with this client population? **OR** How were you affected in the session?
    - How might this affect you? (physically, emotionally, mentally)

- Do clients' suicidal thoughts raise thoughts for you regarding the meaning of life? How does it impact the therapy?
- Do you experience any emotional or physical sensations in sessions?
    - Did any images, memories, urges, or sudden thoughts come to mind?
    - Or after the sessions
- Do you think about your client's, who have suicidal thoughts, when you are at your home/personal space?
    - How is that different to other clients you might think at home?

5. How is your relationship with your client, who has expressed having suicidal ideation?
    - How much do suicidal thoughts affect your relationship with your client?
    - Sense of empathy/unconditional positive regard/congruence.
    - Closeness or distance with the client
    - What is your sense of responsibility when working with this client population?
    - I wonder what role might hope play in your practice

6. When working with this client population, what are your thoughts and feelings about yourself as a practitioner?

7. In your personal experience what have you found beneficial or useful to support clients with suicidal ideation?
    - Something that you said or done

8. How has your training and supervision impacted your work with this client population?

9. What are your thoughts on your personal self-care?
    - What do you currently do for self-care? **OR**
    - Are there specific things that you do in order to manage any negative psychological impact of your work?

Closing questions about any further questions, feelings, or any recommendations:

Is there anything that you would like to ask?

If you were the researcher, is there anything else that you would have explored?

How did it feel participating in this study?

Prompts

Can you tell me more about that?

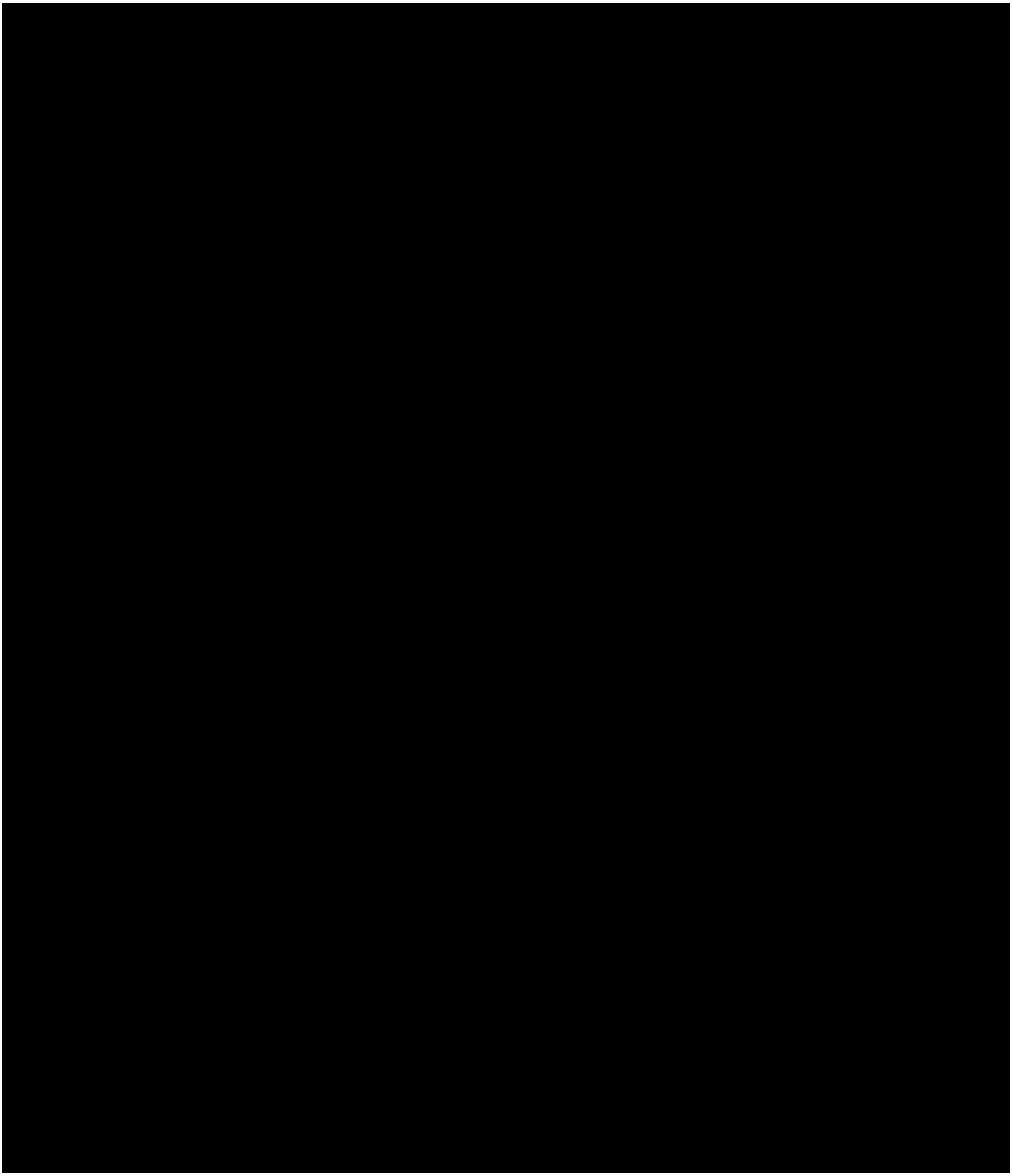
Appendix F – Coding Example

	And what kind of strong feelings come up for you?	
Societally controversial topic	For me in particular? I am aware that it is a societally controversial topic and I think people have strong feelings for and against it. People believe that is okay to take your own life or not and why. And I think for me in particular, in my own kind of belief set, believing that if, which probably is what autonomy would say, if somebody wants to kill themselves and that's kind of an informed decision and then fundamentally okay but having worked with people whose parents or loved ones have killed themselves, and seeing things from the other side as well so I pretty empathise with both sides in the situation. And then as a practitioner I think it brings up feelings of, I think it is a situation, which I feel particularly vulnerable as a practitioner because I am very aware of potentially being drawn into you know a kind of a coroners court or some legal kind of wranglings or em. I guess although I am not around or ever having a client, who has killed himself I think being aware of how would I feel if that happens, I think that would, I cannot even imagine what that would feel like but I am sure it would be hugely impactful. So I think there is a real sense of responsibility as a practitioner to the client, to the people around them. Yes, and it is quite a culpability potentially if something happens in a way that isn't then so I think I mean safe for example or working with someone who is thinking of ending a relationship, whether they do it or not, it is not a life or death scenario and I wouldn't expect there to be any legally precautions for me, the kind of emotional and the kind of legal implications in the extent to which I anticipate that I	
Personal beliefs-autonomous		Personal beliefs
Suicide-informed decision		Suicide-informed/personal decision
Empathising with both sides-suicide survivors		
Feeling vulnerable		Vulnerable as a practitioner
Coroners court, legal wranglings		Legal consequences
Cannot even imagine-scared		Feeling scared of losing a client
Hugely impactful		Impactful
Sense of responsibility to the client and people around them		Sense of responsibility to the client and loved ones
Culpability		Culpability-blame
Life or death scenario		Life or death scenario-urgency-seriousness
Legal precautions		
Emotional implications		Legal and Emotional implications

	might be brought in, why somebody would kill themselves it is yeah that is a bit different.	
	Can you tell me about more about your sense of responsibility?	
Suicide is legal	Yeah I think I am aware of, more aware of I guess the legal position, say in fact that you know suicide is legal that one can't sort of counsel someone to kill themselves so and that feels quite a fine line I think. I am so aware that obviously what happens in the room between me and a clients is confidential, so I think if a client were to kill themselves then it would be essentially, well, they would be dead so they couldn't say anything about, it would be my word and that's it. So I am certainly mindful when there are issues of suicidal ideation I am particularly careful of my notes, really to write what I have done in, the risk assessment, my thinking that I have spoken to my supervisor or some kind of safeguard. So I think there is a sense I really feel that with that in particular I have to prove in case anything happens I have to prove that I have really thought about it and I have done a risk assessment, I have spoken to my supervisor that I am aware that it is a serious issue and to make that very explicit and in a way that I wouldn't with necessarily other things. I think, I guess it makes me very aware that the power we might have as therapists, the idea that if you are working with someone, who is having suicidal thoughts then it sort of feels, not more so, I am so aware of the criticality of what I might say, I think it is very difficult not to feel a sense of responsibility for somebody's life or death. In the sense, well If I maybe have talked to somebody in a particular way or not it could make a difference between whether they live	Suicide is legal
Personal decision cannot counsel sb		Cannot counsel sb/prevent it – out of her control
It would be my word-weight of responsibility		Exposed/unprotected-client dead
Careful of notes		Mindful, careful, alert, urgency
Alert , cautious, urgency		Follow protocol-careful of notes
Prove – like in a court		Have to prove-self-preservation
Follow protocol		Follow protocol-urgency, self-preservation
		Serious issue
Power of therapists		Power as therapist
Sense of responsibility		Sense of responsibility-unpreventable?
		Criticality of what I might say-responsibility

Criticality of what I might say	or die, especially if somebody is in a quite impulsive state or in a quite heightened state in the session. I know people fundamentally make their own choices, but it is the criticality of it, I think weighs particularly heavily on me that there is no going back from death, so the absoluteness is very difficult. So with the other clients issues, one might have a difficult session and it might be kind of a tension so you know you might end a session with an issue in the air or with the client feeling angry about something but you can pick it up next week, whereas with suicidality ultimately you couldn't. And being very aware of working with suicidal clients of the space between the sessions and sort of wondering what is happening for the client and it feels more important to leave each session with the sense that the client would be okay between one session and the next. So, I think holding the client more in mind from week to week, than I might with another client.	Being cautious- criticality of words
Weight heavily on me		Sense of responsibility
Definite-not going back from death- powerless		Absoluteness of death
Irreversible, absoluteness of death		Definite-not going back from death- powerless
		Irreversible, cannot change anything
Being worried about the client		
Holding the client in mind		Holding client more in mind- worried

Appendix G –Theme Clustering



Appendix H – Example of Theme Table for Olivia

Super-Ordinate Theme	Therapeutic Relationship	Life or Death is in The Room	Just Sitting in a Different Chair	Sense of Support	Duty of Care	Sense of Responsibility
Sub-Ordinate Theme:1	*Openness and Honesty*	*Anxiety about uncertainty*	*Making sense of suicidal thoughts*	*NHS-Team Work*	*Checklist/ following protocols*	*Meet me halfway*
Quotes	*- we have to be open with each other, so I model that* *- the therapeutic relationship should actually be encouraged by the honesty and openness; it shouldn't be shut down* *- …it is very brave to sit down with an absolute stranger who asks you all these really intrusive questions about your life and mental state and your emotional world and then you answer honestly. That is weird, that is a really strange relationship, hi nice to meet you so tell me about your suicidal thoughts, it is odd.*	*- from a scale from 1 to 10 how strong is your intent to act, they are oh I don't know, you know people who are more elusive I think, those are the ones where there is more anxiety in the room* *- Those clients are different from the ones, who are like oh I don't know, what would it take for that to shift into plans, oh I am not sure*	*- whereas now I think that when I work from a position of it makes sense in the context of what is going on for people in their wider life, it becomes one of the things that I work with.* *- So I think that when people express suicidal thoughts I have more of a sense of your thoughts are a product of your day to day experience, which leaves me to that, it makes sense* *- I understand that without that sense of purpose I might lose myself actually. Without that sense of purpose, I might lose that passion that vitality for life, so then that enables me to think that well without this I might be that person in that chair.* *- I always think that when we train as psychologists there is this view that we are somehow different because we have this lofty training, you*	*- I work alongside duty doctors who are amazing, who would call clients invite them in for review sessions and I really enjoy that system.* *- whereas in the NHS now we have this big system around us, you know, there are colleagues, we have an onsite liaison team who would do psychiatric assessments, we work in a hospital setting, so if anyone was at risk, we are in the right place.* *- I work alongside beautiful team of people and there is always someone that you can speak to when you need to*	*- There are conversations that I have to have with the client, there is a risk assessment that is going on t and there is also a risk management plan that we are developing, conversationall y but this is something that we really have to go through in minds and tick the box of how to keep this individual safe* *- if these thoughts shifted over into plans so in that kind of reporting and recording side of things there are things that then happen, which are then different to the things that would happen with any other client* *- have done everything that I can to take care, so I have recorded things adequately, I have communicated with the people I needed to communicate*	*- They are responsible for themselves, so I will work with them, but they have to meet me halfway or maybe even further halfway, right? They have to kind of bring 70% and I have to bring 30%.* *- I will connect them to people and to elements of themselves, their own resilience, and their own resources, but they also have to have that sense of responsibility for themselves as well*

			know we do these doctorates, we get these letters after and before our names, almost like that separates us from others. Actually, no we are just sitting in a different chair.			
Sub-ordinate Theme 2	*Unconditional Positive Regard/ Positive remarks*	*It is live - Urgency*	*Normalisation of Suicidal thoughts*	*Private Practice-The Lone Worker*	*Guiding light*	*Sense of agency*
Quotes	*- It is incredibly brave that you have done that and working systemically I might say do other people know, who else would congratulate you for talking about these things* *- I think that actually it can have a very positive impact; the oh I said it and I survived, and this person still wants to work with me* *- I think there is something inherent to systemic practice about positively connoting things and I think that helps particularly in this area, when people bring suicidal thoughts.*	*- Oh my goodness, this is live, it is in the room, life or death is in the room, it is realistic, isn't it?* *- I want to think about from now moving forward how do we keep you safe and well or how do we, what do we need to do if you feel that these thoughts are turning into plans, so I would be doing a lot of those conversations*	*- I think because suicidal thoughts are kind of natural to us as human beings, this desire to escape when things are difficult is inherent to all of us* *- Because actually we all have as we think I would rather not be here, whatever here means to us that changes from person to person* *- it is funny you now making feel that maybe this has become so common place that it doesn't create the kind of 'ou' reaction*	*- how would I manage suicidal ideation in the context of working as a lone worker and I thought to myself actually that I would as part of my practice of working privately I would have initial conversations with clients(..)I didn't want people to come in who I couldn't contain the risk working privately.* *- Typically, yes, you might get GP details and you get their permission to contact GPs if needed but you are a lone worker, you are kinda out there on your own.* *- working within your limits of your competence, you know, thinking about working safely and I think it is all of those things because*	*- I have a guiding light in my mind if that makes sense of continuously assessing for risk, especially when working with parents because the risk that I am assessing for is in the family.* *- I am constantly assessing not just for the parent who sits with me but for the family at home and their ability to keep themselves safe and also to safeguard their own children* *- So, for example, the assessment session that I had earlier today when suicidal thoughts were mentioned I was just doing the narrative I was not going oh my god, oh no, I was just in it, I guess*	*- They are the experts on their life and for us to work together effectively; they have to connect with their own sense of agency in their life* *- everyone has their own personal agency, so that we all make decisions about our life every single day, so I guess I have always worked from the perspective that if a client is to do something to harm themselves I want to know that I have done everything that I could have done* *- I create a space for people to come in and think about their lives and they come in with their own agency and responsibility as well.*

				in the private practice arena you don't have this system of support around you.		
Sub-ordinate Theme 3	*Sense of Hope*					*Feeling competent*
Quotes	*- I am trying to connect to the client's hope.* *- our job as psychologists is to reconnect people with their hope but we also have to have hope in the process because if we don't we would all feel hopeless* *- So actually, there is something I think about maintaining connection to the hope in yourself as the therapist or the helper so that the helpee can also be oh yeah I remember or reconnecting them to stories of hope*					*- I think I guess as I have become more experienced and feel more competent, I realise now that it is as much a part of this work as anything else that we do* *- I think that now because I am more at ease working with suicidal clients we have really interesting kind of almost existential conversations about life, for sure, absolutely and I think that must come then from a relaxed position rather than an anxious position*
Sub-ordinate Theme 4						*Responsible to them*
Quotes						*- I am responsible to them in terms of helping them, but I am not responsible for them* *- we as psychologists have a responsibility in terms of our response to people telling us these things.*

Appendix I – Tables of Final Themes and Quotes

Super-ordinate Theme 1	**Therapeutic Relationship**		
Sub-ordinate Theme	**Chess Game or Dance**	**Withdrawal**	**Sense of Privilege**
Quotes	*I give an intervention and then he tries to step aside from the intervention and tries to distract me and then we will touch to something painful and then he pushes me away. And it has always been like a chess game or a dance, as much as I am trying to help, he gets uncomfortable and pulls away. (Alice)* *…feeling whatever emotions, you feel with the client in the room there are also boundaries that are there. So you want to make sure that there is nothing there that is going to hinder the work you are doing but of course once the person leaves the room, as long as you know they are ok, they leave the room, you might just shake it off a bit and you then have to go on to do something else. So, it is about being able to let go and so on as well. (Paige)* *…interestingly it also made me feel closer to her when we did resume working, because I was actually sitting with the vulnerability and the reconnection which was*	*And there was another client who, you know, from the moment she stepped in she was like yeah life is shit, I want to, I don't know, stab people in the back and kill myself. And that became a point of detachment, a point of creating distance between us now and again. (…) There is no deepening. There is nothing. It becomes meaningless. So, it depends on the other stuff as well. (Henry)* *I get a bit flashed, this sounds so awful, but it is almost, not another one, not another person that needs a lot from me. (Alice)* *So, when I have clients like that presenting with suicidal ideation I just, to be honest with you I get quite withdrawn. (Alice)* *At this moment in time I might have to be your parent, I might have to be the person that is there for you, that is accepting you despite everything that is*	*I need to see you, you are the person that, you are my psychologist I cannot go to someone else. Um, and there was something within me that I do not like to reject someone when they, it felt wrong and so I thought ok I will see you. (Alice)* *I think it is very hard when you have been working with someone for so long, as well, you know because the therapeutic relationship is such that you see them through all sorts of different ways and obviously it is a little bit more unique when you see someone at the hospital, because obviously they are an inpatient at times and they are in a gown in bed, so you are seating at their bedside. (Alice)* *So I think it, in some senses it may be the case of slight hope or slight motivation in therapy that you've*

	quite significant probably for both of us. (Fiona) *At some point she said, 'I don't know if life is worth living' and it made absolute sense in that moment. My relationship didn't change at all, if anything, well, if you were to say it changed, it kind of deepened. (Henry)* *So then I had to always monitor and ask the same questions and then I was like 'fuck me'. Wanna play that game? (Henry)*	*going on and then I need to learn, I need to almost withdraw from that step by step because you have become stronger. (Peter)* *…it is hard to sit with that struggle, you know, when obviously if you have lost somebody, you would just give one more day, you would love to have one more day with them but for those who feel suicidal one more day feels unbearable. (Fiona)* *I felt very awful for her and really concerned and then I went straight to feeling really angry. [...] He was literally fighting for his life and she was fighting to end her life, and this was difficult to sit with those complete polarities and I felt very angry caught in the middle of that. (Fiona)*	*disclosed it to somebody, you want somebody to step in and I think the power of hearing somebody in that and being able to hear somebody and be able to withstand that and then work with what is going in on, it can be something really powerful to offer. (Zoe)* *…it is very brave to sit down with an absolute stranger who asks you all these really intrusive questions about your life and mental state and your emotional world and then you answer honestly. That is weird, that is a really strange relationship, hi nice to meet you so tell me about your suicidal thoughts, it is odd. (Olivia)* *I am less concerned about my own mortality now and just thinking oh when my time comes, my time comes and that will be the end of that. Actually, I am hearing in front of me somebody who hasn't got that yet, hasn't got that confidence and I think that for me to be able to think like that feels like quite a privilege. It feels like a privilege of education, like a privilege of I*

			suppose of status, all of those things that allow me to feel safe enough to think ok I have lived a reasonable life. (Peter) *So I think that we are best placed as psychologists to be able to sit and contain a lot of that distress, we are able to sit and manage a lot of that distress that we hear and to help people find that life worth living, and we've got so many therapies now that can help people to recover and not just recover but to manage their own recovery and to build on that layer by layer and if we can help people go through that process and eventually exit our service, we have done a good job. (Peter)* *Working in mental health is abnormal, it is not normal, never normalise it. People behave like that because they are distressed, and they are dysfunctional. All I can do is make sure that outside my life is calm enough to be able to manage that and be able to go back in. (Peter)* *I feel that the trust, she trusts me, for her to trust enough, she hasn't even told her husband, so for*

			her to be able to come into that space and share this information, which feels shameful and to feel able to share the despair around that for me that is a really positive thing. (Ivy)

Super-ordinate Theme 2	**The Overriding Feeling of Trepidation**	
Sub-ordinate Theme	Taking the Client Home	Sitting with the Uncertainty
Quotes	*Yeah, I guess occasionally, very occasionally quite rarely I need to sort of go home and say oh I had this sort of situation today and I just need to speak about it and say oh it was worrying and so on and then I am like ok that's it and I can leave it. Sometimes you need to take it at home with you and then have to let it go there. (Paige)* *Oh gosh I can't believe what I heard today, someone was suicidal, and I was worried. (Paige)* *It matters to them, it matters to me, if I have suicidal thoughts, If I am in love. Of course, it matters but this is the most important thing, and it is the most important thing for them, but I will not take it home with me because I have my own shit. (Henry)* *I know people fundamentally make their own choices, but it is the criticality of it, which weighs particularly heavily on me. There is no going back from death, so the absoluteness is very difficult. So, with the other clients' issues, one might have a difficult session and there might be a kind*	*The challenge is that you can never know for sure, if that person is going to do it or not and I think that being able to sit with that can sometimes be very uncomfortable. (Alice)* *…you know ironically, he was the one that I was not worried about in terms of suicide. (Alice)* *Oh, I would kill myself but I don't know when and I don't know why... Whatever... They did their own bit* *(…)* *Maybe they want to score more points and they found that question and oh if I put it from a zero to one they will pay more attention to me or I will be more eligible for help. (Henry)* *…it is like ouf so what do we do here, can we get this person help, if they have not been clear either, I suppose the anxiety is still there. (Paige)* *So, I get very concerned when men with poor communication skills talk to me about suicide because I think actually if you haven't got the words, then how are you*

	of tension so you know you might end a session with an issue in the air or with the client feeling angry about something, but you can pick it up next week, whereas with suicidality ultimately you couldn't. [...]So I think I hold the client more in mind from week to week, than I might another client. (Zoe) *I go home to my partner, and I am thinking, you know it is confidential I cannot say anything, I wouldn't say anything anyway. (Alice)* *I get quite tearful, you know, which I think is actually good, you can get it out, which is sometimes confusing [laughter], having people around me, especially when I am home and watching a heavy movie or something, I do find it comes out like that, yeah. (Alice)* *…those are the clients that I sort of take home with me and I do reflect on them quite a lot. I find myself wondering you know are they ok and sometimes there is a feeling like oh should I send them a message and check in on them, but I don't. But there is that feeling of responsibility that I want to check in and see if they are okay and again hoping that they will make it to the next session. Or should I contact their doctor, or it is kind of sitting with the weight of that responsibility. (Fiona)*	*going to let us know that you are safe or that you are not feeling safe. (Peter)* *Actually, you have got no idea if you are going to see that person again, and it is quite difficult to let that go because once she has left you just don't know. (Ivy)* *I mean luckily no one has, touch wood ever gone on to do it and please God, I hope to God I don't, but you never know in this career. (Ivy)* *So she was very knowledgeable in how to do it but it was always sitting with the delicacy of that and the uncertainty. (…..) I was always sitting with sort of when will she actually say something to somebody, I guess, I took it to supervision a lot and we did kind of set a bit of a support plan for her in place, who to call and in what circumstance. (Fiona)*

Super-ordinate Theme 3	**Sense of Urgency**		
Sub-ordinate Theme	Put a Different Hat On	Self-Preservation	It is Live
Quotes	*During the session, I try to focus on risk assessment but also on the material of*	*I would dread to think that one of my patients would*	*Oh my goodness, this is live, it is in the room, life or death is*

	the session because it is not just the risk assessment, you have to do your job, you know the other part of the job as well and after I make sure that I record everything that is needed of me. I assess the risk but also make some real thinking around whether the person will actually commit suicide. (Henry) *During the session, is almost like a kind of checklist in some ways, so it is more like what happened, describe it to me, was there an intention, is there a plan, you know, I start to go through more of the checklist protocol really. And then once I realise, if there is no intention or plan, then I kinda want to explore the deeper elements to it. (Alice)* *So with that client I stopped, did a risk assessment, made a quite structured plan if you have these thoughts again what would you do, so in that sense, I do normally work in a more structured way, so yeah it changes the process of the work, I go into risk assessment. (Zoe)* *Ok, we need to get you in contact with your GP, (...)*	*commit suicide and I didn't do the paperwork. (Henry)* *My supervisor very strongly encouraged me to contact the client's GP [...], I could if I wanted to, I have the client's GP number, so I could do it but it is not something that I regularly do and also, in all honesty, I think it does feel like something to protect the therapist rather than the client because you know GPs are very busy and if I were to talk to the GP, what would they do, probably they would do a note about it, unless the client goes to see them, we are not going to section this particular client so it almost felt like it is going to be something for me rather than something for the client. (Zoe)* *So, I think that I have to be careful of myself and protect myself ethically and psychologically, as you said at the beginning this is an emotive area.* (Olivia) *So that is the unpleasant side of what we do and I always from the first time this happened I always thought okay I am gonna make sure that I have done everything so that I*	*in the room, it is realistic, isn't it? (Olivia)* *And if anyone indicated at any point that there was any kind of suicidal thoughts, I was oh you know oh what is going on here, I have to make sure that I focus on this. (Paige)* *I think the other thing that I would never say to somebody, would be…well I would never ever say to somebody I don't believe you, you will never say that. […] No, actually if you have come and expressed that desperation to me, I am going to respond to that and make sure that you know that I've listened to you. (Peter)* *I am quite careful with the words that I am using. I try to be quite clear and express my concern rather than leave anything up to interpretation. (Fiona)*

	with a service that can actually manage that risk. (...) so I guess that there is this sense of urgency to make sure that you have done all you can. (Paige) *I have a guiding light in my mind if that makes sense of continuously assessing for risk, especially when working with parents because the risk that I am assessing for is in the family. (Olivia)* *We want to make sure that we are informing the rest of the MDT as quickly as possible, we are making sure that we have a risk management plan in place and that may mean restricting leave. (Peter)* *I have to support them in a different way, because they might be really vulnerable and have other things but actually, this is the protocol that I need to follow with these suicidal people and I need to, it is just ways of developing coping strategies and making sure that they have support beyond the therapy room. (Ivy)*	*can actually look them in the eye. (Peter)* *I think it is the reassurance. You know I think you can feel quite vulnerable, so being able to communicate with my supervisor and knowing, you know did I do it, do you feel that I could have done more, do you think that this is right, you know what I mean, I think that is helpful. (Ivy)*	

Super-ordinate Theme 4	**Raison d'Etre**		
Sub-ordinate Theme	Feeling Constrained	We Can All Be in that Chair	Not a Deity
Quotes	*It depends on the system. In the NHS, IAPT, all that, all these systems... it falls on you to monitor it as best as you can so you can avoid litigation. That's it. That is the end of it. (…) If there is space of worrying about somebody's wellbeing it will not happen because of tick boxes, I will feel it. (Henry)* *Hmmm in a setting such as the NHS because I do not work psychoanalytically. I allow myself free rein to say whatever bullshit comes to mind. So, I take the master position as opposed to the analytic position and I go with hope. There is hope, of course, let me tell you all about hope. The only thing that I haven't done yet is do the genie dance sequence from Aladdin. Yes of course. I am gonna say there is hope, there is point in trying because that is the ideology of the NHS being alive is ok.[…] At the end of the day we*	*I understand that without that sense of purpose I might lose myself actually. Without that sense of purpose, I might lose that passion that vitality for life, so then that enables me to think that well without this I might be that person in that chair. (Olivia)* *I always think that when we train as psychologists there is this view that we are somehow different because we have this lofty training, you know we do these doctorates, we get these letters after and before our names, almost like that separates us from others. Actually, no we are just sitting in a different chair.. (Olivia)* *…if you connect to what makes you strive, what connects you to your own sense of purpose, you can connect to that within clients as well or the absence of it that they might feel.* (Olivia) *…how little sense reality makes and of course suicide will be the fantasy of pressing the escape*	*If the person is going to do it, they are going to do it, I kind of come to that place. (Alice)* *I let go of my desire to have the power to change their minds, to save them. (Henry)* *It can be suicidality of patients who actually have nothing to live for, very sadly they have absolutely nothing to live for. At that point, I cannot tell them anything, especially in the IAPT service that I used to work. I couldn't but join in the hopelessness. In my head I was thinking yes you have nothing to live for, sorry. There is no amount of CBT that will fix that. (Henry)* *Imagine being thrown in a football game and before you go in, they cut your arms and your legs and you are expected to play well and not complain about it. What's the fucking point? And then you assign me to that crippled person that crippled football player and you say make them feel good about themselves while playing the football game. The best that I can do 'see the ball, touch the ball, feel the ball, be mindful about the ball', bollocks. (Henry)*

	bring ideology and my ideology is not there is always hope. Sometimes there is no hope. We have to accept that. (Henry) *I really struggled with that, I cried a lot, I sent my poor supervisor an email to her on a Friday night saying, you know, this patient just tried to kill himself and his case was not with a GP, he just moved house, so all the standard things that we would do, I couldn't do right away. I had to wait for him to register with a new GP, I couldn't you know write the letter to the GP right away and I had to sit with it for the weekend obviously and in hope that he signs up. (Alice)* *A lot of senior managers within the NHS would tell you that we need to lower suicide rates and you know that we can never have another preventable death, then I will just go take my magic wand [sarcastic tone]. (Peter)* *I guess there is a kind of restriction or tightening and I lose the exploratory capacity, so I find it quite difficult I*	*button again and again and again. (Henry)* *And that creates a debate, is life worth living? And everybody is happy to say 'yes it is!' [exaggeration]. These clients have the strength of a despair, but now you see it actually begs the question. Is it? Is it worth living? (Henry)* *The routine, the monotony, the lack of future orientation can be enough to kind of think you know what, escape would be a great thing to do. (Peter)* *I think from that early experience of thinking that I will never work with death [laughter] or suicidal thoughts, which is crazy because it manifests in some shape or form through this work and to where I am now. (Fiona)*	*…this nonsensical idea that we have that we can prevent all suicides, how is that possible? I am not a deity, I do not have supernatural powers, if somebody leaves my consulting room or leaves my service and goes and kills himself, I have no power to prevent that. (Peter)* *…if someone is going to do something, they are going to do it and you know as a therapist we are not superhumans. (Ivy)* *So, I guess on a personal level that is something that I need to wrestle a bit with sometimes in supervision of not taking on that feeling that you need to be an all-powerful therapist and fix everyone. (Fiona)*

	think in my work when I feel I have to be very pragmatic and very, you know I have to ask certain questions. (Zoe) *I think the question of suicide is a really interesting one and I think what it brings up for me, in particular, is the difference between how you might approach it from a psychological point of view and the kind of legal parameters or restrictions. For me, there is kind of entrenchment between these which are difficult to balance them against each other. (Zoe)* *Ehm and yes, the idea of the law coming into the therapy room, I find that very difficult, so the idea that I have to do certain things, there are certain things that I can't do because of the law. But I then become aware of myself and keeping myself safe and what am I doing. Could what I am saying be seen to condone suicide, it is difficult because I think people have the right to kill themselves. (Zoe)*		

Super-ordinate Theme 5	**Feeling Vulnerable**			
Sub-ordinate Theme	The Law Is in the Room	Not Prepared	Feeling Alone	Sense of Responsibility
Quotes	*I always thought that I would be fired because I didn't tick the right boxes, or that I didn't ask the right questions or didn't get the right answers or was not specific enough. (Henry)* *Of course, it is not their fault, these are the means of communication and they are communicating something to me, it just so happens that what they are doing in my own silly fantasy also risks my career because if they then go and kill themselves, a crafty lawyer somewhere, a very pissed off parent and a very hurtful family member might say yes but they scored this on the questionnaire and then everything collapses and*	*I I didn't feel like I had as many tools or knowing what to do with all the emotions that it evoked. (Alice)* *So, I definitely have a sense I suppose of an imposter syndrome, which is more like a sense of I can quite even unqualify, so if somebody is telling me that they are planning to kill themselves this is so what can I do with this. I feel so, not to say deskilled but definitely, it makes me feel less I suppose because of the enormity of what the client is bringing. (Zoe)* *…it often causes us to feel inadequate, it often causes a crisis of*	*I have always felt very alone with the work so, I don't know if it is because everyone is working so hard in giving so much to the patients or clients, however you want to describe it, that they do not have anything to give to each other but I just feel and it makes me a bit angry sometimes that you know I have chosen an industry and this is all my choice and think it is more feeling angry with myself than anything else because I chose an isolating industry and I am isolated with the responsibility of this. (Alice)* *So, I think if clients were to kill themselves then it would be essentially, well,*	*I do have a sense of responsibility even though I know that I am not responsible for that person and their life in a lot of ways. (Alice)* *…he was really alone and the weight of responsibility of him not having a sort of support network, it really hurt me actually. (Alice)* *Ehm I think the sense of criticality, I think the ultimate fear is that if I do something wrong, whatever that might be then this person could die. (Zoe)* *I cannot obsess over sugar when I am making a cake but if I spill sugar all over me, yes, I have to somehow clean it. (Henry).* *So there is the sense of*

	people can just roll you up in a piece of paper and I hate that, it sucks. (Henry) *And then as a practitioner, I think it brings up feelings of, I think it is a situation, which I feel particularly vulnerable as a practitioner because I am very aware of potentially being drawn into you know a kind of a coroner court or some legal kind of wranglings. (Zoe)* *I am suddenly very in the room, my needs are in the room, the law is in the room and all of these things are in the room and can become very pragmatic. Yeah, so I hate that, what it does to the work, there is a loss of that exploratory capacity but maybe that's coming from my own fears and why can't I just explore it, yeah, interesting. (Zoe)* *…so not only there is a personal*	*confidence if people go into completion. (Peter)* *No one trained you to deal with the emotional impact of this or whether you carry it when you leave the room or dealing with that sense of responsibility, and I think that is probably what you take to the supervision and so there is no particular training around that. (Ivy)* *My thoughts as a practitioner are that [pause] I don't think it gets easier, you know the more, there might be an assumption that the more people that you get exposed to that have that you know have these ideas that in some sense you know you could manage it. (Ivy)* *I mean in my actual training we touched on things*	*they would be dead so they couldn't say anything about, it would be my word and that's it. (Zoe)* *I think it is important for us to know what the law is and to think about how that links with HCPC and BPS guidelines but not to the extent that we are so scared and paralysed. I am not sure if this is just my reaction or if other people feel the same way. (Zoe)* *..in the NHS now we have this big system around us (..) In private practice I don't have that, it is me in a room, sometimes in a house on my own (…) I was doing some trainee evaluations and one of the questions is about working within the limits of your competence, you know, thinking about working safely. (Olivia)*	*responsibility but it is very cynical for me, it points towards covering your own ass. (Henry)* *I just thought I can't let you go,[frustration] I don't know what you plan, I can't, I felt it was my responsibility and of course you know as a counselling psychologist you know we are taught to, you know it is not about trying to persuade people to do things that you think they should do, it is all about what does the person want and so on, but in that situation, it is like no I can't just let you go off and perhaps kill yourself and you know then I would feel that I didn't do anything to help. (Paige)* *They are responsible for themselves, so I will work with them, but they have to meet me halfway or maybe even further halfway, right? They*

	impact if somebody completes, so you kind have to question well ok did I do everything okay, were there things that I have left out, you know with the things that I didn't spot, then you have to think that there is somebody external alongside with the police investigation, there will be external people, senior in your organisation that would then lay eyes on your work and kind of think about well ok did Peter do everything that he could, that we would expect of him, which is reasonable and if not well that I would become accountable for them, so why I may have done that. (Peter)	*like risk assessment and suicidal thoughts, but not in too much depth about how to actually work with that. So, when I was confronted with that as a trainee for the first time, I felt completely out of my depth and very unskilled [laughter] and a bit clueless about what I was really doing. The learning really came from talking about that in supervision as opposed to being given a great deal of direction in my training. Even though it was a great training, it was very thorough, but I feel that was an area that was a bit glossed over. (Fiona)*	*I do feel quite sad and concerned and especially working in private practice where often you know there is, you don't have that kind of web of care around you so you actually have to create it by making contact with doctors, psychiatrists, just to make sure that there is enough support in place because obviously in private practice you only see the person once a week and not really having much clinical contact. (Fiona)*	*have to kind of bring 70% and I have to bring 30%. (Olivia)* *Well, I think we do have a responsibility to listen and to respond appropriately and to ensure that you know we have done everything that we can to ensure our client's safety, that's my responsibility. (Peter)* *I feel a sense of responsibility when I am in the room but once they have left, I have no control over how their behaviours are going to be. So, I also have responsibilities outside of work and I have a life and I feel that if you don't have boundaries in terms of between your professional and your personal life then it can really have a negative impact on your wellbeing. (Ivy)* *I have to take it very seriously and I have a responsibility for this client's welfare,*

				and I have to sort of make a judgment. (Ivy) *So, for me, it is a bit of a journey as well, the sense of hopefulness and then relief and again when they leave if they do not feel safe then it is again sitting with that kind of responsibility and just being mindful of them. (Fiona)*

Part 2: Client Study & Process Report

Behind the Laughter: Exploring the meaning of tears in Person-Centred Therapy

This content has been removed for data protection reasons

Part 3: The journal article

A qualitative study of counselling psychologists' experiences of working with clients with suicidal ideation: Therapeutic relationship and personal and professional vulnerabilities

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Author note: This article was submitted as part of a doctoral thesis portfolio for the DPsych Counselling Psychology Programme at City, University of London, supervised by Dr J. Farrants. The research was conducted in accordance with the ethical requirements of the BPS. Correspondence should be sent to Rafaela-iro.schiza.1@city.ac.uk.