Therapists' experience of working with suicidal clients

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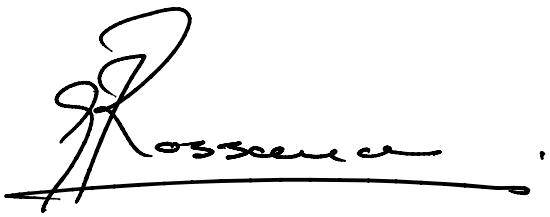
Table of contents

Attestation of authorship

I hereby declare that this submission is my work and that to the best of my knowledge and belief it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma or an university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.



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Undertaking and completing this project has been a deeply rewarding experience. My thanks and gratitude goes to the participants who were willing to participate and talk to me about their experiences which, in many cases, remain alive for them.

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This was a journey of discovery I would not have predicted, thanks to Kerry, Liz and Peter.

Abstract

This study explores therapists' experience of working with suicidal clients. Using a hermeneutic-phenomenological method informed by Heidegger [1889 – 1976] this study provides an understanding of the meaning of therapists' experiences from their perspective as mental health professionals in New Zealand.

Study participants include thirteen therapists working as mental health professionals in District Health Boards from the disciplines of psychiatry, psychology and psychiatric nursing. Participants' narratives of their experiences of working with suicidal clients were captured via audio taped interviewing. These stories uncover the everyday realities facing therapists and provide an ontological understanding of their experiences working with suicidal clients in District Health Boards.

The findings of this study identified three themes. All the participants experienced shock and surprise upon hearing their clients had committed suicide without presenting with signs and symptoms associated with suicidality in their assessment. All the participants experienced the responsibility of assessing suicidal clients and intervening to be a burden. Further, they suffered from guilt and fear of punishment in the aftermath of a client's suicide. They also found themselves in a professional and personal crisis as a result of their experiences and struggled to come to terms with events. This study has shown how these experiences could be understood by uncovering the perspectives therapists bring to working with suicidal clients. I have shown how mainstream prevention and intervention strategies follow on from the misrepresentation and misinterpretation of our traditional way of knowing what it means to be human. I show when therapists discover that phenomena are not necessarily what they appear to be they feel unsettled and confused about their responsibilities and what it means to live and die as a human being. The experience of being a therapist to a person who commits suicide has been revealed in this thesis to leave a profound legacy of guilt, doubt and fear. This thesis proposes that it may be time for the profession to care for its own that therapists in turn may not shy back from caring for and about the vulnerable other

Chapter One

Introduction

This hermeneutic phenomenological study seeks to explore and explicate the meaning of therapists' experience of working with suicidal clients.

The problem

Despite considerable efforts in the last decade, suicide remains a significant problem in New Zealand. According to Warwick Holmes (The Dominion Post, 2006), a coroner in Napier, suicide is undoubtedly a chronic problem. Coroners around New Zealand are dealing with it almost on a daily basis. Warwick Holmes is reportedly most troubled that New Zealand does not appear to be making any progress with suicide amongst young men. His advice is that more attention be brought to the problem. While more attention may well be required, it is, I submit, equally important to consider how researchers have been paying attention to the problem. They may have been asking too many questions about suicide that conceal, rather than reveal the true nature and essence of this perplexing phenomenon. There may be an advantage for researchers in adjusting their attitude to how they go about asking questions of suicide. Rather than ask whether the response to their question can be measured, perhaps they could ask whether the response to their question will carry meaning.

My original aim was to interview clients who had been treated for suicidal thoughts and attempts, hoping that an explication of their experiences may shed light on the problem in New Zealand. After discussions with the District Health Board where I am employed as a psychologist and my supervisors at Auckland University of Technology I decided to shift my focus of enquiry from the client to the therapist. It felt that the opportunity to do research on this topic may be hampered by a raft of ethical and bureaucratic obstacles with the client as focus. I reasoned that it could still reveal something significant for future practice and research by exploring therapists' experiences and the meaning they attach to working with suicidal clients. This phenomenological study will therefore explore the meaning of the experience of therapists working with suicidal clients. It will offer an interpretation of the narratives of thirteen therapists (psychiatrists, psychologists and psychiatric nurses) working in the mental health profession in District Health Boards in New Zealand. The

participants represent ways of understanding and experiences from a variety of educational and institutional settings, within New Zealand and elsewhere.

The context of this study

Suicide is an indicator of the mental health and social wellbeing of society (Ministry of Social Development, 2008). In 1994, the World Health Organization published data, which showed that New Zealand had the highest rate of male youth suicide and the third highest rate of female youth (15 – 24 years) suicide among the 23 OECD countries. According to Disley and Coggan (1996), this raised considerable concern and prompted a range of governmental and nongovernmental responses to address the problem. Government policy and funding were directed to raise the profile of mental health; youth mental health and suicide prevention in particular. In 1998, the Ministry of Health announced a Youth Suicide Prevention Strategy stating at the time that it was working on a similar strategy for all age groups. Part of this strategy is a suicide prevention 'toolkit' for District Health Boards, developed with reference to national and international research and literature on suicide prevention (Ministry of Health, 2004).

In 2001, New Zealand had the second highest rate for male youth (15-24 years) suicide and the fourth highest rate for female youth suicide among the OECD countries, according to the Ministry of Health and thus continued to be a significant public health problem (Ministry of Health, 2004). Reducing suicide and suicide attempts became one of thirteen health priority areas for the Ministry of Health (2001).

In 2005, New Zealand had the second highest male youth (15-24 years) suicide rate and the third highest female youth suicide in comparison with 13 OECD countries. New Zealand is one of a small number of countries which have higher suicide rates at younger ages than at older ages (Ministry of Social Development, 2008).

Research at a national level has explored trends and possible correlations between a range of societal, interpersonal and intrapersonal variables and increased risk of suicide. Coggan (1997), for example, found a fourfold increase in youth suicide between 1974 and 1993. Emphasis on youth suicide has, however, obscured the fact

that suicide still constitutes the clear majority of all suicide deaths amongst adults and older adult males (25 years and older), says the Ministry of Health (2001). From a demographic perspective Maori predominate the group in which suicide is associated with factors of vulnerability, disadvantaged and difficult life circumstances (Beautrais, Joyce, & Mulder, 1998b) and according to the Ministry of Health (2001), Maori continue to have a higher suicide rate than non-Maori. In 1998, Maori males committed suicide at a rate almost 50 percent higher than non-Maori males and Maori females 41 percent higher than non-Maori females. From an inter- and intrapersonal perspective, suicide has been correlated with isolation, estrangement and alienation from others (Coggan, 1997). Mental disorders (in particular, affective disorders, substance use disorders and antisocial behaviours) and a history of psychopathology correlate with suicide, says Beautrais (2000b). Almost all suicides in New Zealand can be accounted for by hanging and to a lesser extent, vehicle exhaust gas, but it is considered impractical to restrict or limit access to means of suicide, because the two major means are so widely and freely available (Beautrais, 2000a; Beautrais, Horwood, & Fergusson, 2004). Studies by Coggan (1997) and Edwards (1998) have suggested an improvement in knowledge of common warning signs and more affective assessment of risk factors. These researchers believe that initiatives of this nature may assist people at risk, parents, teachers, general practitioners and public health agencies in preventing and intervening in suicide attempts.

Prevention and intervention strategies are consistent with suicide trends and correlates with research findings. The recommended strategies by the Ministry of Health, previously mentioned, demonstrate this. Risk factors for suicide and suggested intervention and prevention strategies are also remarkably consistent across countries and cultures. This is borne out by comparing some national research findings with, for example a study in which Gould, Greenberg, Velting & Shaffer (2003) reviewed the youth suicide risk and preventive interventions of the past ten years in the United States of America. These authors, as many others do, encourage further research to focus on developing and evaluating ‘empirical based’ suicide prevention and treatment protocols.

The rationale for this study

I have shown how suicide remains a problem in New Zealand in the context of this phenomenon being understood as a correlate of many factors. Practitioners make use of these correlation studies, exploring how these factors may predetermine, precipitate or maintain suicidal thoughts and attempts. Those factors that are deemed to contribute to the client's suicidal thoughts and behaviour become the focus of treatment, for example, the symptoms of depression become the practitioner's primary concern when they are associated with suicide. However, mental health professionals are reportedly struggling to address this problem in New Zealand despite the many correlation studies and the interventions that flow from them. This would suggest that a different approach is needed. A similar trend has been observed in Canada where numerous empirical orientated studies and interventions appear to have made no significant difference to managing the problem of suicide in practice (Cutcliffe, Joyce, & Cummins, 2004). One of the main reasons for this, according to these authors, is that a natural-scientific mode of understanding says little about the particular lived experience of suicidal clients and is consequently not taken into account in practice.

Empirical studies with their natural scientific epistemology generally depict suicide as an event that heralds the loss of meaning for the individual. This depiction can imply that suicide is a symptom of not attaining some standard or benchmark of meaning. But, as Cutcliffe, Joyce & Cummins (2004) have pointed out, suicide is not the end of something; it is part of a process. It is part of the process unique human beings find themselves in, in searching for meaning in the unfolding life that belongs to them. Thus, suicide is not a comment on the attainment or failure of a standard of meaning. It is a statement about the perpetual struggle and search for meaning in the lifeworld of each and every person. Empirical studies do not reflect an understanding of this subjective experience of the individual for whom suicide becomes a necessary act. If empirical orientated studies fail to reveal the life-world of the suicidal client, what do therapists encounter in their work? What do they experience in these encounters that could say something about the difficulties inherent in the traditional way of understanding suicidal clients that perpetuate in practice? It is conceivable that the efficacy of prevention and treatment of suicidal clients is jeopardised by not attending to that which is found between the predicted and the revealed. The experiences of therapists may say something about this fallow ground.

A world understood in accordance with the laws of natural science is not the lifeworld of being human. Instead "we only understand a world somehow finding a way into it and the experience of things it gives birth to" (Wrathall, 2005, p. 20). Whilst the philanthropist, the suicide bomber and the suicidal person are subject to the same physical and chemical laws, they in a real sense inhabit different worlds. If we fail to understand this, we fail in understanding ourselves, says Wrathall (2005). It may be that one of the reasons mental health professionals are struggling to address the problem of suicide in New Zealand has to do with the failure to entertain the notion of many different worlds and the many different meanings individuals are able to extract from dwelling there. In a natural scientific paradigm of understanding there is only one world (Willig, 2001). When you have someone dwelling in a world they consider being the only world attempting to help those who dwell in different worlds there is an abrupt discontinuity of intelligibility. What are the consequences when therapists have to negotiate disruptions of intelligibility, as they encounter something in their work that does not accord with what has been predicted by mainstream research findings and the recommendations that emanate from there? What happens when therapists lose these referential threads of understanding that could say something about the difficulties encountered in working with suicidal clients? The purpose of this study is to somehow find a way into the worlds of being human and the experience of things it gives birth to. It is my hope that by finding a way into the world of therapists' experience of working with suicidal clients that I may arrive at understandings which could augment our traditional way of understanding the problem and what we do with it

The methodology of this study

I have decided on a hermeneutic phenomenological methodology to approach this problem of suicide in New Zealand. If I intend to understand how therapists experience working with suicidal clients and want to avoid the pitfalls of a natural scientific epistemology – particularly the notion of a one and only world – then I must take an epistemological position which attends to phenomena in themselves and the reality that is theirs. Heidegger's phenomenology of Dasein (human being) makes this possible. The branch of research which calls itself phenomenology is "to let that

which shows itself be seen from itself in the way in which it shows itself from itself" (Heidegger, 1962, p. 58). For Heidegger to understand how human beings make their world intelligible and determine what to do and how to live requires first and foremost an understanding of the being 'who' is making meaning and deciding. Thus, understanding therapists experience working with suicidal clients begins with understanding who is experiencing, giving meaning and deciding what to do.

Heidegger's phenomenology studies the phenomenon of being human (Dasein) and the modes of being-in-the-world. His phenomenology is ontology because it concerns the nature of being; the experiences of being human from whose vantage points other beings are understood. His phenomenology aims to let the things of the world speak for themselves and asks: what is the nature of this being? – what lets this being be what it is (Van Manen, 1990)? Heidegger's phenomenology wants things to show themselves – that which it is being (verb) – by distinguishing between how it appears (ontically) and its essence (ontological). His phenomenology attempts to offer an account of experienced time, place and human relationships as it is lived.

Hermeneutics is the science and practice of interpretation (Van Manen, 1990). Why is there an interpretation of our own being and the being of things necessary? Heidegger asserts that the understanding of our being is never fully accessible because it is covered up. We go about our everyday with such familiarity and self-evidence, and in such an unreflecting matter of fact manner, that the nature of our being becomes associated with what we do. But our doing is not our being, yet there is a reference to who we are in our doing. It is due to this phenomenon of 'covering up' that interpretation is required. Interpretation is the method by which we distinguish between appearance (ontic) and essence (ontological), the 'what' and the 'who' of the beings we are. "Our Being alongside the things with which we concern ourselves most closely in the 'world'…guides the everyday way in which Dasein is interpreted, and covers up ontically Dasein's authentic Being, so that the ontology which is directed towards this entity is denied an appropriate basis" (Heidegger, 1962, p. 359). To grasp the meaning and significance of what we do requires a grounded understanding of who is doing it. To understand how therapists experience working with suicidal clients the way they do requires an understanding of their being human in itself.

Why do I propose a qualitative methodology, which hermeneutic phenomenology is? A qualitative methodology is inductive and open to new meanings and redefinitions (Willig, 2001). I argue that a scientific attitude is not the appropriate attitude to adopt if one is interested in understanding phenomena relevant to being human. The reason for this is that an investigation into phenomena with an epistemology founded on philosophy of mind decontextualizes the lived world of Dasein. The phenomenon is uprooted from its origins and becomes detached from its referential context of meaning and significance from a human experiential point of view (Heidegger, 1962). "Scientifically relevant 'facts' are not merely removed from their context of selective seeing; they are theory-laden, i.e., recontextualized in a new projection" (Dreyfus, 1991, p. 81). This is a projection which no longer belongs to Dasein and its existence, but now belongs to the existence of science. The theory of mind philosophy behind a natural scientific enquiry diverts its focus and attention to a phenomenon which no longer matters for the experiencing person. It develops an understanding based on its interpretation and not the self-understanding based on the interpretation of the being that is human. It begins to understand itself rather than Dasein.

The impetus for this project

The impetus for this project has many strands, some of which I will also make explicit in chapter four. The phenomenon of suicide in a peaceful New Zealand, its generally gentle people and stunning natural beauty, perplexed me soon after emigrating from South Africa in 1994. The enigma deepened when I discovered that New Zealand, in the context of its high youth suicide rate, is also a country for whom extreme sport appears to be important and self defining (Mahne, 2004). Why would people want to challenge death in this playful manner when there are already disproportionately many around us who are failing to hang on to life? Has death got no meaning?

My reading of Milan Kundera (1995) and his notion of 'the voice of emptiness which calls us from below' resonated with the idea of existential anxiety (Kierkegaard, 1980). I came to think that suicide and death defying acts converge in the question; what is the significance of my life and my death? Correlation studies do not begin to address this question in research into suicide and practitioners consequently pay little

attention to this idea when they consult with suicidal clients. Perhaps this is why mental health professionals are struggling to address the problem. Positivist orientated research findings in practice fail to reveal this dynamic for the suicidal client. Therapists consequently concern themselves with treating and addressing factors associated with suicide, instead of attending to suicide itself and its relationship with the meaning of life and death for the suicidal client. "It is vital for psychotherapy that the work of helping our patients with 'the question of the meaning of Being'" is attended to because it is a question at the heart of everything our patients bring (D. Loewenthal & Snell, 2003 p. 26). Further, it is important to reveal what it is like to be the therapist who receives news that a client has committed suicide. How does such news impact on therapists? What is the on-going experience of living through the aftermath? The phenomenon of suicide is about more than the person who takes their own life.

The structure of this thesis

This thesis is presented in eight chapters.

Chapter one, **"Introduction"** identified the problem to be investigated, the context and complexities, the purpose, why I selected a hermeneutic phenomenology as methodology and the original impetus for embarking on this project.

Chapter two, **"Literature Review"** explores literature specifically relating to 'suicide'. I describe what is already known about the phenomenon and how therapists experience suicidality. I discuss the foremost therapeutic modalities towards suicidality and the interface between research and practice.

Chapter three, **"Philosophical Foundations"** describes the philosophical ideas of Martin Heidegger which have provided the foundation and guidance for this study.

Chapter four, **"Method"** clarifies the conditions by which understanding in this study has taken place and my pre-understandings. I show the congruence between the philosophical underpinnings and the steps taken to answer the research question.

The interpretive analysis of this study is presented in Chapters five to seven:

Chapter five, **"Being surprised and shocked"** explicates therapists' shock and surprise at the unexpected and unpredictable suicide of their clients. I discuss how there is a disjunction of understanding and experience which can be attributed to an epistemological confusion in the field of mental health embodied in practice which generates a misrepresentation and misinterpretation of what it means to be human.

Chapter six, **"Being responsible"** makes the extraordinary sense of responsibility therapists felt towards their suicidal clients explicit by looking closely at what it means to care and the fear and guilt they encounter in the process. It shows how therapists face a number of dilemmas in their wish to be responsible and caring practitioners and no matter how they cared, people committed suicide.

Chapter seven, **"Being unfamiliar"** discusses how the crisis of existence suicidal clients talk about in therapy resonates within the therapist at a very personal level. I discuss how suicidal clients confront therapists with certain professional, institutional and personal issues which bring them to experience their own crisis of existence during the course of therapy.

Chapter eight, "**Discussion"** considers the implications of this study for practice, education and future research about therapists' experience working with suicidal clients. Limitations are offered as a means for further research and I offer recommendations how our understanding and treatment of suicidal clients could be broadened and augmented.

Chapter Two

Literature Review

Introduction

What do I anticipate when I ask about 'therapists' experiences of working with suicidal clients?' I anticipate that therapists' experiences with suicidal clients will hinge on their assessment and treatment of the problem. That is in essence what therapists do. For Heidegger our way of knowing and doing is influenced by the fore-structures of our understanding. The aim of this chapter is to gain a broad view into what therapists already know about working with suicidal clients. Our 'knowing' as therapists is represented by the ascendant thoughts and practices in existing literature. The literature on suicide discloses our understandings of suicide which contributes to how therapists experience suicidal clients. First, I will discuss those factors most often associated with suicide in a causal way and the inherent limitations of this way of knowing. Then I will offer an overview of the more dominant therapeutic modalities towards suicidal clients in New Zealand and their associated limitations. I will then discuss the interface between psychological research and practice in New Zealand and also consider research findings into therapists' experiences with suicidal clients in view of this interface. The chapter will conclude with a summary of the limitations identified and their impact on the way in which mental health professionals practice their understanding of suicidality. I will suggest how these limitations could be minimized, showing the need for the particular focus and methodology of this study.

Suicide and Mental Health

It is widely accepted that suicide is a complex problem that cannot be reduced to a single causal factor. Nevertheless, the New Zealand Ministry of Health (2006) is of the view that the mental health of an individual is a major contributor to suicide. The mental health of an individual is said to be affected by factors such as mental disorders, childhood adversity, cognitive and affective factors and a possible neurobiological predisposition towards suicidality.

Mental Disorders

It is said that mood disorders, substance-abuse disorders and antisocial behaviour play the strongest role in the aetiology of suicidal behaviour (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005; Beautrais, Joyce, & Mulder, 1998a; Harris & Barraclough, 1997). This view is shared by the psychological autopsy studies of Cavanagh et al (2003). A psychological autopsy is a method of investigation in which the relationship between antecedents and a phenomenon is examined, often relying on a computer aided search of relevant studies. By means of statistical methods and formulae, correlations are determined to identify causal relationships. The aforementioned researchers found that mental disorder was the one factor most strongly associated with suicidality and they suggest that suicide prevention strategies may be most effective if they are focused on the treatment of mental disorders.

Mood disorders that are most commonly associated with suicidality are major depression, bipolar disorder and dysthymia (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005; Kay & Francis, 2006). Harris and Barraclough's (1998) statistical overview of the literature on suicide and causal factors found that the risk of death from 'unnatural causes' is especially high for schizophrenia and major depression. In a study by Kuo, Gallo & Eaton (2004) hopelessness was found to be an 'extremely important' and a more consistent predictor of suicidal behaviours than the presence of a diagnosis of either depressive disorder or substance abuse. Kuo et al assert that intervention strategies which focus on ameliorating feelings of hopelessness, in addition to the specific treatment of depression and substance abuse, may prevent suicide.

Substance-use disorders (alcohol, cannabis and other drug abuse and dependency) are often associated with suicidality and frequently coexist with other mental disorders (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005). A psychological autopsy study conducted by Shen et al (2006) found that almost one-half of the suicide victims in a large metropolitan area in America had a mental illness and twenty six percent of those had a history of alcohol or substance abuse. Another study in America, using questionnaires and statistical analysis, found a similar association between major depression and substance-use disorder when these disorders present concurrently

(Davis et al., 2006). A psychological autopsy study at a mental health service in Auckland (New Zealand) by Fortune, Seymour, & Lambie (2005) found that a previous history of deliberate self-harm was a predictor of future suicide behaviour. Children and adolescents with suicidal behaviour show higher rates of bio-psychosocial stressors such as maternal substance abuse, own substance abuses, a family history of offending and sexual abuse when compared with a similar clinical sample in which suicide is not a factor. These authors assert that suicide behaviour is not the result of a single life event, but rather, the outcome of multiple risk factors, often accumulated over a lifetime. These authors suggest that a successful reduction of suicide behaviours is likely to include individualized interventions that target the young person themselves as well as the associated risk factors in the wider context of their lives. In a longitudinal study in New Zealand (Fergusson, Horwood, & Swain-Campbell, 2001) the use of cannabis was found to be associated with a range of adjustment problems in adolescents and young adults, adjustment problems such as crime, the use of other illicit drugs, depression and suicidal behaviour. Their method of investigation consisted of a statistical analysis of data gathered through reports, psychometric assessment results, medical records and parental interviews.

Anxiety disorders are found in three to seventeen percent of those with serious suicidal behaviour, according to Beautrais et al (2005) and often occur with mood and substance-use disorders. The aim of the longitudinal study by Waerne et al (2002) was to analyze the association between anxiety disorders, depression, alcohol dependence or abuse and suicidal behaviour. The conclusions of their face to face interviews were correlated with psychiatric diagnostic results. They found that anxiety disorders with suicidal behaviour occurred secondary to mood disorders and do not make an independent contribution to suicide risk. However, Sareen et al (2005), using a similar method of enquiry, concluded that a pre-existing anxiety disorder is an independent risk factor for the subsequent onset of suicidal ideation and attempts.

Personality disorders in correlation with suicide appear to follow a similar pattern as anxiety disorders. Two studies, using similar methods of investigation (structured and semi-structured interviews to confirm diagnoses) found an increased risk of suicide and suicide attempts associated with personality disorders and Axis I Disorders (Preuss, Koller, Barnow, Eikmeier, & Soyka, 2006; Schneider et al., 2005).

While schizophrenia occurs infrequently (estimated at one percent) in the general population, a relatively high percentage of those with schizophrenia will make a suicide attempt, according to some literature reviews (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005; Harris & Barraclough, 1998).

High rates of comorbidity are thus found among those making suicide attempts or dying by suicide and, according to Beautrais (2005), the risk of suicidal behaviour increases exponentially with an increased number of comorbid mental disorders.

Childhood adversity

Adverse childhood experiences have an enduring influence towards the development of mood disorders, substance abuse and suicidal behaviour, which persist into adulthood (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005; Molnar, Berkman, & Buka, 2001). Pronounced suicidal behaviours are found among young people from disadvantaged and dysfunctional family backgrounds that are characterized by features such as parental separation or divorce, parental psychopathology, a history of sexual, physical and emotional abuse or neglect, impaired parent-child relationships, parental discord and parental violent behaviour.

Corcoran et al (2006) assessed the effect of adverse childhood experiences on the lifetime prevalence of suicide ideation in a cross-sectional study involving 182 patients aged 18 to 44 years. All participants were interviewed using standardized questionnaire instruments. The response rate was 73%. In multivariate logistic regression analyses, those with a history of two or more forms of childhood adversity relative to those with none were at increased risk of depressed mood and suicide ideation. The authors suggest that the findings emphasize the need to set suicide prevention within the broader context of society's obligation to protect children from physical, emotional and sexual abuse. In a study by Rossow (2001) the self-reported data collected from structured interviews with therapists indicted suicidal behaviour and ideation among drug addicts to be highly prevalent and more so with an increasing number of areas of childhood adversities. In another study seventy-four subjects, 65% of whom were women, consecutively admitted to a general hospital, after having made a suicide attempt, were interviewed as part of the intake interview

about prior suicide attempts and self-mutilation and given psychiatric diagnoses. It was found that physical and sexual abuse was significantly and independently associated with repeated suicidal behaviour (Ystgaard, Hestetun, Loeb, & Mehlum, 2004).

Neurobiological factors

According to Beautrais (2005) there is a strong focus on the role of genetic and biological factors in current suicide research. The fact that higher suicide rates and attempts are found in families of individuals with suicidal behaviour, than in the families of people without suicidal behaviour, would suggest that genetic factors are involved in suicidal behaviour. Serotonin system dysregulation is also associated with increased risk of suicide and suicide attempt, but little is known about the processes by which serotonin and suicidal behaviour might be linked, says Beautrais (2005).

Cognitive and Affective factors

Psychodynamic theories about suicide contend that the meaning of suicide for patients derives from both affective and cognitive components. It is Hendin's (1991) view that conscious and unconscious ideas about reunion, rebirth, retaliation, revenge, self-punishment and atonement give meaning to suicide in the same way that it gives meaning to death. Similar affective dynamic factors were found by analyzing the data collected from twenty six therapists who had been treating patients when they died by suicide (Hendin, Maltsberger, Haas, Szanto, & Rabinowicz, 2004). Case studies have explored the causes of rage and anger in association with suicide. Conscious rage was found to originate in early personal exposure to violence (Hendin, 1991), in experiencing one's own limitations (Bron, 1985) and in experiencing the shortcomings and failure of others (Oldham, 2006). In more recent times, suicide has been linked with the anger and outrage inspired by radical ideologies of hate and violence enacted by the suicide bomber (Orbach, 2004; Zakaria, 2005).

Guilt is frequently associated with suicide and said to be engendered by disparate experiences such as combat-related guilt in the analysis of Vietnam war veterans' questionnaire and interview results (Hendin & Haas, 1991), belief of having committed a religious sin (Exline, Yali, & Sanderson, 2000), the belief of inadequacy

or unworthiness, as in the case study by Kalafat & Lester (2000) and the correlation analysis of psychometric test results by Lester (1998).

Suicide can also be understood as an act of revenge or a reaction to threat. Suicide has been interpreted as an act of revenge for perceived political injustices (Ozernoy & Saleh, 2005; Preti, 2006), cultural oppression (Counts, 1987) and the result of a breakdown in spousal relationships (Milroy, 1995). In their research, by interview about the problems in psychotherapy with suicidal patients, Hendin et al (2006) found that suicide was used as a method to control the course of therapy and the therapist. The threat of suicide is used to demand a certain attitude or activity from the therapist.

Suicide may also be understood as an act of self-punishment or atonement. Burns-Cox (2005), in a case study of suicide by self-starvation, found that it represented a means of self-punishment. Hemmings (1999) interviewed people who self-harmed and found that accident and emergency staff may unwittingly reinforce the cycle of guilt and self-punishment, if they fail to take cognizance of self-harming victims' perception that accident and emergency staff are punitive and judgmental. In a study of Sigmund Freud's notes and formulations regarding suicide, Leenaars & Balance (1984) found frequent reference to suicide as an act of self-punishment.

Baumeister (1990), in his literature study, suggests that suicide is an escape from the self and the world through cognitive deconstruction. He defines cognitive deconstruction as a refusal of meaningful thought and a low level of awareness. It is a state of mind preceded by a process in which a person had come to experience themself as inadequate and a failure, when measured against societal standards and norms. This experience of self as inadequate has an aversive effect on the 'agents of meaning', namely affect, emotional states, attributions and self-awareness.

A reading of Binswanger (1958) and Tillich (2000) would suggest that the aforementioned affective and cognitive factors that cause people to commit suicide are born from an existence of despair. Central to the arguments of Schopenhauer (1970), Kierkegaard (1983), Nietzsche (1990) and Laing (1965) is the conviction that the modern person's overemphasis of ego consciousness neglects and eschews the inner world of human experience as a legitimate aspect of human reality and that this

is at the heart of human despair and suicide. Suicide, when positively considered, is seen to be a meaningful act. It aims to resolve this existential impasse from a psychological perspective.

Hopelessness and despair may also stem from less metaphysical experiences encountered in every-day life. A statistical data analysis by Butterworth et al (2006) indicate a strong association between demoralization and suicidal behaviour for people dependent on government income support, compared with those who are not. Pompili et al (2006) analyzed the test inventory results of psychiatric nurses and found a strong correlation between burnout and hopelessness which, according to this research, are indicators of suicide. Bonner (2006) found a similar result in his correlation study of hopelessness and suicide for prisoners held in segregation.

Researchers in the United States of America have found that some therapists and society in general, conceive of suicide as an act of reason in response to a terminal illness or a prolonged and debilitating disease such as AIDS. Under these circumstances some therapists consider it reasonable that a person would decide to end their suffering by suicide (Rich & Butts, 2004; Siegel, 1986; Werth, 1995; Werth & Cobia, 1995; Westefeld, Sikes, Ansley, & Hyun-Sook Yi, 2004).

Psychosocial Factors

Psychosocial factors which are most frequently associated with suicidal behaviour are stressful adverse life events such as humiliation, loss, defeat, threat, shame and inter-personal losses or conflicts (Bhatia, Khan, Mediratta, & Sharma, 1987; Counts, 1987; Houle, 2006). Other psychosocial factors associated with suicidal behaviour relate to various forms of social interaction such as social isolation, feelings of loneliness, poor social support and a lack of a close and confiding relationship (Beautrais, 2001; Kidd, 2006).

Social and Demographic Factors

Internationally suicide has been associated with a range of social and demographic factors and these findings follow a similar trend in New Zealand. For instance, the risk of suicide increases with age after puberty and internationally suicide is the most common among those aged 18 to 24 years, whilst in New Zealand the risk of suicide

is highest among men aged 20 to 44 (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005). Females are more likely to make non-fatal suicide attempts, while males are more likely to die by suicide in New Zealand across all ages and across ethnicities (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005).

Religious affiliation and religious activity appear to protect against suicide, with higher rates of suicide among those without religious affiliation (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005). It is neuroticism, rather than religion, that is an indicator of suicidal ideation, according to Hills & Francis (2005). In their sample of 501 undergraduate students at a church-related university-sector college in Wales, the participants completed a number of assessment scales and questionnaires which were then statistically analyzed.

In the Buddhist tradition death has a particular meaning. They refer to it as the moment of true liberation when you realize that what you consider to be real is nothing other than the projection of your thoughts and images (Nakazawa & Penick, 1994). In their comparative study Zhang and Jin (1996) set out to provide insight into cultural factors that impact on suicidal ideation among American and Chinese college students. The study was designed to include both social structural and psychological theoretical models of suicide and how they may relate towards a broader understanding of this phenomenon. The statistical analysis of questionnaires designed to identify the occurrence of suicidal ideation, pro-suicidal attitudes, depression, family cohesion and religiosity found that American and Chinese females scored higher on suicidal ideation. It has been suggested that Protestant culture has become more tolerant towards suicide in the previous century and that Jewish culture has traditionally not condoned suicide, supported by reports that suicide rates are somewhat lower among Jews than among Protestants (K. M. Loewenthal, MacLeod, Cook, Lee, & Goldblatt, 2003).

By means of a questionnaire Kay & Francis (2006) set out to study whether churchgoing provides protection against suicidal ideation among young individuals in England and Wales. A statistical analysis of the results suggests that church attendance is shown to offer significant protection against suicide ideation, while the protection of team sports is insignificant. These researchers offer the interpretation

that the church functions as a therapeutic community and it does this more effectively than the secular activity of team sport. It is suggested that the nature of this protection is emotional and cognitive support. Theological theories about suicide suggest that religiosity is a significant protection against suicide due to a number of factors (Kay & Francis, 2006). It offers a shared system of beliefs made explicit by religious institutions which strengthen the sense of mutual longing. The powerful narrative about the resurrection is a benchmark against which all human experience can be set and which can put all human problems in proportion. It thus offers meaning as well as hope.

Cultural Factors

Maori, the indigenous culture in New Zealand, predominate the group in which suicide is associated with factors of vulnerability, disadvantaged and difficult life circumstances (Beautrais, Joyce, & Mulder, 1998b) and according to the Ministry of Health (2001), Maori continue to have a higher suicide rate than non-Maori. The suicide death rate for Maori youth (15-24 years old) in 2003-2005 was 33.2 per 100, 000, compared with the non-Maori rate of 14.6 per 100, 000 (Ministry of Social Development, 2008). These statistics provide compelling evidence that cultural issues are related to suicidal behaviour and suggests that a New Zealand suicide prevention strategy must include, as a major objective, measures to reduce inequalities in suicidal behaviour for a range of populations defined by age, gender and ethnicity (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005).

The limitations of our 'already knowing'

In the literature suicide is conceived of as something that is part of a causal equation. This conception of suicide stems from the notion that human beings have bodies rather than embodied beings, in other words being "the bodily expressions of that unity called existence" (Brooke, 1991, p. 148). It is this notion that human beings have bodies which validates the practice of naming and categorizing, because the body is seen as a causal source that produces symptoms as it relates in a functional way with other entities in the environment. From this premise it makes sense that one can heal human problems by healing bodily symptoms; if one heals depression one heals the person. The ascending literature on suicide does not entertain the possibility that "the human body is an expression of meaning and not a causal source" (Brooke,

1991, p. 148) and this leads to our misinterpretation of suicide as something that is ontic rather than ontological. The literature reflects how it is possible to transform the multifaceted nature of human existence into a one dimensional cause-effect relationship. On this basis practitioners attend to what is said (symptoms) as if that is what it is, and forget that what something is remains concealed in the being telling. In this way of seeing suicide the idea of correction and cure follows suit. How can psychology begin to attend to suicide as the embodiment of being, which surpasses the notion of the suicidal body to be cured and corrected? It is a challenge.

Hillman (1992) gives further expression to this notion of the embodied beings that we are. In his view our inclination to name and categorize differences as pathological is motivated by our monotheistic history and tradition that instils "the normative ideals of health as balanced wholeness which derives either from statistical averages or idealizations of a sound mind in a sound body, a superhuman image of God-man" (p. 89). But what if suicide is not a wish to be perfect and whole but an appeal to understand 'the person in the words' who is not speaking about human perfection, "or even about the complete human being carrying his wounds and his cross" (p. 89), but about the lacunae, the gaps and the wasteland? The problem in our literature on suicide is not that it portrays suicide as an illness, an aberration or a deviation, the problem is that we tend to misinterpret these statements for what they are. Hillman asserts that illness is an embodiment of our being that invites an imagining of life through this deformed and afflicted perspective. In other words, it is a mode of being and an ontological statement.

Another limitation of understanding a phenomenon through literature reviews, correlation studies, surveys, test inventory results and case studies is that the phenomenon under investigation too frequently gets covered-up with discipline specific names and categories which are used to develop theories and hypotheses about what suicide is for the person-that-is-there. When we are being with things in such a present-at-hand mode of understanding we are standing back, removed in a spectator/theoretical attitude of understanding (Dreyfus, 1991). In this mode we make a phenomenon intelligible through isolation and categorisation, we remove it from its referential network and associations and it becomes known in an atomistic way. This form of understanding does enrich knowledge-about, but not meaning-of. The essence

of a phenomenon as lived and experienced by the person-that-is-there is lost in this mode of understanding.

The existing literature on suicide shows how suicide is correlated with mental disorders, which is seen as major contributing factor. People are said to be predisposed to mental illness due to adverse childhood conditions, genetics, biological factors, demographic factors, etc. The problem with correlation studies is that the appearance and essence of phenomena are conflated during enquiry, in other words, suicide is what it looks like. Suicide is understood when it looks like a mood disorder, or like schizophrenia, or like past sexual abuse and is thus not understood for what it is for the person who is suicidal. Phenomena are not accurate in showing themselves and the essence of a phenomenon is veiled by how it appears (Heidegger, 1962). When appearance and essence are conflated, as they are in correlation studies, the phenomenon is misrepresented and this results in the misinterpretation of the phenomenon in practice.

Another limitation associated with this theoretical form of knowing is that the practitioner is tempted to limit their enquiry into what suicide means for a client by reducing the phenomenon to the understanding of the profession and its research findings. The consequences of this are twofold. One, this form of knowing and practicing not only deconstructs the client's experience but also reconstructs it into an understanding which does not resonate with the life-world of the client and how the client understands and interprets the way in which they have come to exist. Secondly, this form of knowing and practicing encourages practitioners to be therapeutic technicians, applying research findings without recognizing the full significance and importance of how symptoms 'speak about' the factical life experience of the client's way of existing. When practitioners adopt this theoretical way of understanding they proceed and act in a way that responds to the understanding of theory and the profession and not an understanding of the person present. In view of this I want to give a brief insight into how our 'already knowing' becomes evident in therapists' approach to suicidal clients and their experiences. I will now discuss the preferred therapeutic modalities towards suicide in mainstream psychology, with particular reference to New Zealand.

Therapeutic modalities and their approaches towards suicide

Understanding precedes interpretation, says Heidegger (1962). Both inform one's attitude and response to the phenomenon under consideration. The aim of this project is to understand how therapists experience their suicidal clients, motivated by the high suicide rate in New Zealand and the apparent ineffectiveness of mental health professionals to address the problem. Epistemology and praxis are inseparable and inform each other in a circular fashion. What I do is determined by what I understand and what I understand is determined by what I do. For this reason it is important to consider the mainstream therapeutic practices that are brought to bear on addressing the problem of suicide in New Zealand.

Dialectical behaviour therapy and cognitive-behaviour therapy

The Royal Australian and New Zealand College of Psychiatrists say that "Cognitive-behavioural therapy (CBT) and problem-orientated approaches appear promising for reducing repeated self-harm for most patient groups, but no single treatment has confirmed superiority. Dialectical behaviour therapy (DBT) appears to confer most benefit" (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003, p. 150). Cognitive-Behaviour therapy has been the mainstay of therapeutic treatment in New Zealand (Evans & Fitzgerald, 2007). In the British National Health Service this position is shared with psychoanalytic psychotherapies and systemic psychotherapy (Milton et al., 2003). Support for therapeutic interventions motivated by Existentialism and Phenomenology is challenged to be recognized more formally in the British National Health Service (Milton et al., 2003). It is not a therapeutic attitude that I have come across in New Zealand District Health Boards in a noticeable way.

Cognitive-Behaviour therapy is a therapeutic modality situated in the broader tradition of behaviourism; a category of treatment focused on the interchange between the person and his environment, i.e. stimulus and response (Kruger, 1979). According to cognitive theory, dysfunctional beliefs stem from negative learning experiences in childhood. These beliefs endure into adulthood, are inflexible in nature and lead to cognitive distortions. When dysfunctional beliefs and their associated cognitive distortions are activated, it often results in angry outbursts and impulsive behaviour to reduce the anxiety caused by the distorted appreciation of things. It is hypothesized that the principle mechanism for change in cognitive therapy is the modification of

dysfunctional beliefs (Corrie & Milton, 2000; Wenzel, Chapman, Newman, Beck, & Brown, 2006).

It is now well established, according to some researchers (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003; Goldney, 2005; M. M. Linehan, Heard, & Armstrong, 1993; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006; Verheul et al., 2003) that dialectic behaviour therapy (DBT) is perhaps the most 'specific effective psychotherapeutic intervention' to reduce 'life-threatening impulse-control disorders' such as borderline personality disorder, in which suicide is a significant feature. Perseius et al (2003) set out to determine how dialectic behaviour therapy is perceived by both borderline personality disorder patients and their DBT therapists, in other words, the therapeutic factors inherent in dialectic behaviour therapy which prevent patients from harming themselves through suicide or other means. Their study concluded that dialectic behaviour therapy resulted in a significant decline in suicidal attempts and acts of self-harm. The client participants attributed this to experiencing respect, understanding and confirmation from the DBT therapists and felt that this therapeutic model placed an expectation on them to be actively involved and take responsibility for their therapy and their lives. In addition, they considered the skills acquired in treatment crucial to conquer suicidal and self-harm impulses. The therapist participants concurred with these findings in their narrative accounts. The therapist participants attribute the success of the DBT approach to its "theoretical underpinnings and therapeutic techniques [and the] personality of the therapist is of minor importance" (Perseius, Öjehagen, Ekdahl, Åsberg, & Samuelsson, 2003, p. 224). The therapists also felt that it was critical to stick to the therapeutic manual and stated that failures occur when "you don't stick to the manual but instead" therapists work "by 'their own heads'" (Perseius, Öjehagen, Ekdahl, Åsberg, & Samuelsson, 2003, p. 224).

Standard behavioural modification techniques appear to be successful regardless of the phenomenon of intent. It is claimed to be successful with suicidal individuals (M. Linehan, 1993; M. M. Linehan, Heard, & Armstrong, 1993) and is equally successful with all the syndromes that fall within the diagnostic parameters of anxiety and depression, according to researchers (Beck, 1976; Beck & Emery, 1985; Beck, Rush, Shaw, & Emery, 1979; Heimberg, 1993; Meichenbaum, 1977; O'Leary & Wilson,

1975; Rush, 1982; Zinbarg, 1993). Technique driven therapies that apply their techniques across a disparate range of phenomena suggests two things in my view. One, the person is not primarily understood in his or her specific life-world and is made to fit a theoretical construct of being human and seen as a representational object. Two, technique driven therapies are an extension of the scientific/theoretical way of knowing and the therapist no longer trusts the reality and truth that emerges by virtue of being-with as human beings (Cohn, 2002). Therapists no longer trust what the person present has to say and therapists have come to distrust the adequacy of their understanding by virtue of their own humanness.

In the study by Perseius et al (2003) the patients attributed the success of dialectic behaviour therapy to feeling respected and understood. Yet, the therapists attribute the success of treatment to the 'minor importance' of their personalities as therapists and claim that failure occurs when a therapist fails to 'stick to the manual'. In my view it would seem that the success of dialectic behaviour therapy for suicidality in this study may not be attributable to what the therapists consciously did, but may rather be the result of what they think they deliberately didn't do. They seem to have a therapeutic effect despite themselves. How is it possible to know why a particular activity has a certain effect in view of this kind of misinterpretation? This discrepancy is not identified or noticed by these researchers in their results and it demonstrates the phenomenologist's challenge to the validity and reliability of research where researchers do not consider their personal contribution to the research process and believe that they are dispassionate observers. This discrepancy also illustrates how a technical-theoretical driven approach to therapy misinterprets the beings that we are. No matter what we think we do when with others, we are always first with-another as Dasein being-in-the-world.

Corrie & Milton (2000) point out that in cognitive-behaviour therapy the emphasis on 'doing' neglects a full appreciation and understanding of 'being', the one who is doing, or asked to do in therapy. In their view cognitive-behavioural therapy and existential-phenomenological therapies have the concept of meaning in common and could augment one another, but it would require the therapist to remain phenomenological rather than being theory led. The idea of 'skills transfer' from therapist to client and the prescription of how to change thoughts and behaviours is

therapeutic dogma eschewed by phenomenological therapists. Dasein is embedded in a multifaceted world as being-in-the-world where there can be no Dasein that is self-sufficient and independent (Corrie & Milton, 2000), and for that reason requires a full appreciation of 'being' in thought and mood. Milton et al (2003) are of the view that it would be helpful to consider replacing the epistemological framework that underpins clinical practice with an existential one.

The significance of the being the therapist is in the therapeutic encounter is not a primary concern in cognitive-behavioural therapies. The emphasis is on knowledge and technical skill.

Psychodynamic therapies

A reading of the literature on psychoanalytic informed therapies suggests that it is a modality that claims to also be successful in treating suicidality. After a year of twice weekly psychotherapeutic treatment of 30 patients diagnosed with Borderline Personality Disorder (BPD), Stevenson and Meares (1992) reported a significant improvement in key diagnostic indicators such as self-harm and suicidality. Bateman and Fonagy (2001) report a similar result in their study with BPD patients who completed a psychoanalytically orientated partial hospitalization program. According to Kernberg (1975) BPD patients have difficulty integrating disparate representations of themselves and others because negative emotions, such as aggression, disrupt their capacity to integrate these partial representations. "Strong, unmetabolized or unprocessed emotions have the capacity to overwhelm positive representations", says Kernberg (Levy et al., 2006, p. 484). This lack of differentiation and integration of internal images of self and others is called identity diffusion (Levy et al., 2006).

Based on Kernberg's object relations model of BPD, Transference Focused Therapy has shown a reduction in suicidality and anger (Levy et al., 2006). BPD people have a "split psychological structure" where "negative representations are split or segregated from idealized positive representations of self and others", says Kernberg (Levy et al., 2006, p. 486). The putative global mechanism of change is the integration of these 'object relations dyads' into a more coherent whole. This increased coherence results in a greater capacity for intimacy and reduction of self-destructive behaviours. From the therapist's point of view the mechanism of change consists of a structured

treatment approach, using a treatment manual, clarification, confrontation and interpretation. The technical application of therapeutic constructs such as clarification, confrontation and interpretation is traditionally central to treatment in most psychoanalytic informed psychodynamic therapies (Davanloo, 1978; Malan, 1978, , 1979; Sifneos, 1978; Waska, 2009). "Today, most psychodynamically-oriented therapists would agree on the significance and importance of understanding a patient's defensive functioning in therapy. This theoretical position undoubtedly raises the question as to how a clinician should deal with a patient's defences during a therapy session" (Junod, Yves de Roten, Martinez, Drapeau, & Despland, 2005, p. 419). Psychodynamic therapeutic methods rests on the theory that problems have their origin in the past, are usually associated with the frustration of biological derived needs that are repeated, or inappropriately transferred into the present until satisfied. In psychoanalytic theory a person is seen as a complex structure of Id, Ego and Super-ego, driven by biological needs. The unconscious biologically driven needs are often frustrated and inappropriately acted out in the here-and-now, and the dynamic tensions between the structures of Id, Ego and Super-ego require interpretation towards clarification, resolution and equilibrium. Psychodynamic therapeutic methods and theoretical positions, in my view, seem to deconstruct lived human experiences and reconstruct them in accordance with their own technical structures of understanding. I have attempted to illustrate this point in the aforementioned quotation of "split psychological structure" where "negative representations are split or segregated from idealized positive representations of self and others".

Todres (2002) asserts that contemporary culture and science enables a view of human identity that focuses on our 'parts' and the compartmentalisation of our lives into specialised 'bits'. This is a kind of abstraction which psychology has taken upon itself to mimic, says Todres. My view is that our understanding in therapeutic practice should reflect and resonate with what is making sense for the client. The inherent danger of the technical reconstruction of human experiences is that it creates a breach in the being-with the client. Something gets lost in translation. Todres views therapeutic self-insight as the self-experience of a client of 'being more than' or being 'as possibility'. My reading of Todres would suggest that our contemporary culture's view of a person as 'parts and bits' result in psychological practices which aim to reconfigure and reassemble a person towards greater functionality and efficiency.

This technological view is embodied in some therapeutic modalities' intent and understanding. This embodiment manifest in words, such as 'split structures' and 'segregated human representations' of 'part objects' we collect within ourselves. This way of understanding and talking perpetuates and colludes with the compartmentalisation of human identity and living. This way, from a phenomenological perspective, depersonalises the human order, according to Todres. Our technological culture and its traditional ways overlook the possibility that humans are 'more than' things and self enclosed entities that react to forces and causes. Humans are more than functions and efficiencies.

Milton et al (2003) point out that psychoanalytic theory in practice discourages therapists to reveal anything about themselves. Furthermore, the encounter between the therapist and client is theoretically understood and reduced to transference and counter-transference exchanges. An example of this deconstruction of an authentic human encounter can be seen in the reflections of Taylor-Thomas & Lucas (2006) of their work with suicidal clients. The 'real' relationship (Cohn, 2002) is that which unfolds between therapist and client because of their being together. The notion of transference reduces what is 'actual and real' between therapist and client to something in the past; it transforms what unfolds here-and-now to something else that happened there-and-then which is now artificially transferred to you and I to explain what is happening between us.

Others contend that it is the therapeutic relationship and not technique that is the most important and overriding factor in the treatment of suicidal people in all forms of therapy (Leenaars, 2006; Michel, Dey, Stadler, & Valach, 2004; Reeves & Seber, 2004). "You have to know whom you are treating" and if you ask a patient what was helpful, he or she will state the therapist, not this or that technique (Leenaars, 2006, p. 305).

Suicide prevention is not an efficiency operation, but a human exchange in which the person's story is primary, not some demographic fact or nosological category of understanding or some form of reductionism (Leenaars, 2006). Research has found that suicidal patients with multiple contacts with different people over the years had a much higher rate of suicide than expected, according to Leenaars (2006). This finding

seems to support the notion of the primacy of the relationship that is a human exchange during which a story is woven. This process requires continuity and familiarity. Research by Hendin et al (2006) into the factors that appear to contribute to suicide whilst receiving psychotherapy, identify six recurrent problems. The most important ones, in my view, are not recognizing the meanings of patients' communications, and lack of communication between therapists where a patient's care was transferred from one to another. Knowledge of another begins as an act of intimacy, an experience-near encounter. The traditional medical model leaves the needs of suicidal patients unmet (Leenaars, 2006). The therapist is the sole expert. The model is linear and causal; regrettably, people and for that matter, nature, are not, according to Leenaars.

Relational therapy is a discipline of thought and practice in the field of psychology and psychotherapy which assesses and treats human problems within the context of human relationships expressed in dyadic, triangular and larger systems. Magnavita (2000) acknowledges that all therapeutic encounters unfold within a relational matrix, whether it is in cognitive-behavioural, experiential or psychodynamic therapies. Relational therapy, however, does not view psychopathology and symptoms as existing within the closed system of the patient (intrapersonal). Relationship therapy views an individual's problems as dialectic of the complex relational matrix within which the individual behaves, thinks and feels. The relationship between therapist and client is part of the client's relational matrix. Unlike previously mentioned therapies, relational therapy views the relationship between therapist and client as an intersubjective experience, as opposed to a transference relationship, according to Magnavita. This attitudinal stance in relational therapy has consequences for the therapist and his/her traditional way of assessing a person towards a diagnostic category of understanding and the treatments developed in accordance with diagnosis. As we expand the borders of traditional diagnostic nomenclature, distinguishing health from disorder becomes complex and it is "especially true when the diagnostic lens views individuals as they exist within families that reside within wider social milieus" (Rigazio-DiGilio, 2000, p. 1017). Our traditional way of assessing and responding to human problems tends to pathologise differences, subjugate individuals to the symptoms they exhibit, and perpetuate treatments designed to ameliorate dysfunction assumed to reside in individuals, says Rigazio-DiGilio. These traditional

approaches seem to ignore the relational, social and cultural systems that may contribute to and construe presumed disorders and their treatment. To avoid the problems associated with traditional methods of assessment and treatment, and subscribe to a relational therapeutic approach, places certain demands on the practitioner. It requires a philosophical orientation which can incorporate individual, relational and network diagnostic systems, says Rigazio-DiGilio. It requires the practitioner to weight the relevance of individual, family and wider relational system variables in therapy.

The interface of psychological research and practice in New Zealand

In examining the relationship between psychological practice and the basic scientific principles of psychology in New Zealand, Evans and Fitzgerald (2007) point out that the dominant mode of practice in New Zealand has always been behaviour therapy, and more recently, cognitive behavioural therapy. Psychodynamic theory has not had a strong influence in the psychology departments at New Zealand universities. According to these authors psychology in New Zealand has been strongly influenced by the Vail model of practice. This model of practice is characterized by treatment protocols derived from basic laboratory science, commonly known as 'evidence based practice' in which randomized controlled trials are used to attest to the value of a particular form of treatment, most often cognitive behavioral therapy. The behavioural principles of classical conditioning, learning theory and operant conditioning are tested and validated in controlled experiments which result in treatment prescriptions (manuals). "The Vail model conceptualized training as preparing professionals to be good consumers of science" (Evans & Fitzgerald, 2007, p. 285). Manuals of treatment abound. For the treatment of mood disorders there is the eight session program of the *Mindfulness-based cognitive therapy for depression* (Segal, Williams, & Teasedale, 2002), *Mind over mood: change how you feel by changing the way you think* (Greenberger & Padesky, 1995) and *Adolescent volcanoes: helping adults and adolescents handle anger* (Carroll & Hancock, 2001), to name but a few.

There are consequences associated with the aforementioned model of psychological training and practice that have to be borne in mind, if the aim is to better integrate research and practice, according to Evans and Fitzgerald (2007). With an over-

reliance on formal manuals of treatment, practitioners become more like technicians rather than scientist-practitioners and the authors refer to research evidence that highly trained practitioners are now no more effective than lesser qualified 'paraprofessionals'. A further consequence associated with this positivist model of psychology in New Zealand, according to Evans and Fitzgerald (2007) is that it has not benefited Maori. These indigenous peoples of New Zealand are over represented in acute mental disorders and this is reflected in the alarming rise in suicide and attempted suicide among their youth (Durie, 1999). Durie is concerned about the way in which behavioural and psychological phenomena are conceptualized, stating that the medicalisation and classification of disorders according to DSM IV diagnostic categories is not capable of measuring the degree to which cultural and spiritual factors are associated with the problem. Furthermore, a DSM IV diagnosis conjures up the expectation that 'treatment' is possible and that a diagnosis will somehow lead to a resolution. Unfortunately this 'value-free' science of health and wellness refuses to take into account the value-laden factors of culture and spirituality that are associated with Maori health and wellness. It is this value-free intent of science, which supposedly ensures objectivity, that discredits treatment approaches which make greater sense in cultural terms, according to Durie (1999).

However, according to Evans & Fitzgerald (2007), there appears to be a shift in the social sciences in New Zealand with greater emphasis placed on more subjective and qualitative models of 'knowing'; recognition that scientific knowledge is not indisputable and absolutely certain knowledge. Quantitative and qualitative methods of understanding are not similar but they do have strengths and limitations that can both be used to increase understanding. "This ecumenical perspective is not, however, universally shared in New Zealand, or internationally" (2007, p. 295). Without one there is no other and in therapy there can thus not be an object (therapist) and a subject (patient), or an 'inside' subject, or experiences that can be measured or encapsulated by theoretical representations. The world of a therapeutic encounter is a 'clearing' where the significance of what is received-perceived is laid bare for the first time by being-with one another. Therapies designed to treat suicidality with a predetermined method violates this reality of human existence.

Guignon (2006) asserts that there are substantive and unavoidable moral questions that form part of any attempt to understand human beings in psychological practice. Before our modern industrial-technological age people experienced the meaning of their lives in a daily discourse with rituals, practices and institutions that bound whole communities together at a religious, cultural, social and occupational level. The question how to live and what to do was attended to in this way of being-with others. In our modern technological age this sense of being-with and being part of a community has fragmented and therapists are now challenged to fill the vacuum. Therapists are now called to attend to the question of how to live and what to do. It is a problem associated with our modern way of being and central to the issues frequently dealt with in therapy. Guignon (2006) is of the view that therapists may feel poorly equipped for this task. Psychology in practice in New Zealand for instance thinks of itself as an 'applied behavioural science' and endeavors to be value-free and objective, to trust as truth only what can be observed and explained by cause and effect reasoning. How to live and what to do at an ontological level – and the moral dilemmas inherent – are consequently not attended to in therapy. This in itself is a valued laden attitude; to be 'value free'. There can be no such thing as value free in the true sense of the word.

There are assumptions drawn from naturalism which underlie the conception of humans found in most psychotherapy theories (Guignon, 2006). According to Guignon humans are objectified like other physical objects, humans are agents of action and perceived through the lens of instrumental reason and technological control, and human reality is viewed as self-encapsulated individuals who interact in social systems competing for resources towards self-actualization. The aim of psychotherapy, with this calculative-instrumentalists approach, is levelled down to what is realistic and consistent, says Guignon. Based on these assumptions therapy fails to address the 'substantive and unavoidable moral questions that form part of any attempt to understand human beings in psychological practice'. Therapy has come to attend to 'merely living', just functioning and satisfying needs, according to Guignon.

Therapists' experience with suicide

Psychoanalytically orientated case studies are recognised by their interpretation of what therapists experience via theoretical constructs of understanding. For example, people commit suicide because they associate death with fantasies of a journey, eternal sleep, fusion and reunion (Jones, 1996). Suicide is postulated as an enactment of gratification and self destructive tendencies (Menninger, 1996); or seen as a 'mental mechanisms' specific to suicidal patients (Zilboorg, 1996a); or as an unresolved Oedipus Complex (Zilboorg, 1996b); or the unconscious re-enactment of a mythological wish to die (Friedlander, 1996); or an act due to unresolved therapeutic transference and counter transference issues (Hendin, 1996; Shneidman, 1996).

There are studies of the effect that a patient's suicide has on professional groups such as psychotherapists, psychiatrists, nurses and social workers. In Bratter's (2003) article he discusses how the suicide of some of his clients affected him as a psychotherapist. He experienced a sense of loss and failure, was forced to recognise his limitations and that he could not prevent suicide. He doubted his worth and wondered whether he had chosen the right profession. He then discusses specific therapeutic issues upon reflection, such as limit setting, therapeutic neutrality, counter transference and confidentiality. Similar variant effects, therapeutic specific issues and reflections on practice are discussed by others (Gitlin, 1999; Hendin, Haas, Maltsberger, Szanto, & Rabinowicz, 2004; Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000; Jørstad, 1987; Reeves, 2004; Reeves & Seber, 2004; Tillman, 2003, , 2006; Valente & Saunders, 1993).

There are studies that focus on the interpersonal relationship between the suicidal patient and the health professional. A common theme that emerges from these studies identifies difficulties in communication as a significant variable. In a qualitative study by Anderson et al (2003) they investigate how doctors and nurses perceive young people who engage in suicidal behaviour. A grounded theory approach to the analysis of the semi-structured interview highlights the lack of skill to engage with someone in their life-world. The difficulties with relating stem from moral and value judgements, or the clinicians' sense of professional duty (i.e. preservation of life). A similar theme emerges from the qualitative study of young physicians and suicidal patients by

Høifødt et al (2006). In McLaughlin's (1999) qualitative study the focus is on the care of suicidal patients by psychiatric nurses. Communication is identified as the most important alleviating factor by both groups but is compromised by the lack of therapeutic knowledge and skills of relating and the avoidance of patients by nurses due to moral and emotional prejudices.

Utilizing a Consensual Qualitative Research methodology, the doctoral dissertation of Darden (2008) found that the impact of client suicide on the six participating psychologists met with the criteria of complicated grief. Their recovery was found to be significantly influenced by their respective work settings and the administrative component associated with their duties. The participants found themselves left to their own devices in the aftermath of client suicide. Their feelings of isolation were noted as a typical obstacle in the healing process and Darden recommends that supervisors be proactive in the event of client suicide. Agee's (2001) qualitative doctoral dissertation with focus groups found that the participant counsellors experienced uneven levels of support. Some participants experienced an insensitivity to their needs in the aftermath of suicide and she recommends better support for counsellors in coming to terms with the suicide of a client. The impeding influence of work setting and administrative duties on therapists' recovery in the aftermath of client suicide resonates with the findings of Forterner's (1999) doctoral dissertation. In Forterner's study, correlating emotional 'burnout' with work setting, client prognosis and client suicidal ideation, it was found that psychotherapy is a moderately emotional exhausting kind of work and that self-employed therapists had significantly lower emotional exhaustion and depersonalisation scores compared with therapists that were not self-employed.

Anderson's (1999) doctoral dissertation focuses on the impact of client suicide on master's level therapists in training. In this qualitative study Anderson found that therapists experienced strong emotional responses to client suicide including anger, sadness and grief, fear, confusion, shame, guilt and relief. The doctoral dissertations of Maher (1990), Wert (1988), Lapp (1986) and Lapidus (1990) identify similar personal and professional responses to client suicide. In Wells' (1991) doctoral dissertation the aim was to generate a deeper understanding of the reaction of psychotherapists to client suicide. The semi-structured interview data of six

participants were analysed using an existential-phenomenological approach and method developed by psychologists at Duquesne University. Three major themes were identified by this study; therapists' sense of failure to detect signs of suicidal intent, therapists' sense of omnipotence as it relates to their power as therapists and the choices of clients prior to suicide, and their sense of responsibility with perceived guilt and culpability. Wells suggests that the sense of loss and mourning which pervade the participant therapists' experiences is one of mourning the loss of identity as a competent healer.

Anderson's (1999) doctoral study found that the participant therapists were reluctant to discuss the suicide of a client with other professionals out of fear of being viewed as unprofessional and incompetent. Five of the seven participants made comments regarding anger towards their supervisors for their lack of support and the lack of understanding from management and supervisors about the emotional state of therapists following a client's suicide. In some cases it was reported that supervisors were more concerned whether the therapist had done something wrong which may implicate the supervisor in the suicide. Anderson asserts that while supervisors may have an obligation to protect the agency or organisation against legal action, they have an equal obligation towards the wellbeing of their supervisee. In Marantz's (1990) doctoral dissertation the focus was on clinical social workers' reaction to a client's suicide. This descriptive study found that the participants experienced a climate of blame in the aftermath of client suicide and that they became more cautious and avoided work with suicidal clients. Some participants found that their supervisors blamed them for the suicide when they were expecting support from the supervisor. Marantz asserts that guilt, fear of blaming and other therapeutic blind spots are not the exclusive property of therapists, but apply to supervisors as well. Marantz says that in this ubiquitous 'negative network' clinical social workers are often unprepared for client suicide and unsupported when it occurs. The recommendation from this study is that supervisors receive training to develop methods of supporting supervisees who experience client suicide and training to manage their own anxiety about blame.

It would seem that the response of administrative and clinical supervisors after the suicide of a client has a considerable impact on the recovery of a therapist. In their interview with counsellors, McAdams and Foster (2002) found that the participants

rated ‘psychological autopsy studies’ highly useful in coping and recovery, because it assisted them in understanding the clinical antecedents of the suicide and the impact on them. However, participants almost unanimously gave personal therapy the highest rating of all the coping resources for dealing with client suicide, since “it may be the only way that you will give yourself time and permission to focus on your own feelings”, according to one participant (McAdams & Foster, 2002, p. 236). Shultz (2005) notes that therapist-survivors of client suicide are often left to find their own comfort and receive little support from the institutional review of suicide cases. The reason for this, according to Shultz, is that supervisors in many work settings are charged with the duty to participate in a formal case review as well as provide support for the therapist. This can be problematic for the supervisor and the therapist-survivor. Shultz suggested that these supervisory functions be clearly separated. In Shultz’s view there are special needs for the therapist-survivor and supervisors can be prepared to attend to these by being sensitive to themes that often occur in therapy with suicide survivors. These themes are; searching for answers to the question of ‘why’, guilt about having done something wrong, altered social and collegial relationships as a consequence of real or imagined stigma, grief that resembles symptoms of Post Traumatic Stress Disorder, suicide as a solution to problems and the survivor’s capacity to trust others. Clinical supervision typically includes the features of evaluation, enhancement of professional competence and monitoring the quality of professional service offered to clients (Howard, 2008). But, according to Howard, there are also broader considerations in supervision to consider which could confuse the boundary between therapy (with its focus on personal growth) and clinical supervision without sufficient guidelines for the supervisor. In Howard’s view one of the key functions of clinical supervision as practised by health professionals such as psychologists includes the restoration of wellbeing. Howard provides guidelines in her article to preserve the traditional boundary between therapy and clinical supervision, whilst attending to the wellbeing of the supervisee without detracting from the traditional and primary aim of clinical supervision. A narrative method of supervision achieves this in her view, since the emphasis is on collaborative enquiry, where the supervisee is able to ‘re-author’ or ‘re-story’ their experiences in a way that allows more distance from the problem, enabling the supervisee to “reclaim their lives from their problems” (Howard, 2008, p. 109). This method of supervision offers the

supervisee an opportunity to reassert their values, hopes and commitments towards the restoration of their wellbeing in times of stress and emotional turmoil.

These studies which explore the lived experience of therapists and health professionals with suicidal persons which highlight the need for change in the development of practice, research and education are however rarely described in the literature. There is the phenomenological-hermeneutic study by Talseth et al (2000) with 19 physicians at a Norwegian psychiatric hospital about their lived experience in caring for suicidal psychiatric patients. I will refer to their findings in chapter eight.

Conclusion

The overall aim of this chapter was to develop a preliminary insight into why mental health professionals are apparently struggling to address the disproportionate suicide rate in New Zealand. My review of the ascending literature on suicide has revealed the dominant mode of understanding the phenomenon in New Zealand to be a natural-scientific mode of enquiry. I located the unpublished qualitative theses of therapists' experience of client suicide late in my research. It shows that this phenomenon has attracted a qualitative way of understanding at an international level and yet I could find no evidence of this in New Zealand. It is a gap my study aims to fill. Furthermore, I have identified what I consider to be the limitations of a natural-scientific mode of enquiry which begins to shed light on why mental health professionals may be struggling with suicide in practice.

A natural-scientific mode of enquiry establishes a spectator/theoretical attitude from the outset, from where theories and hypotheses are developed, based on the ontic manifestations of a phenomenon such as suicide. In this way the essence of a phenomenon is misrepresented or misunderstood, as it is removed from the experience of the meaning giving person. It is a mode of enquiry in which appearance and essence are conflated with the result that the phenomenon of suicide is misinterpreted in practice. This conflation sees the reduction of the unique being that exists to a being that is an object, rendered measurable and comparable to norm. The person in treatment is thus objectified like all other objects in the natural world and the therapeutic relationship becomes an efficiency exercise, rather than an encounter of revelation.

The literature portrays suicide as a factor in a causal equation and something pathological, deviating from an idealized image of being whole and perfect. I have argued that upon this premise suicide, as an ontological statement, is misunderstood for what it is. I have forwarded the notion that suicide, as an ontological statement, has to be interpreted in all its metaphorical guises, and not to be taken literally as is the wont of a natural-scientific attitude. This literal way of understanding distorts the meaning of suicide, reduces it to a set of 'risk factors' measurable along the yardstick of normality and seen as the response of 'a body' in relation to other entities in the environment. In this attitude the 'body' with symptoms is understood in terms of a corpse, but from a hermeneutic-phenomenological perspective the body is understood in terms of a lived-body (Thoibisana, 2008). If suicide is understood as an ontological statement of human possibilities then suicide will be heard as a yearning to be a perfectly whole being (lived-body) rather than a whole and perfect body (corpse).

I have discussed how the ascending attitude of knowing in research is translated into mainstream practices characterized by methods and procedures, manuals and guidelines about what to do with and for a suicidal person. I have argued that this mode of being with another in practice is a continuation of the spectator/theoretical attitude evident in research, bent on fitting the human experience of being-in-the-world into a theoretical straight jacket. Once humans have been thus misrepresented – in accordance with models and constructs – the most any therapy can hope to do is make it a better object, not a healthier person, says Medard Boss (in Heidegger, 2001). The thoughts and practices of relational therapy would suggest that therapy can 'make a healthier person' if practitioners adopt a philosophical stance in their assessment and treatment of human problems which takes account of the relevance and significance of the person's relational matrix.

The literature on therapists' experiences with suicidal clients suggests that client suicide has a significant impact on the therapist who experiences an array of emotions, not least, the experience of loss and mourning of his/her sense of competence as a healer. Whilst these studies articulate how client suicide affects therapists, these studies do not explicate an understanding of the being that is a therapist. An understanding of the being who is a therapist will provide a deeper

appreciation of how the therapist comes to experience client suicide in the way s/he does. Furthermore, the literature suggests that therapists are generally left to their own devices in the aftermath of client suicide and that supervision neglects to attend to the needs of the therapist as a person who is attempting to reconcile their experiences within the context of being human.

These are then some of the reasons why I have chosen to follow a qualitative method of enquiry in this research project. To guard against the misinterpretations that stems from the conflation of appearance and essence and the reduction of human existence to objective events, I decided to follow a hermeneutic phenomenological mode of enquiry. It allows phenomena to speak for themselves and aims to understand experiences from the perspective of the one experiencing. These are principles central to this mode of investigation and hold true for research and praxis, it is a methodology at home in the 'laboratory' as much as it is in the 'field'. With this congruence of intent the distinction of laboratory and field can be dispensed with. The laboratory of a hermeneutic phenomenology is the field of human experience. The following chapter will consider the philosophical underpinnings of this study to gain a perspective on how therapists experience working with suicidal clients. It is my hope that these insights could lead to alternative ways of understanding and treating suicidal clients.

Chapter Three

Philosophical Foundations

Introduction

Science says Max Weber (Safranski, 1999) had become our destiny. With its technological consequences it has transformed our lives, yet it fails to provide answers. The fact that "science cannot make any decisions on meaning or value" (p. 90) should be a liberating opportunity for the individual. But, says Weber, this has not been the case because our (Western) civilisation has so thoroughly and comprehensively embraced the belief in rationality that it completely undermines the individual's ability to make decisions. The question of what is true and real has moved from the individual to the collective, influenced by a predominantly empiricist epistemology that tends to distort primary experiences altogether. This paradigm shift is what Heidegger attempts to redress. He suggests that a philosophy of science ought to ask how we experience reality before we arrange it for ourselves in a scientific, or value-judging, or worldview approach. The dominating influence of natural science in matters human is 'de-experiencing', says Heidegger (1962). The secondary process of reason and logic objectifies the subject and the unity of the situation is dissolved. "One has dropped out of direct Being and now finds oneself as someone who has 'objects', including oneself as an object, called the subject", according to Heidegger (Safranski, 1999, p. 103). Secondary processes and the natural scientific method allow for the analysis and reduction of a thing infinitely, in the process discovering 'some things', but moving further and further away from the thing that is experienced. "It is not that phenomenology is against empiricism, but rather that it is more than merely empirical" (Giorgi, 1997, p. 236). Phenomenology is concerned with the ways in which human beings gain knowledge of the world around them.

Beginnings of Heideggerian hermeneutic phenomenology

Husserl [1859 – 1938] is regarded as the founding father of phenomenology and his project was to give science firmer philosophical foundations through a new descriptive method. This method – phenomenology – provides an antidote to the excesses of the current dominant medical/scientific model, according to Loewenthal and Snell (2003). These authors are of the view that Husserl's work became an

invitation to think about psychotherapy in a way that is different from what has now become mainstream psychology. Husserl's most important contributions are the notions of intentionality and searching for the essence of things with his famous rallying cry 'to the things themselves'.

Transcendental phenomenology, as formulated by Husserl, is concerned with the phenomena that appear in our consciousness as we engage with the world around us. Consciousness is the medium of access to whatever is given to awareness. It is therefore not neutral or objective in its presentation of objects or givens. An essential feature of consciousness is its intentionality. It is always directed to an object that is not itself consciousness (Giorgi, 1970; Kruger, 1979). It is this intentionality of the perceiver that allows objects to appear as phenomena, given meaning by its varying modes, styles, forms and so on. It therefore makes no sense to think of the world as objects and subjects as separate from our experience of it, since all objects and subjects must present themselves as something which vary by the nature of intentionality (Willig, 2001). Object and subject determine one another and do not exist as substances in and of themselves. Without one there is no other. Making 'subjects' and 'objects' of things of the world creates the illusion that they are substances of permanence and constancy. Consciousness cannot be understood as a cause and effect relationship. It is only through the methods of reflection and description that the intentional relationship of consciousness can be discovered and thereby reveals the experience and meaning of human activity (Giorgi, 1970). It would be more accurate to say that consciousness is not a substance, immaterial or otherwise. Consciousness intends and being conscious means an intentional act through which man lets the world appear to him (Kruger, 1979). From this it would appear that a person is *conscious in* rather than *conscious of* his world. "Our consciousness of being, i.e. of being in the world, precedes all our thinking about the world" (p. 24).

According to transcendental phenomenology, it is possible to transcend presuppositions and biases in order to experience a state of pre-reflective consciousness. This involves three distinct phases of contemplation (Giorgi, 1997; Willig, 2001). First, *epoche* requires the suspension of presuppositions and assumptions, judgments and interpretations to allow researchers to become fully

aware of what is actually before them. Second, *phenomenological reduction* is to describe the phenomenon that presents itself in its totality – the texture of the experience. Third, *imaginative variation* involves the attempt to access the structural components of the phenomenon. While phenomenological reduction is concerned with 'what' is experienced, imaginative variation is concerned about 'how' this experience is made possible (i.e. structure).

Heidegger [1889 – 1976] is considered one of the twentieth century's greatest philosophers without whom there would be no Sartre or Foucault, but also a man with great failures and flaws (Safranski, 1999). A great deal of uneasiness persists to this day about his association with National Socialism. This association threatens to tarnish his philosophical work with political ideology. However, analysis of his seminal work *Being and Time* by prominent scholars since its publication does not satisfy this accusation and suspicion. His work is accepted as a most unique contribution to the field of philosophy and valued as a refreshing philosophical grounding to many disciplines, such as psychology (Safranski, 1999). Heidegger's philosophy allows psychology to "let beings be", free from preconceived dogmatic constructions and the uncritical imposition of theoretical frameworks by therapists on clients, according to Medard Boss (in Heidegger, 2001, p. 313).

Heidegger was a student of Husserl, and whilst building upon his ideas of phenomenology Heidegger disagreed with Husserl's method of uncovering the 'thing in itself'. Husserl's approach of epoche and phenomenological reduction is at the expense of the life-world of the person and goes against Heidegger's notion of the very experience of being-in-the-world which defines human existence. Understanding the essence of phenomena has to take this into account (Cohn, 2002). Heidegger compared Husserl with Descartes in that both wanted to seek clarity within themselves, in consciousness, and pursue the ideals of certainty and a 'rigorous science' at the expense of the non-scientific life-world (Inwood, 1999). This Heidegger argues goes against the spirit of phenomenology. He also believes that Husserl's concept of intentionality is too theoretical with a focus on the bare ego which wants to make everything too sharp and explicit; it ignores the background of which one is tacitly aware by being-in-the-world (Inwood, 1999).

Heidegger's notion of being contrasts noticeably from prevailing notions steeped in science and technology and is important from a psychological and therapeutic perspective on a few accounts (D. Loewenthal & Snell, 2003). An ontological enquiry must make the inquirer transparent in his/her own being because the understanding of being is in itself a definitive characteristic of Dasein's being. This involves an understanding-with and underscores Heidegger's notion of 'the world' emerging in being-with, as opposed to an enquiry from an observing and theoretical perspective. An ontological enquiry includes Dasein's temporality and historicality. The place and the time of the therapist and the client – the condition for both being there – must be brought into account in therapy which aims to help clients with the question of the meaning of being, which Loewenthal and Snell argue is part of everything the client brings to therapy. In order to understand the being that is human you have to start with what is and not with abstract speculations. Heidegger says that only with phenomenology is ontology possible (D. Loewenthal & Snell, 2003). A phenomenological inquiry arrives at meaning through interpretation and this resonates with the interpretation of the being that exists in their self-understanding. It underlines the importance of interpretation in psychotherapy as a therapeutic method.

Choosing a Heideggerian phenomenology seems appropriate for this study which is inquiring into the therapist's experience of working with suicidal clients. I am also not looking for a theoretical understanding of their experiences and cannot 'bracket' out my own understandings of what it means to be a therapist working with suicidal clients. The question and the possible interpretations of their experiences are already foreshadowed in my understanding of being in this world where human existence is born in an inter-subjective space or social field.

Heidegger's method of phenomenology - hermeneutic phenomenology

The scientific attitude is not the appropriate attitude to adopt if one is interested in understanding phenomena relevant to being human. The reason for this is that an investigation into phenomena with an epistemology founded on a philosophy of mind decontextualizes the lived world of Dasein. The phenomenon is uprooted from its origins and becomes detached from its referential context of meaning and significance from a human experiential point of view.

"Scientifically relevant 'facts' are not merely removed from their context of selective seeing; they are theory-laden, i.e., recontextualized in a new projection" (Dreyfus, 1991, p. 81). This is a projection which no longer belongs to Dasein and its existence, but now belongs to the existence of science. The theory of mind philosophy behind science has diverted its focus and attention to a phenomenon which no longer matters for the experiencing person. It has begun to develop an understanding based on its interpretation and not the self-understanding based on the interpretation of the being that is human. It begins to understand itself rather than Dasein.

The phenomenology of Dasein is a hermeneutic – an interpretation. In the natural sciences objects can be reduced to basic rules which explain why something appears, behaves or reacts the way it does. But Heidegger (1962) argues that human beings are not objects that can be understood in this manner. To understand phenomena – as they appear to humans – and to understand the nature of the phenomenon of being human in itself requires a different method of inquiry. The method required is that of interpretation because phenomena are not always accurate in showing themselves. A phenomenology of Dasein has to account for this and bear in mind the possible structures of a phenomenon and how it shows itself from itself. These structures of phenomena, nevertheless, articulates or points one to the phenomena as such and Heidegger's phenomenology aims to wrestle the phenomenon from these phenomenal plains – transcend them through interpretation – to arrive at phenomenological truth (Cavalier, 2006).

Heidegger argues that the natural scientific view is a derivative of phenomenology, which he considers to be a 'primordial science'. He says that the phenomenological method already works with the aid of a critical destruction of objectifications which are always ready to accumulate on the phenomenon (Crowe, 2006). The natural scientific view distorts life and barricades itself from life with these accumulations. Destruction is an integral part of the phenomenological method and justified because objectification obscures the immediacy of practical life experience, i.e. the experience of the average everydayness of being human.

According to Crowe (2006) Heidegger's project is to gain a deeper appreciation of life and he uses a procedure called 'phenomenological-critical destruction'. By means of this procedure one is able to reach 'moments of sense' that are concealed by contemporary discourse. According to Crowe, Heidegger's method of phenomenological critique (destruction) aims to get to the 'basis of enactment' which is 'factical life-experience'. One way in which to do this is to trace commonly used terms back to their origins in factical life experience. The aim of destruction is twofold: To strip commonly used concepts and terms of their veneer of self-evidence and to uncover the essence of these expressions. This is the entry point into the hermeneutic circle. Stripping our understanding of its common sense meaning brings one closer to the genuine 'moments of sense' as we go about with self-understanding in everyday life.

Crowe argues that Heidegger's philosophy is motivated by the ideal of an authentic existence and that this ideal is difficult to realize, due mainly to tradition. In tradition the individual encounters a life that is already made meaningful; it has already been interpreted and given expression in discourse prior to the arrival of the individual. It is Crowe's view that the individual finds it easier to join in this discourse and to pass off ideas and interpretation of phenomena as self-evident, as the collective is prone to do. It is easier to allow one's identity to be shaped alongside this reality of the 'One' because the alternative is a daunting and anxiety provoking quest. The quest is to re-interpret that which is apparently so self-evident, and it is through this endeavour that a person begins to create a more authentic existence. Hermeneutic phenomenology shows what it means to create a more authentic existence. It is a method towards that ideal of authenticity. The starting point is the re-interpretation of that which has become so self-evident and to rediscover the original meaning of phenomena in the context of lived experience.

Guiding philosophical notions

Discovery of phenomena

The phenomenon under investigation in this project is therapists' experience of working with suicidal clients. I anticipated encountering experiences familiar to me as a registered psychologist in New Zealand, practicing in a District Health Board where I have work with suicidal clients, some of whom have attempted suicide and some

whom successfully ended their own lives. When talking about these events and one's experience of it, it is more often than not done in the everyday language of psychiatry and psychology – self-evident style – upon first presentation. Heidegger (1962) refers to this phenomenon as 'contemporary discourse', when a certain meaning is ascribed to a phenomenon which, with repeated use and reference, reduces the phenomenon to something self-evident. Meaning becomes part of contemporary discourse and gets passed along as common knowledge. The challenge was to find a way of looking for the significance and the meaning of these experiences for therapists which may be concealed and overlooked when first presented to me in this self-evident manner.

In phenomenology the challenge is, says Heidegger (1962), to find a way in which to discover phenomena behind their concealment because they do not necessarily show themselves the way they are in themselves. Phenomena, according to Heidegger, can show themselves in a variety of ways. For example, they can show themselves in a privative manner where a thing can seem to be such-and-such, when it is not. Like when a stick appears through the surface of the water and then appears to be broken. Or, phenomena can announce themselves through something else such as when the heart murmur signals an underlying disorder of a valve within the heart. The way in which phenomena tend to conceal their very being in appearance and resemblance is "the point of departure of analysis" (1962, p. 32) because how a phenomenon appears is part of the phenomenon in itself.

By following these ideas regarding phenomena and their appearances I hoped to be more discerning about what I heard and understood. I trusted that this would guide me to reveal the essence of the experience of therapists' working with suicidal clients.

The being that is human – Dasein

I needed to bear in mind that therapists are fallible human beings who understand and give meaning to their experiences in their particular way, which influences how they respond. To guide me in this regard I relied on Heidegger's notion of Dasein which refers to any and every human being (Inwood, 1999). Heidegger was also of the view that we tend to misinterpret ourselves in certain ways. This misrepresentation and misinterpretation of the beings that we are may well distort or skew what we hear and

see; give meaning to experiences which conceals the experience for what it is and also conceal from us the beings that we are as therapists.

Each therapist comes with their own unique historical horizon, i.e. their culture and its traditions into which they were born. Dasein is thrown into a historical moment and it is something which does not "*follow along after* Dasein, but something which already goes ahead of it" (Heidegger, 1962, p. 41). The person is born into a reality which already has its own knowledge of how things become intelligible and how things are done. We are prepared for life and educated in this reality. Upon this reality people understand themselves, how they interpret their world and themselves. In view of this Heideggerian notion, of being thrown into a reality from the outset, I wondered how I could begin to understand therapists when, for example, they said they were well prepared at university to work with suicidality, but they nevertheless experienced shock and disbelief when they heard their client had committed suicide? Why the shock and disbelief if therapists are formally prepared for the fact that people have been committing suicide for as long as we know and that it appears to be exceedingly difficult – probably impossible – to prevent a suicide when that commitment has been reached? What were they shocked about and what could they not believe?

Heidegger suggests that we begin to understand people in their undifferentiated character – their average everydayness – in order to get clarity on 'who' they are in their differentiated character and their definitive way of existing. Did therapists experience shock and disbelief because they attempted to understand their clients from an "entity of knowledge", which always runs the risk of "passing over" the unique human being (Heidegger, 1962, p. 69)? Did therapists experience disbelief because they did not have an accurate account of what it is they were trying to understand? Heidegger's *magnum opus* 'Being and Time' is dedicated to deepening our understanding of what it means for something to be (language, abstractions, people, things) and how they are related to human beings. His philosophical thesis starts with the question; "Do we have an answer to the question of what we really mean by the word 'being'" (Heidegger, 1962, p. 1.)? He does not think that we have an adequate answer to this question and that it is imperative that we understand what we mean by 'being' if we are to pursue our endeavours as human beings without a distorted view of who we are. Heidegger raises this age old question anew because he

claims that tradition has misrepresented and misinterpreted human beings. His philosophical conclusions are crucial for the human sciences, for one can not understand something if one does not have an accurate account of what it is that one is trying to understand (Dreyfus, 1991).

"Dasein is an entity which, in its very Being, comports itself understandingly towards that Being… (it is)…an entity which in each case I myself am" (Heidegger, 1962, p. 78). Dasein is that being that is mine and comports (conducts or behaves) itself towards its being. Characterizing Dasein in this manner has a double consequence.

1) The essence of Dasein lies in its 'to be', in other words, in its existence. A table or a tree is a 'what', a present-at-hand entity of the world. Dreyfus (1991) translates the term present-at-hand as an *occurrent entity*, a non-human entity or object/thing which occurs. A human being is a 'who', an entity that exists differently to a thing-like entity. If we are going to get to Dasein, then we have to get to it from its ownness, as opposed to examining it from the outside as another thing in the world that is self-sufficient, independent with functions and properties (Dreyfus, 1991; Waters, 2005).
2) This existence 'that is mine' also emphasizes the responsibility that Dasein has in choosing how to conduct itself and behave in its being. Dasein is its possibility and it has this possibility, and because "Dasein is in each case essentially its own possibility, it *can*, in its very being, 'choose' itself and win itself; it can also lose itself and never win itself; or only 'seem' to do so" (Heidegger, 1962, p. 68). I will attend to these modes of being human in due course and their significance to this project of understanding therapists' experience of working with suicidal clients.

Misrepresentation and misinterpretation of Dasein

If human beings tend to misinterpret the nature of their being, then I needed some reference to ensure that I understood therapists and their experiences in full recognition of this tendency. How may therapists as human beings be drawn into misinterpreting the meaning of their everyday experiences? What happens when, for example, a client unexpectedly commits suicide and the therapist can think of nothing else but "what did I miss? How could I have prevented that?" How do these experiences reflect on their self-interpretation? The following paragraphs provide

guidelines towards understanding how therapists may come to misinterpret the beings that they are.

How does tradition misrepresent and misinterpret the beings that we are? "Dasein is ontically 'closest' to itself and ontologically farthest; but pre-ontologically it is surely not a stranger" (Heidegger, 1962, p. 37). With this Heidegger is suggesting that human beings have a tendency to misinterpret who they are. Because Dasein finds itself among entities of the world from the outset, Dasein is prone to understand itself through these entities as if it is a thing-like object. This conceals the true nature of human existence which exists in a different manner than the entities of the world exist. Dasein 'not being a stranger at a pre ontological level' says that Dasein has an unarticulated sense that there is something different and more to itself than the understanding of itself through entities in the world.

This aforementioned misrepresentation of Dasein has been entrenched through the sciences, the human sciences in particular which make the 'categorical error' of interpreting the nature of being via the categories of knowledge such as psychology, anthropology and theology. These categories of knowledge fail to do justice to an understanding of human existence. These categories do not take the existence of Dasein into full account and "We must rather choose such a way of access and such a kind of interpretation that this entity can show itself in itself and from itself" (Heidegger, 1962 , p. 37).

A further source of misinterpretation is that human beings tend to interpret their own nature in terms of tradition. "Its own past – and this always means the past of its 'generation' – is not something which *follows along after* Dasein, but something which already goes ahead of it" (Heidegger, 1962, p. 41). An understanding of Dasein's own being ought to take account of the fact that 'Dasein is inclined to fall back' on its world and its traditions; that living according to these determinants is so self evident, Dasein forgets its own original nature. Heidegger contends that it is necessary to "destroy the traditional content of ancient ontology" because these categories of knowledge conceal a full understanding of the nature of being (Heidegger, 1962, p. 44).

According to Heidegger (1962) tradition conceives of a self-standing subject first, who then looks at self-standing entities in the world, divided in the first instance. This is the traditional dichotomy of subject and object which presents problems at a philosophical and epistemological level to explain how subject and object interact and relate. But for Heidegger there is no such division in the first instance. The subject is already in the world, already in an inter-subjective space or social field. This is the primary and fundamental mode of being and only later do we come to find our self as a self. How therapists make sense of their experiences may thus be founded upon the aforementioned misinterpretations. Their questions "what did I miss? How could I have missed that?" may stem from understanding themselves as being thing-like objects, or being the kind of beings explained by a theory of 'who' we are, or being the kind of beings that tradition predetermines for us. This I had to keep in mind when analyzing the experiences of therapists.

Making our world intelligible: modes of being

To understand the experiences of therapists working with suicidal clients I had to be clear on how humans make things intelligible. What did it mean, for example, when therapists said "The threat of suicide does not worry me, I go into management mode, I protect myself, do the paperwork and follow the procedures" or "I avoid emotional involvement and follow procedures of care"? How did these experiences reflect on the therapist's way of understanding the client?

Being-present-at-hand

When we are being with things in a present-at-hand mode of understanding we are standing back, removed in a spectator/theoretical attitude of understanding (Dreyfus, 1991). In this mode we make a thing intelligible by isolating it as a substance with properties and arrive at knowledge which is then categorised. In this mode of making something intelligible we remove it from its referential network and associations and it becomes known in an atomistic way. Assessment and treatment are the order of the day in psychiatry and psychology with which therapists become familiar in their roles. Mainstream psychiatric and psychological assessment and treatment procedures usually result in categorical knowledge about peoples' mental health problems and 'suicidal risk'. These are theoretical and scientific orientated ways of knowing, i.e. present-at-hand modes of understanding. But, says Dreyfus (1991) properties cannot be isolated, they belong to a whole. When you isolate properties and focus on it

without reference and consideration of the referential network, you switch from an ontological to a scientific attitude.

What is the foundation of entities present-at-hand? What makes it intelligible? Dasein founds entities present-at-hand. Dasein's world of coping and going about its everydayness make entities intelligible and not Dasein's properties (Dreyfus, 1991). "Taken strictly, there is no such thing as *an* equipment… there always belongs a totality of equipment…. Equipment is essentially 'something-in-order-to'…" (Heidegger, 1962, p. 97). "The primary 'towards which' is a 'for-the-sake-of-which'. But the 'for-the-sake-of' always pertains to the Being of Dasein, for which, in its Being, that very Being is essentially an *issue*" (Heidegger, 1962, p. 116). In other words, when psychiatric and psychological assessment tools are used to identify properties, phenomenon becomes known from a scientific attitude and what is an issue for the being that is Dasein is at risk of being misrepresented in this manner of knowing.

Being-ready-to-hand

Being-ready-to-hand is a mode making intelligible and understanding by using things as equipment. It is a familiar, non-theoretical and a non-thinking way of going about and doing things on an everyday basis. It is a holistic understanding of things that are what they are because they are situated in a frame of reference. It is a mode of being that stands in relation to other things, a relationship that defines its being. For example the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to diagnose for the sake of understanding a person and their presenting problem. But when equipment breaks down it arrests the flow of things and the situation becomes conspicuous. Heidegger (1962, p. 105) says that "when our circumspection comes up against emptiness [we] now see for the first time what the missing article was ready-to-hand with, and what it was ready-to-hand for. The environment announces itself afresh". In conspicuousness the referential network lights up and one discovers that things have aspects, which cannot be divorced from the situation (Heidegger, 1962). For example, the DSM and Risk Assessment procedures sometimes fail to identify suicidality – our equipment of familiarity breaks down and we find ourselves at a loss.

I had to bear the character of mainstream psychiatry and psychology's theoretical mode of understanding in mind. Therapists are confident and familiar with the 'equipment' that grows from this attitude – the tools of the trade. These tools of the trade are situated in a socially sanctioned network of reference, the world of psychiatry and psychology. But when tools of the trade break down – when the client commits suicide even when assessment methods and procedures have declared the person safe – the situation becomes 'conspicuous'. Then therapists are confronted with the essence of these procedures, i.e. that a present-at-hand way of knowing conceals and decontextualizes the lifeworld of the client and that it is an unsuitable mode of understanding a person.

Modes of being human

Therapists work within professional disciplines and are employed by institutions each with their own culture and way of doing things which may have a direct bearing on therapists' experiences with their suicidal clients. What guidance could I find in Heidegger's philosophy to keep me focused on the therapists' experiences and work within a particular discipline and institutional setting? A starting point was to keep in mind the ways in which humans choose to exist, or more accurately, the possibilities open to them in their average everydayness.

By virtue of its essence as a self-interpreting being Dasein is essentially its own possibility and can "in its very Being, 'choose' itself and win itself; it can also loose itself and never win itself; or 'seem' to do so" (Heidegger, 1962, p. 68). What do these three *possible* modes of existing mean, and what is the significance for my study? I will attend to that now, but before I address modes of existence I needed to clarify what I understand by existing – that which therapists and their clients do – and its characteristics.

Dasein's way of being: Existence

"Dasein's essence lies in its existence" (Heidegger, 1962, p. 67). Human beings are distinctive beings insofar that in their way of being they embody an understanding of what it means to be. "Its ownmost being is such that it has an understanding of that being, and already maintains itself in each case in a certain interpretedness of its being" (Heidegger, 1962, p. 36). Only self-interpreting beings exist. "Being arises from the average understanding of Being in which we always operate and in which

the end belongs to the essential constitution of Dasein itself" (Dreyfus, 1991, p. 28). Understanding here refers to 'know-how' in our daily practices and activities. It is pre-reflective and pre-conceptual. We are naturally drawn to things and use them before naming or describing them. We walk through a door because we want to enter or leave a room. That is the most basic understanding (know-how) of getting along in the world – without thinking or reflecting – but with being familiar. We are completely absorbed in this form of understanding, in a taken for granted manner, and we are indistinguishable from the world in this manner of being.

What are the implications of Dasein's self-interpreting way of being? Dreyfus (1991) draws our attention to the fact that Dasein begins to exist (understand who they are) in a manner that is already contained in the social practices of a culture and a public world. This is what is referred to as Dasein's facticity – the facts to which we arrive in this world, for instance our body, our history, our words, our culture … our situation, which Heidegger refers to as 'thrownness' (Inwood, 1999; Wrathall, 2005). This 'common world' is primary and governs every interpretation of the world and of Dasein. The implication of this formulation by Heidegger is that Dasein's reality and future – the 'who' and the possible ways of being – has already been decided by virtue of 'being-already-in-a-world'. For example, a psychologist registered with the national body of psychology in New Zealand, working with suicidal clients in a District Health Board has a basic understanding or know-how about assessing the situation and the possible treatment approaches that are used in these circumstances, and this becomes self-evident with repetition and practice. This self-evident know-how is associated with inter alia, professional ethics, research, treatment protocols, work habits, peer expectations, etc. It is a sanctioned social role in which a therapist understands what to do, understanding shaped by these aforementioned factors – tradition.

A further implication of this self-interpreting way of being is that Dasein tends to misinterpret itself. I have already made reference to how we tend to misinterpret the beings that we are. Dasein "grounds its actions in its understanding of human nature" (Dreyfus, 1991, p. 25). We are lead to believe that we are what we do and our habitual way of doing things in a particular culture and social milieu becomes known as 'human nature'. A suicide bomber in Kabul is a terrorist and in Palestine he is a hero

and a martyr. However, our doing is not what Dasein *is*. Our doing rests on a social/cultural self-interpretation which is not synonymous with the self-interpreting beings that we are. Self-interpretation is not something that is static and fixed. It is always already open to re-interpretation and therefore it can be said that 'Dasein is interpretation all the way down' (Dreyfus, 1991). This is what Heidegger (1962) refers to as the 'nullity' of human existence. There is no absolute or final interpretation which can define Dasein and this is the cause of its basic unsettledness and anxiety. Dasein's basic unsettledness and (existential) anxiety is an essential structure of being human. However, to exist in accordance with the cultural and societal definitions of what it means to be a person in a particular culture, or be a therapist in a particular society is a way of avoiding this existential unsettledness and anxiety. It is a way of fleeing 'who' we are by adhering to the 'what' we are as defined. Yet, Dasein can not be defined by its facticity, 'what' it does in its so-called nature. It can only be defined by its self-understanding, 'who' it is. Dasein can therefore never escape itself by 'falling' into the common world where human nature tends to be defined by what it does. Therapists can thus not avoid being confronted by this existential given in their practice. The question 'who are you?' constantly stands in the shadows of what we do. The extent to which therapists are sensitive to this reality will inform how they interpret and understand what they experience.

Characteristics of existence

How did I begin to understand therapists who said they were unable to explain the suicide of a client who appeared to be fine a couple of hours before committing suicide?

State-of-mind (mood) and understanding

Mood and understanding are two of the structures which are definitive of human existence (Heidegger, 1962). Heidegger wants to say that moods are not something below the level of disclosure or truth or how the world comes to us, but something quite fundamental. And we are always, he says, in some mood. Mood determines the way in which things come to us out of the world and how it is disclosed; it is what allows the world to matter. "A mood makes manifest 'how one is, and how one is faring'. In this 'how one is', having a mood brings Being to its 'there'" (Heidegger, 1962, p. 173). To articulate this sense that mood is primordial and beyond rational control, that one discovers oneself in some sort of mood at a given time, Heidegger

employs the term 'throwness' and 'being delivered over'. We do not know the 'whence' or the 'wither' of our mood, merely the fact that we find ourselves thrown there. In mood Dasein is disclosed to itself "*prior to* all cognition and volition, and *beyond* their range of disclosure" (Heidegger, 1962, p. 175). Phenomenologically speaking we will fail to recognize *what* the mood discloses and *how* it discloses if we attempt to explain what Dasein knows and believes, or is acquainted with at the time of a particular mood, says Heidegger. In other words, seeking a rationale for something that is by nature irrational is to not see it at all.

Understanding is an equiprimordial constitutive of Dasein (Heidegger, 1962). Understanding is not some particular competence to carry out some given task, but rather Dasein's own competence at being as such. It is not that we first exist and then later we understand some things; our existing is a matter of understanding our world. Our existing is our understanding. Dasein does not just determine its world but is thrown into a world. Dasein is thrown into the world of 'they'. It is not a world of its choosing nor is it a world where Dasein can predict what is revealed. "And in so far as understanding is *accompanied by* state-of-mind and as such is existentially surrendered to throwness, Dasein has in every case already gone astray and failed to recognize itself" (Heidegger, 1962, p. 184). Dasein's competence to be itself and project itself into its own future possibilities are taken from the 'they'. Therefore, its potential to be itself is to find its own possibilities in the possibilities of thrownness. The therapist who is anxiously trying to explain how a client in a good mood committed suicide two hours later is attempting this in a 'thrown world', i.e. the world of their profession and institution, the world of their culture and society which tend to look for reason where sometimes none is to be found. The mood and understanding a client experiences today is not predictable of the mood or understanding of the client tomorrow. Why does understanding always press forward into possibilities? Understanding has in itself the existential structure called 'projection'. Stated differently; in Dasein's understanding it is throwing itself ahead of itself (projecting). "Because of the kind of Being which is constituted by the *existentiale* of projection, Dasein is constantly 'more' than it factually is" (Heidegger, 1962, p. 184). This projecting is about possibility and not about what is necessarily going to happen, because its projecting is an opening onto a future that it cannot predict.

Dasein's modes of existence

I now return to the question of the modes of human existence and their significance for this project. By virtue of its essence as a self-interpreting being Dasein is essentially its own possibility and can "in its very Being, 'choose' itself and win itself; it can also loose itself and never win itself; or 'seem' to do so" (Heidegger, 1962, p. 68). What do these three possible modes of existing mean?

Dasein 'seems to win itself'

This is the primary mode of existence. The way in which Dasein exists where it seems to win itself is "the undifferentiated character which it has primarily and usually…the undifferentiated character of Dasein's everydayness" (Heidegger, 1962, p. 69). This undifferentiated mode, neither authentic or inauthentic, is a mode of existence according to Heidegger where Dasein continues to understand itself within the public collective of understanding human nature; 'this is what we do…this is how we go about things around here…this is how things flow around here'. Dasein has not yet taken a stand on itself and it is a way to cover up its basic unsettledness. Dasein can thus avoid the possibility of interpreting itself by going along with tradition, by not making its own existence an issue for itself. The acceptance and approval which goes along with this way of being gives the appearance of Dasein being itself. Be it therapist, pauper, saint or sinner, we find ourselves in this mode of being first and always.

Dasein can 'loose itself and never win itself'

In this mode, an inauthentic mode of being, Dasein actively identifies with a social role such as being a therapist, a victim or a philanthropist. It is a socially sanctioned identity that allows Dasein to disown, or cover up its self-interpreting structure (Dreyfus, 1991). By following and adhering to the relations, expectations, purpose, procedures and ethics that accompany a sanctioned identity, Dasein can avoid self-interpretation. Dasein continues to understand itself according to the givens of the role. To identify with who one is through a socially sanctioned role is a mode of existence in which the therapist goes to work *for purpose*. The purpose of existence has already been chosen for the therapist. The therapist has lost him or herself, never to win the self that they are. They are who they are in accordance with what they are supposed to do and expected of them. This socially sanctioned identity always goes ahead of them. But when a therapist goes to work *with purpose* s/he understands that

their purpose can never be determined in this manner. With this 'comportment' to life the therapist ventures to practice self-understanding, despite being already understood. This worldview introduces the next mode of existence. In this mode Dasein is actively conscious of its fundamental unsettledness and nullity which enlightens and grounds being, for instance, a therapist discovering themselves confused and unfamiliar as a result of their experiences with a suicidal client.

Dasein can choose itself and win itself

This is a mode of existence, an authentic mode according to Heidegger (1962), in which Dasein chooses to live and occupy itself – in a given social/cultural milieu – that would disclose its understanding of the groundlessness of its own existence. This formulation of being was important to understand the anxiety and confusion many therapists experienced in working with suicidal people.

Existing is Being-in-the-world

Therapists told me that they could not understand why their clients committed suicide when they were objective and professional in their care, that they did things to the client and for the client according to the book. How did I attempt to understand this phenomenon of therapists' experiences when doing things to and for their clients?

Heidegger calls the activity of existing 'Being-in-the-world' (Dreyfus, 1991). Whether Dasein exists authentically or inauthentically, the character of this existence must be understood *a priori* as grounded in a state of being as Being-in-the-world (Heidegger, 1962). This compound expression indicates a unitary phenomenon. We are inclined, according to Heidegger, to think of being-in as being in something. This kind of being is a spatial relationship between things – like water in a glass – but this is not the being in he is referring to. He is referring to Being-in as an existential structure and as such belongs only to Dasein (Cavalier, 2006). Dasein is in the world, active and dwelling among entities of the world. Dasein is involved with concern, is touched and affected in this related existence. Self-interpretation emerges being-in this network of activity. Being active, dwelling, being involved, being concerned and being affected, reflect the act of care.

Human existence is grounded in our always already finding ourselves in the world. Traditional thought posits a 'mind' which exists without a world. The mind can have

thoughts and feelings regardless of the world – I think therefore I am. Whilst this is one mode of Being (as a categorical structure of existence), it is not the Being of Dasein. Within this categorical structure Dasein is factually being present-at-hand (Wrathall, 2005).

The traditional notion of an inner and outer self, subject and object, creates epistemological problems for understanding the nature of being human. Knowing in a theoretical way is a specific way in which Dasein can be in the world. But a theoretical knowing is founded upon the primary mode of concernful absorption and it is a knowing that involves a disengagement from such a primary mode (Cavalier, 2006). It creates objects and subjects in a functional relationship and nurtures the thought of being able to do things to and for the other. However, Dasein exists (ek-stasis) outside itself. There is no inner or outer. "The Dasein which knows *remains outside*, and it does so as *Dasein*" (Heidegger, 1962, p. 89). Inner and outer explains something about Dasein as a categorical structure of knowledge – it offers a theoretical understanding of being human – but it does not give an ontological explication of the being that exists – the who that is struggling with thoughts of committing suicide as they dwell in an active, concernful and affected manner in a related world with others.

What does 'world' mean in the expression Being-in-the-world? World is something Dasein has. Without Dasein there will be no world (Waters, 2005). It is an existential structure bound together with Dasein and represents the undifferentiated surroundings of Dasein. If one "fails to see Being-in-the-world as a state of Dasein, the phenomenon of worldhood likewise gets *passed over*" (Heidegger, 1962, p. 93). One way of understanding the world is by depicting, describing and giving an account of occurrences in and with them (the 'what'), for example the signs and symptoms of suicide. But this totality of things objectively present does not correspond with Heidegger's view. From an ontological perspective 'the world' is something invested with meaning – the meaning understood by a person who happens to be suicidal. The signs and symptoms of suicide are insufficient to reveal the world of the person present and how they understand themselves and exist. The world of the suicidal person or the world of the therapist is not the world of nature.

Our everyday understanding of things of our world conceals the true functioning of nature. The rules of nature were scientifically established only once scientists undertook to disregard the world as it makes sense to us, as it appears in our everyday dealings with things. For example, the everyday understanding of the sun rising in the East and setting in the West is proven false by science. There is no rising or setting of the sun – the earth revolves around the sun. For science the world is 'Nature', but this is not the world of Dasein (Heidegger, 1962). The danger, says Wrathall (2005), is that our reverence for physical science makes us dismiss as unreal anything that cannot be proven by scientific method and we then run the risk of overlooking the world. This in turn makes it impossible to understand ourselves and others. 'Our world' conceived of as a revolving planet says very little about the nature of the world of human existence. But with a 'sun rising and setting', as it appears to us in our everydayness, we can get closer to an understanding of human existence through the activities and objectives dictated by this everyday understanding of our world. "Nature is a limiting case of the Being of possible entities within-the-world… as a categorical aggregate of structures of Being…(it) can never make *worldhood intelligible*" (Heidegger, 1962, p. 94).

My understanding of Heidegger's idea of world is that it is a creative act by which entities become meaningful and take shape and become connected during the process of understanding 'in order to' and 'for the sake of', 'with which'. The world understood according to the laws of natural science is not the lifeworld of being human. "Instead, we only understand a world by somehow finding a way into it and the experience of things it gives birth to" (Wrathall, 2005, p. 20). Whilst the philanthropist, the suicide bomber and the suicidal client are subject to the same physical and chemical laws, they in a very real sense inhabit different worlds. If we fail to understand this, we will fail in understanding ourselves (Wrathall, 2005).

Dasein's understanding (of the world) is not a collection of facts and 'knowledge' but founded upon the way that Dasein does things – how to live in it. The world structures activities by providing one with different possible ways to give order to one's life – one's existence is based upon these decisions (Wrathall, 2005). Things over the world need to be understood to be seen for what they are. This understanding refers to the understanding of Dasein's comportment to its existence, an understanding which

manifests in one's knowing what to do and why it makes sense to do it. A standard assessment and treatment procedure belongs to the 'facts and knowledge' about suicide in its ontic guise, which disregards how the world makes sense to the suicidal person. It fails to appreciate the world of the being 'who' is suicidal and the activities and possibilities that are part of their suicidal world. When the therapists' tools of the trade break down, this misinterpretation comes to the foreground and disillusions the therapist. The therapist is then confronted with the possibility of many different worlds that have no relation, in human terms, to the one world of nature.

Care and the with-world of Dasein

The with-world of Dasein

Why it is that therapists felt they were guilty of neglect or not caring enough for their clients when their clients committed suicide? Against what were they measuring their care and concern? Were they perhaps equating manifestations of care (modes of care which gets passed along as self-evident with the passage of time) with care itself, thereby undermining their human capacity for care? Heidegger's (1962) conception of our world and what care is would suggest that we are always already caring for others. Therapists – like everyone else – cannot but care for their fellow human beings and they may have forgotten this because of our everyday understanding of our world as something governed by natural laws, that we are 'in' this world and care like we care for things. By considering the being that is human as a substance in the traditional paradigm, the 'who' Dasein is, is missed, says Heidegger (1962). Heidegger says that Dasein is *ek-sisting*. Dasein is a being outside of itself, a process, an acting, and a projecting itself already 'out there'. As Overgaard (2004, p. 126) says, "we are transcendental subjects, we are 'places' where the world opens up, acquires meaning, becomes articulated; but these 'transcendental places' emerge in the midst of the world". The world of being human is a with-world. There is no world without the other.

"The world of Dasein is a *with-world*. Being in is *Being-with* Others. Their Being-in-themselves is *Dasein-with*" (Heidegger, 1962, p. 155). You can thus not have a world on your own. In the first instance when we are in our world space, we are in that space as within a totality of others from whom we do not differentiate ourselves because we pursue our projects in the context of other people who this work is for. "By 'Others'

we do not mean everyone else but me – those over against whom the 'I' stands out. They are rather those from whom, for the most part, one does *not* distinguish oneself – those among who one is too" (Heidegger, 1962, p. 154). The condition for the possibility of world is being-with, your being within the sharing of world within a social group. So it seems that being with others is a foundational condition for the possibility of the being which Dasein has, which is a condition of there being 'a world'.

Care

How could I understand therapists' extraordinary sense of responsibility which manifested in the form of fear and guilt after the suicide of a client? Therapists faced a number of dilemmas in their endeavours to be responsible and caring practitioners, and it seemed that no matter how they cared, people committed suicide. This was a most disturbing experience for therapists and in order to understand the nature of this phenomenon I relied on what may be understood about the act of caring for a fellow human being at an ontological level, i.e. the nature of care itself.

The way in which we care about people is different to our care of things that are not human. Care is a noticing of others with interest and circumspection, according to Heidegger (1962). We notice this underlying being-with only when, like with equipment failure, we do something out of place. It is only when our modes of care – our everyday understanding of care as it gets passed along as self-evident with repeated use, reference and time – that we remember the origins of our being already always caring and how this has been misinterpreted without us noticing. It is when the client commits suicide despite our traditional way of caring that we are brought back to the question what it means to care. Being for, or against, or without one another, passing one another by, or not mattering to one another, are "deficient and indifferent modes that characterizes everyday, average Being-with-one-another" (Heidegger, 1962, p. 158). It is due to this inconspicuousness and obviousness of Being-with in our everydayness, just like the inconspicuousness of equipment, that empathy "gets its motivation from the unsociability of the dominant modes of Being-with" (Heidegger, 1962, p. 162), that we believe doing for and to the other is care.

Dasein is in the world, active and dwelling among entities of the world. Dasein is involved with concern, is touched and affected in this related existence. The word 'care' expresses this relationship and its influence from which Dasein's understanding emerges as to how to comport itself towards its existence. "Dasein, when understood *ontologically*, is care" (Heidegger, 1962, p. 84).

Heidegger says 'Dasein exists as a being for which, in its being, that being itself, is an *issue*' (Dreyfus, 1991, p. 238). The person is always already thinking ahead towards the possibilities of being itself. It is this being ahead of itself that is the issue. It is the future (ownmost possibilities) Dasein cares about. This is 'care' understood ontologically because it concerns the existence of being. It is for this reason that Heidegger says Dasein *is* care. All ontic senses of care are modes of ontological caring. "Because Being-in-the-world is essentially care, Being-alongside the ready-at-hand could be taken in our previous analysis as *concern*, and Being with the Dasein-with of Others as we encounter it within-the-world could be taken as *solicitude*" (Heidegger, 1962, p. 237). Heidegger further points out that care is not an attitude towards an isolated self or 'I', because ontological care includes care as concern and solicitude whichever form the latter two may take. Even neglect is care, for neglect is not possible without care, it is merely a deficient mode of care.

Ontological care thus includes concern and solicitude because it refers to existence, existence defined by Dasein's understanding in relation to its activities and being with others. While concern focuses on the present and on being alongside things within the world (equipment), solicitude – whether authentic or inauthentic – focuses on other people and not equipment. This care structure unifies Dasein's three central features, according to Inwood (1999). Care unifies existence (future), facticity (past) and falling (present). Therapists, one can then argue, are always already caring about the future, the past and the present of the existence of the client by virtue of our always being-with. The manner in which this care manifest in practice may however dilute this truth of our existence and it is only when our ways of caring fail that we question our capacity to care. Of our capacity to care there should be no doubt, if I understand Heidegger correctly. What we should question and doubt is how we have chosen to interpret this given of existence in our everyday practices as mental health professionals by doing things to and for people in need of care. Heidegger (1962)

suggests that solicitude can take on different forms of expression. When it 'leaps in' it dominates or takes the other over. When it 'leaps ahead' it invites the other to explore the possibilities/potential for their own being.

Crisis of existence: The call of conscience

The crisis of existence suicidal clients talked about in therapy – not knowing what to do and how to live – resonate within the therapist at a very personal level during the course of therapy. Therapists experienced a crisis when they suddenly found themselves confronted by professional, institutional and personal matters which had become an issue for them as a result of their experience of working with suicidal clients. Heidegger's (1962) notions of authenticity and the call of conscience provided me with a philosophical foundation towards understanding this phenomenon.

In Heidegger's view we do not start off as authentic beings. Being part of the collective 'they' is where we start out in the world. Who we are and where we have been, where we are going has already been decided for us in this primary mode of existence. I have already referred to this mode of being in which we seem to win ourselves in our identification with the collective everydayness of being. This mode of being is however the font of the possible ways of being oneself. Heidegger (1962, p. 161) points out, "Knowing oneself is grounded in being-with".

In order to be ourselves, become Dasein, we have to get away from the average everydayness of the crowd which keeps watch over everything exceptional that thrusts itself to the fore. In this primary and inauthentic mode of existence one is levelled down, unburdened and accommodated by the collective 'they', says Heidegger. It is this felt sense of security and comfort, provided for by being unburdened and accommodated by 'they' which "retain[s] and enhances its stubborn dominion" (Heidegger, 1962, p. 165). However, to be accommodated and cared for by the collective exacts its price in one becoming anonymous. "Everyone is the other, and no one is himself. The *'they'*, which supplies the answer to the question of the *'who'* of everyday Dasein, is the *'nobody'* to whom every Dasein has already surrendered itself in Being-among-one-another" (Heidegger, 1962, p. 165). In this mode of existence one is affirmed as to who you are by the collective. One is unburdened of the responsibility to care about your own existence and to find the

answer to who you may be. With these existential matters accommodated by the collective, they lose their sting and never rise to become an issue for you, and you are not expected to stand by yourself.

This inauthentic mode of being is however a self-misinterpretation of what it means to be human which includes the possibility of being in your own unique way. A fuller interpretation of what it means to be human includes the possibility of being authentic. Being authentic is a derived mode, a modification of being 'they' and Heidegger cautions us to think about authenticity and inauthenticity in a neutral fashion. He does not wish to place a value judgement on this phenomenon, he merely wants to differentiate modes of being in which someone who has taken possession of their being or not taken possession of their being. "The Self of everyday Dasein is the *they-self*, which we distinguish from *authentic* Self – that is, from the Self which has been taken hold of in its own way" (Heidegger, 1962, p. 167).

A crisis of existence occurs when one suddenly discovers the world in one's own way. Everything that had been taken for granted and affirmed – one's identity and the care over what you do – suddenly becomes conspicuous and less certain. Heidegger describes it as an event in which Dasein discovers the world in a way which breaks up the disguises with which Dasein bars its own way. Is this what therapists experienced when they suddenly found themselves no longer familiar with what they understood and have been doing everyday? Is it perhaps the unexpectedness of a client's suicide which breaks the therapist's disguise of being-they and being-a-therapist? Heidegger's concept of the call of conscience suggests that there is a third way of being. The call of conscience is towards a more authentic way of being which refines and differentiates our primordial way of being-they, and our way of being within a socially sanctioned definition of who we are.

The call of conscience

The event which precipitates a crisis of existence is an interrupting experience that leads to self-knowledge, a renewed resolve and vocational commitment (Crowe, 2006). Crowe draws a parallel with the numinous and ineffable experience of Paul on his way to Damascus. One therapist in this project said "it was something out of the

blue", when reflecting upon the unexpected news that his client had committed suicide.

What is meant by conscience? Heidegger (1962) refers to conscience as a 'voice' or a 'call'. It is a phenomenon which attests for the possibility of Dasein to find itself in its lostness in the 'they'. Crowe (2006) argues that the 'voice of conscience' is Heidegger's formal indication to identify those moments where the person's situation is revealed to them. It is a moment of uncannyness accompanied by a realization that one's reality has already been chosen by history, tradition and culture. It is a moment in which one faces the freedom to choose differently. It is a moment in which one suddenly feels out of place and anxious of being able to choose a different way of being, free to reach towards one's ownmost potential of being oneself. To be able to choose means the possibility has always been there and that is why Heidegger (1962) refers to this experience as *choosing* to have a conscience. Being inauthentic is the possibility for being authentic, says Heidegger.

Where does the voice of conscience find one? "Dasein exists as a potentiality-for-Being which has in each case, already abandoned itself to definitive possibilities" (Heidegger, 1962, p. 315). The voice of conscience reaches one in that place where one is accommodated and cared for, where the answer to whom you are has already been affirmed. The voice finds us where we fail to hear ourselves, busy listening to the voice of custom and heritage and its reassurances with choices presented to us, our fate and destiny secured. The voice reaches us in abandonment, there in the 'they-self' of being in an average everyday manner or in a socially sanctioned manner of being.

Who does the voice of conscience belong to? "In conscience Dasein calls itself". It comes "from me" and "yet beyond me" (Heidegger, 1962, p. 320). I understand this to mean that the caller is the dialectic of being here and being yonder simultaneously. Beyond me is future orientated and holds the possibility of being whole in time to come; being here and yonder expresses Dasein's transcendent nature. But yonder has no form or content and this formlessness is a source of anxiety. The form and content of the possible existence in the future is dependent on the person's decisions and self understanding. Living with this uncertainty is 'uncanny' and a source of anxiety; of being thrown into an existence where one's reality has already been chosen, yet

recognising in ‘moments of truth’ that one is reticent to venture into the unknown, preferring the comfort and ease of being absorbed by the many. This is the inauthentic they-self fleeing from the possibility of being oneself. The caller is Dasein in its uncanniness, says Heidegger. Dasein’s basic constitution is care for itself. It is from care that Dasein is called forth; back from the reticence of being oneself who exists comfortably in tradition, culture and the socially acceptable ways of being. It is there where one is cared for, where one is unburdened by the issue of caring about one’s own way of being.

What does the voice of conscience give to understand? Heidegger says we must not think of the call as communication from a mysterious voice or of words or as a soliloquy, conscience “discourses solely and constantly in the mode of keeping silent” (Heidegger, 1962, p. 318). He says it passes over the ‘they-self’ and the idle talk which characterises this inauthentic way of being. Concealed by the empty cacophony of idle talk a different meaning and significance is waiting silently. It is in that unexpected moment, when something out of the blue silences the hubbub of idle talk, when common discourse finds itself unable to articulate any meaning or significance, that the silent is heard. That is when one hears precisely that which is not said and one suddenly hears something different which arrests one’s way of having been absorbed in the ‘they’ and having gone along with what is usually and idly spoken about in one’s everydayness of being. As Inwood (1999) says, silence is talking and it is a definitive way of expressing oneself. It is like ‘the blues’ genre in music where it is said that the music comes to life between the notes.

In passing over the ‘they-self’ the voice of conscience calls Dasein forth into its ownmost potentiality for being itself, says Heidegger (1962). What Dasein hears is its ontological guilt. This guilt is general and unconditional, it has no contents, says Hoffman (2006). Ordinary or moral guilt has contents in that it is specific and determinate, guilty of doing or not doing what you said you would or tacitly agreed to do by virtue of your socially sanctioned role and position. Was it perhaps ontological guilt, shinning through its semblance as ordinary guilt, when therapists said they continued to feel guilty despite being cleared of any wrong by their institution and profession for a client’s suicide? This ever present form of guilt, silently waiting, seems to speak out during unexpected moments such as being confronted with death;

what are you doing with your life? Dasein is then faced by its nullity and called to become its own basis for a valuable and meaningful life.

Conscience and therapy

Guignon (2006) says that therapists may feel poorly equipped to attend to the substantive and unavoidable moral questions which, in his view, forms part of any attempt to understand human beings in this modern industrial-technological age that we live in. Psychology is ambivalent says Kruger (1979). It has made it its task to comprehend and systematically describe behaviour and in this way defines itself as not necessarily being concerned with a person's fate, but does not preclude its results from being used to improve human conditions. However, "psychology can, and often does, define itself in such a way that it can, as a science, be indifferent to the human condition" (Kruger, 1979, p. 1). He says the world is stripped of meaning because of a long tradition of rationalist positivist thinking which has degraded the thing into mere object. In this mode of making things intelligible the totality of 'things that are' is forgotten whilst knowledge accumulates on mere appearances. The image of being a person is one in which s/he is standing over and against things that are as an uninvolved observer. But humans, asserts Kruger, are involved with things that are their world, have an appreciation of things and make differentiations accordingly. This way of being is not value-free, yet mainstream psychology believes that it is able to split logical thought from ethics in its wish to be accepted alongside the respected biological and physical sciences. If psychology wants to be a science for humankind – as opposed to being one about humankind – it has to appreciate that cognition of 'things that are' was pervaded by an 'ought to' in pre-Socratic thought in which there is no talk of value-free thinking (Kruger, 1979).

Kruger's views are echoed by Guignon (2006) who claims that psychology and psychotherapy in particular, thinks of itself as an applied behavioural science that endeavours to be value-free and objective. Therapists are poorly equipped by a value-free psychology where there is an artificial split between logical thought and ethics, where human beings become what they do rather than being who they are. Mainstream psychology has accumulated knowledge about how human beings appear to be and this is why therapists may be poorly equipped for the task of helping someone with the question how to live and what to do.

Guignon (2006) is of the view that Heidegger's concept of authenticity has a great deal to offer psychotherapy. It points towards a way in which therapists can equip themselves to accompany those struggling with the moral issues to do with better living and being at home in the world. This might be the 'emotional preparation' that is lacking in training which a participant referred to. Inauthenticity is characterized by falling and forgetting. Dasein falls into the busyness of everyday affairs and become ensnared in these concerns, going along with the taken-for-granted practices of everydayness. Dasein forgets itself in the process, preoccupying itself and becoming self absorbed with checking its performance against public criteria.

Therapy must involve moral reflection if Heidegger's concept of authenticity is correctly understood, says Guignon (2006). Modern therapy and its assumptions make it difficult to grasp the moral dimensions of being human and risk perpetrating the problem in the cure. "Heidegger's conception of authenticity, in contrast, can help us make sense of the moral dimensions of therapeutic practice not fully accounted for in most forms of theorizing" (Guignon, 2006, p. 290).

I kept these thoughts in mind when therapists said they felt incompetent or as one recalled in reflecting on suicide and his preparation to become a psychologist, "at an academic level a resounding yes in terms of signs and symptoms but emotionally no…how do you prepare someone for that?" Perhaps Heidegger's notion of authenticity and choosing to have a conscience can begin to shed light upon the inherent "restless to and fro between yes and no" (Heidegger, 1959, p. 75). It is the emotional turmoil of attempting to help a client respond to the call of conscience, a call that inevitably, it would appear, resonates within the therapist who cannot help but be-with the client.

Conclusions

In this chapter I have discussed the philosophical notions that will guide this study.
I have used Heidegger to provide the philosophical basis for approaching this project and to analyse participant's experiences of working with suicidal clients. In the following chapter I will describe how the philosophical underpinnings provide a basis for developing my own process of inquiry.

Chapter Four

Methods

Introduction

In the previous chapter I discussed the philosophical notions of Heidegger that guided this study and I indicated that his hermeneutic phenomenological method is well suited to enquire about the experiences of therapists working with suicidal clients. By way of introduction I will briefly reiterate key aspects of the hermeneutic phenomenological methodology before I discuss how I went about gathering and analyzing the data in accordance with these principles. Heidegger's phenomenology aims to let the things of the world speak for themselves and asks: what is the nature of this being – what lets this being be what it is (Van Manen, 1990). Heidegger's phenomenology wants things to show themselves – that which they are being (verb) – by distinguishing between how things appear (ontically) and their essences (ontological). Hermeneutics is the science and practice of interpretation (Van Manen, 1990) and by means of interpretation it becomes possible to differentiate the ontic from the ontological. An interpretation of our own being and the being of things becomes necessary, says Heidegger (1962), because the understanding of our being is never fully accessible, it is covered up. The aim of an interpretive phenomenological analysis is to explore and uncover how participants make sense of their personal and social world by studying the meanings of particular experiences or events in the life of the participants (Van Manen, 1990; Willig, 2001).

Ethical Considerations

I gained Ethical Approval from the Auckland University of Technology Ethics Committee for this study (Appendix D). Protecting participants by maintaining confidentiality was a key consideration in my study. Therapists are in a vulnerable position when they are invited to talk about their assessment and treatment of suicidal clients, especially when some of their clients then committed suicide despite their therapeutic endeavours. Participants were reassured that I will use pseudonyms to protect their identity and that features such as where they come from and their age will be changed. The absence of identifying features will carry

on throughout the research process and beyond to presentations and publications. I assured them that I would honour the material given to me during interviews and send extracts of their stories I was likely to use in my thesis back to them, so that they could comment or ask for changes that concerned them. All tapes, transcripts and stories were held in a locked filing cabinet. To ensure participation was an informed decision, participants were given an information sheet about the study, the format of the interview, the risks and benefits of participating and how their privacy will be protected (Appendix A). Participants were given a copy of the questions I used to initiate and maintain our discussion of their experiences (Appendix B) and they were asked to sign an informed consent form (Appendix C).

Introduction to the participants

For the purposes of this study a therapist (which may include mental health nurses, psychiatrists, psychologists and other mental health professionals) is someone who has received a professional education in providing psychological treatment to clients. Thirteen participants, between thirty and fifty years of age, took part in the study and all offered their stories spontaneously and freely, for which I am grateful. In order to protect their identities I will provide a general demographic overview rather than individual details. Seven participants were male and six were female, all of European descent with well in excess of five years experience in their respected professions. Six qualified in New Zealand and seven qualified in other countries around the world. All the participants were employed by District Health Boards when interviewed for this study; five psychologists, seven psychiatric nurses and one psychiatrist. They have all worked with suicidal clients, some of whom committed suicide whilst in their care, except for two who have not had a client commit suicide in their care, but have had clients who have threatened and attempted suicide.

Accessing Participants

To ensure that potential candidates were able to participate without feeling or being coerced I followed two approaches. One was to tell colleagues about my study and provide them with the participant information sheet (Appendix A) and a copy of the questions (Appendix B), with the request that they contact me in their

own time if they believed they were eligible and willing to participate. The other approach was to attend one of the regular morning meetings of colleagues working in another mental health unit in the District Health Board with the same request. In this way, potential candidates could simply not respond to my invitation if they were not interested in participating. Once the participants made contact with me, indicating their eligibility and interest, we arranged for a time and place of their choosing where they felt comfortable to talk to me in private. The interviews were arranged within one to two weeks of them approaching me to allow them time to reconsider their decision, if they felt the need to do so.

Protecting Participants

At the arranged time and place of the interview participants were once again given a verbal outline of my study and its purpose. Participants were informed that they would be identified by a pseudonym and other identifying information removed or given a generic name. I agreed with the participants that if they felt distress or discomfort during or after the interview, that I could direct them to a person to assist them. This was not necessary for any of the participants. I asked them to sign the consent form (Appendix C) prior to starting our discussion. The privacy of the participants was ensured at all stages of the study. The recorded interviews were transcribed by me. The recordings (identified by number) and transcriptions (under a pseudonym) are kept in electronic format on my password protected personal laptop.

Assumptions and Pre-understandings

Hermeneutics is the science and practice of interpretation (Van Manen, 1990). Interpretation by its very nature is circular, since new insights and understandings, born from experiences, alter or augment the meaning and interpretation that went before the experience. My experiences and understanding of working with suicidal clients, my understanding of suicide at a professional and personal level influenced the topic of this thesis and were made explicit in an interview with my thesis supervisor. When I arrived in New Zealand in 1994 I could not understand why it had a disproportional suicide rate when the people of the land are living in 'God's own', which in my estimation is an apt description of a most beautiful country with a kind of gentleness to the landscape that has rubbed off on its

inhabitants. I emigrated from South Africa fifteen years ago; sadly, a land known for its history of racial prejudice, inequity and violence. You would think that suicide is more likely in such a seemingly God-forsaken place, yet it is not to the extent it is in New Zealand. Why is that? I wanted to know.

My first encounter with a client committing suicide in my care was when I was in private practice in South Africa. I clearly remember the telephone call from the client's wife informing me that he will not attend his next session because he had committed suicide. She leveled no anger, blame or resentment towards me. The man was being investigated for child molestation. Realizing the significance of what therapists do was brought home by this tragedy early in my career. In New Zealand I have been working in District Health Boards since 1996. I can recall my experience of working with suicidal clients who committed suicide whilst in my care, working in a New Zealand District Health Board service. Although the person presented without glaringly obvious symptoms associated with suicide, the person was nevertheless living a life of despair and torment. When I learnt of the person's suicide I was not overly shocked and surprised, it was not that unexpected. I could understand why the person had chosen to end life in such a manner, given his history and daunting circumstances of everyday life at that point in time. I was however taken by surprise with the authorities' nervous care and concern about the administrative and documented evidence the Board could put forward as a defense against possible culpability. How I may have experienced the tragedy and the opportunity to understand how the person had arrived at taking a hand to their own life attracted no collegial interest from my superiors.

On another occasion, when a colleague and I were implicated in the suicide of a client, I vividly remember the nerve wracking enquiry into the matter by the institution and the coroner. My colleague suffered an episode of major depression in the aftermath and was unable to return to work for a considerable period of time. I felt that something was amiss, that "there is something wrong here", and these experiences gave further impetus to the questions I had about suicide in New Zealand, soon after I arrived in this country.

These fore-structures of my understanding gave shape to the interview questions and the resulting answers in turn influenced my questions. And thus the hermeneutic circle is put into motion with the result that what is revealed is dialectic of what the participants and I brought to our meeting. I was aware of my history and its reality in my subsequent treatment of the data. I was aware of my own views and thought imbued by theoretical and personal prejudices and the loss of words to formally articulate what I had experienced. I am deeply grateful for the help I received to find some way to articulate and understand the experience of working with suicidal clients by helping the participants in this study to find words for theirs. The results and findings of this project is dialectic of our commitment to understand together.

The Interview as a hermeneutic phenomenological investigation

The data for this study was gathered using a semi-structured conversational interview which appears to be the most widely used in qualitative research in psychology (Giorgi & Giorgi, 2003; Smith & Osborn, 2003; Willig, 2001). It is a method which allowed me to enter into the life-world of the participants with results that are compatible with an interpretive phenomenological analysis (Van Manen, 1990; Willig, 2001).

The interviews took place in private and noise free rooms at locations decided by the participants. The interviews were generally between one and one and a half hour in length. I opened each interview by asking the participants to tell me about their experiences of working with suicidal clients. Invariably the participants responded to this invitation by talking about the situation in a general overview and the 'facts' about their experiences in terms of where, what and how things unfolded. This response offered me a broad outline of the situation within which their personal experiences took place. Since I was interested in how they experienced events 'from the inside', so to speak, I then took them back to what they had said and asked them to tell me how they felt about it, for example, "tell me more about what you mean by being shocked when you heard the news". Some of the participants responded to this kind of question by taking a step back and describing their experience from an observer point of view, as if they were spectators. On these occasions I told them that I was more interested in how it was

for them, how they felt and how an event affected them personally. In order to stay close to the life-world of experience that belongs to the participant I returned again and again to those statements where the participant was clearly touched and affected by what they were talking about. With this way of returning to what has been said, I hoped that participants were given the opportunity to say as much as they could about how it was for them at the time.

After interviewing thirteen participants I felt that an adequate depth and breadth of experiences of working with suicidal clients had been reached, since the final interviews were providing similar information and experiences to those collected in the preceding interviews. This gave me the reassurance that sufficient information had been collected to show the phenomenon of working with suicidal clients. All the interviews were recorded and transcribed verbatim. All participants were given a copy of extracts of their narratives most likely to be included in the study for their verification and the opportunity to comment or make requests about its inclusion in the study (Caelli, 2001).

Data Analysis

Once I had listened to the audio-taped conversation and arrived at the completion of its transcription, I found that I already had a 'feel' for the participants' experiences, an intuitive sense of places in their narratives where there was something waiting to be understood more clearly. I would then read through the transcript in its entirety a couple of times, asking critical questions of the text from a participant each time (Smith & Osborn, 2003). I made margin notes where parts of the story seemed to ask what could this mean, "is there something leaking out here that wasn't intended?" or where I had a sense that something is going on that the "participants themselves are less aware of" (Smith & Osborn, 2003, p. 51). I also noted statements which conveyed themes, paradigms and exemplars (Conroy, 2003), statements that conveyed that this is how we always do things, or this is just how it is. I found myself asking "is there something unique concealed in this collective understanding". I was interested in statements that pointed at collective belief and agreement where things become average and their uniqueness forgotten and left behind, for example, mentally ill people commit suicide. I noted statements which I felt contained ambiguity, or modalities and

fluctuations as Conroy (2003) puts it, and included them for further analysis, for example, “I no longer understood people”. In ambiguity lies the possibility for reflection, to discern meaning and to broaden consciousness of our human limitations (Hillman, 1992; Neumann, 1954). A paradigm shift reflects how people incorporate and respond to their unsettled sense of existence in the world (Conroy, 2003). I also identified commonly used terms in order to trace them back to their origins in factical life experience (Crowe, 2006). However, I also noted segments of narratives which drew my attention for no reason I could clearly articulate at the time, I just felt myself being inquisitive about what it may mean; I had no reference for understanding. I recall on those occasions feeling somewhat nervous and insecure, and for that very reason included them for further analysis. Trying to make sense of words and incoherencies is what Caelli (2001) refers to as interpretation in action. I then read through the transcript again and identified additional statements and expressions that resonated and amplified what I highlighted during the initial readings. At the conclusion of this phase I had identified a number of associated statements around a certain conception, or understanding from the participant’s narrative.

The second phase of analysis consisted of gathering associated statements from a narrative into extracts that captured a particular theme, paradigm or exemplar. As Caelli (2001, p. 275) puts it, “there are flows and patterns in the data that relate to each other”. For example, the participant thinking, feeling, or doing something with the intention to follow procedures, or provide care for a client, will be collected into an extract for analysis. With the original narrative still intact I copied associated statements from the narrative and pasted these into extracts on a separate word document. I edited the grammar and punctuation to make the account more readable (Caelli, 2001). I took care to retain the original words and the essence of what the participant said about an experience of working with a suicidal client. I now had a separate document with a collection of extracts from a narrative ready for interpretation. Each extract presented a variety of entry points for interpretation. Where to begin? The interpretative circle ought to be entered at the point where it comments on the person who is doing, thinking and feeling (Heidegger, 1962). I would read through the extract and ‘listen’ to what the

extract ‘said’ about the being (verb) of the participant. I then simply started writing with that as the original impetus. As I wrote, new or related thoughts and ideas would start crystallising and influence the way ahead and form a sentence of their own accord. I took reassurance from the idea that interpretation by its very nature is circular, since new insights and understandings, born from experiences, alter or augment the meaning and interpretation that went before the experience (Van Manen, 1984). In this manner I allowed sentences to lead the way, allowed these sentences to be formed by thoughts and ideas that ‘just arrived’ as I was busy writing. It felt like one sentence giving spontaneous birth to the next, and the next, and I was there to write them down. When I arrived at ‘dead ends’, I sat back and waited, and somehow this process would regenerate itself again. By following a seam in a narrative extract like this, the seam comes to its natural end. Smythe, Ironside, Sims, Swenson & Spence (2008) refers to this way of working with data as an ‘experience of thinking’. An experience of thinking is where one allows the data or the story to ‘call you’ and to let thinking find its own way to insight and understanding. I reflected on what I had written and found a rich mixture of rough philosophical and psychological ideas and concepts. This experience would then initiate the next phase where certain experiences, for example feeling confused, appeared to reverberate with aspects of Heidegger’s conception of being-in-the-world (Heidegger, 1962).

This third phase consisted of a spiral of interpretation-writing-dialogue (Conroy, 2003; Smythe, Ironside, Sims, Swenson, & Spence, 2008) in the same manner described in the aforementioned paragraph. But there was a difference. My writings became more halting and tentative with many apparent ‘dead ends’ and screeds of rambling confusions, ambiguities and uncertainties that would then direct me to Heidegger’s philosophy itself and publications in psychology, psychiatry and philosophy with a Heideggerian imprint. By reading and reflecting the ‘dead ends’ in my writing would open up, the confusions, ambiguities and uncertainties crystallised themselves in a particular direction. There were many occasions when I would ‘do nothing’, leave the work alone for a while, and allow what I had read to wash through me, knowing from experience that something would arrive toward depth and clarity. There were many pieces of work that were the result of waking up, or walking down the road, with an instant realisation that

"that is what it means!" After these moments of clarity I could usually sit down and write, without pause, an entire piece of work that held together conceptually – those were satisfying experiences. It was during this period that I would have the confidence to send my analysis of an extract to my supervisors for their comment, critique and thoughts. Their counter arguments, provocative questions and statements would reignite a rewrite, again and again. In this fashion my supervisors and I worked through all the narrative extractions, following the suggestion of looking in detail at the transcript of one interview before moving on to examine others, case by case (Smith & Osborn, 2003). The intention was to begin with particular examples, slowly working up to more general categorizations or claims. At the end of this phase I had a collection of extract analyses for each narrative.

The fourth phase of analysis began with my supervisor's question; "are you now able to identify general themes about therapists' experiences from what you have shown through your analysis of all the extracts?" I identified three prominent experiential themes that unified all the participants' stories, namely, 'being shocked and confused', 'being responsible therapists' and 'feeling confused' as a result of their experiences with suicidal clients. There were certain pivotal Heideggerian notions, in my mind, which I used as a broad guide whilst writing and reading during this phase. What does 'being', 'in' and 'world' in the compound expression being-in-the-world mean? What can be understood with 'existence' as being thrown, falling and projecting oneself at the junction of past present and future? These three themes were rewritten many, many times in frequent consultation with my supervisors until we felt that what was being shown was consistent with what was said by the participants – staying with the phenomenon – and that my interpretations held together with sufficient philosophical clarity and internal cohesion about the being-in-the-world from where therapists experienced working with suicidal clients. These themes form the following findings chapters.

Trustworthiness

There has been much debate in the literature on how the trustworthiness of a qualitative study should be judged (Davies & Dodd, 2002; de Witt & Ploeg, 2006; Koch, 2006; Koch & Harrington, 1998) but there is agreement that trustworthiness can be judged by the extent to which the method of research reflects the underpinning methodology. Good qualitative research is based on the assumption that the researcher and the researched are not independent entities and the notion of 'objectivity or absence of bias is not a meaningful criterion for judging qualitative research' (Willig, 2001). Koch (2006) and Willig (2001) provide guidelines for the evaluation of a qualitative research report which I made use of in reflecting on the trustworthiness of my study and treatment of the data.

Credibility

Credibility is enhanced when researchers describe and interpret their experience as researcher (Koch, 2006) and check whether their accounts are credible by referring to colleagues, participants and other researchers' interpretation of the data (Willig, 2001). The above description of my own experience of working with suicidal clients and the imprint of my history and culture on my being is part of what I brought to support my interpretation of therapists' experiences of working with suicidal clients during the hermeneutic process. Being explicit about my experience and interpretation thereof thus lends some credibility to how I understood and interpreted the participants' experiences. Throughout the project I referred my work to my supervisors and colleagues to check for the credibility and resonance of my interpretations and conclusions against their views and interpretations. I referred the extracts I intended to use for analysis in this project to the participants for their feedback and comment, asking whether the extracts captured what they meant and intended to say about their experiences.

Transferability

Transferability is dependent upon the degree of similarity between two contexts (Koch, 2006) and requires the researcher to situate the sample to allow readers to assess the relevance and applicability of the findings (Willig, 2001). I have taken care to provide detailed contextual information, such as, my definition of a therapist, their experiences in practise, the background of their task as mental

health professionals towards suicidal clients and the cultural milieu of the profession and its institutions of care. The inclusion of contextual information in the treatment of the data aids the reader to make similar judgements and to 'fit' the meaningfulness and applicability of my findings into a similar context outside of the study.

Dependability

Dependability refers to the transparency of the theoretical, methodological and analytic choices throughout the study, an audit trail whereby another researcher could arrive at the same or comparable conclusions, given the data, perspective and situation (Koch, 2006). I have taken care to describe the philosophical underpinnings of this study, the methodological stance taken and its appropriateness to the research question. I have been clear about ethical considerations, the interview process and data analysis. There is an 'audit trail' of my thinking and doing in the form of comprehensive feedback notes from my supervisors, their views and counter-arguments associated with my interpretive decisions and the subsequent insights I arrived at as a result of this dialogue. De Witt and Ploeg (2006) refers to this process as the 'openness' of the researcher's orientation and attunement throughout the research project that can demonstrate a coherence and integration of theory, methodology and actions.

Conclusion

In this chapter I explained my decision to use an interpretive hermeneutic method of enquiry, grounded in the philosophy of Heidegger as an appropriate methodology to enter the life-world of therapists' experiences working with suicidal clients. I have shown how I dealt with ethical matters regarding the privacy of the participants, how I accessed participants for this study and the methods I employed to gather and analyse data from my interviews. I also provided an insight into my own pre-understandings and assumptions that inevitably becomes part of a research project of this nature. The preceding chapters laid the foundations for undertaking this study and the following three chapters will explore the experiences of therapists working with suicidal clients that were uncovered in the participants' narratives.

Chapter Five

Being surprised and shocked

In this chapter I aim to explore how the phenomenon of being surprised and shocked may be pointing at something that is not showing itself explicitly and the aim is to make this more explicit. The therapists in this study have all followed a standard risk assessment procedure to identify the likelihood of the client committing suicide. It is a procedure developed upon research findings and recommendations made to the Ministry of Health (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005; Beautrais, Joyce, & Mulder, 1998b; Harris & Barraclough, 1997; Ministry of Health, 2006). The main thrust of the procedure is to determine whether a client presents with any mental disorder usually associated with suicidal intent. Without exception therapists recall being surprised when they heard that their client had committed suicide. Whilst one or two therapists said they had a premonition or a 'gut feeling' their client was 'at risk' of committing suicide, they were still taken by surprise and shocked to hear the news because, based on their assessment and observations, the client seemed to be fine just prior to suicide. These clients displayed none of the mental disorders usually associated with suicidal intent identified by research and theory. As one therapist said, 'I felt a hell of a shock because when he left me he was animated and smiling'. Another said his client's mood had lifted, she no longer presented with symptoms of depression or suicidal thoughts and yet she committed suicide. There is a disjunction between how these clients appeared to their therapists and how they 'really' felt. The therapists recall their clients' mood as euthymic yet they committed suicide. They recall that their clients seemed to be fine a couple of days or even hours prior to ending their lives, without symptoms associated with suicidality. Is this phenomenon of shock and surprise the result of a misrepresentation and misinterpretation of the nature of being human?

Essence and Appearance

Kane, like the majority of therapists participating in this study, was shocked and surprised to learn that his client committed suicide whilst showing no signs or symptoms of a mental disorder that is usually associated with suicidal intent. Kane's

colleague, a psychiatrist, concurred with this assessment and was equally shocked by the suicide. This is Kane's account:

> *I said what?!…completely confused and unbelievable. It doesn't hit home…it can't be true…I have an appointment with him. I am expecting him any moment. I was amazed because he had a lot of things going for him. He had bought a little house, he was working in the bush and he had started his own firm. There was evidence that he was on the road to build up rather than break down. I went to the Mental Health Service and met with the psychiatrist and the manager of that service. And I must admit that the man was absolutely devastated, lost for words, he had tears in his eyes, choked voice and repeatedly said that the last time he saw him he didn't think there was anything wrong with him.*

Kane had a similar experience with another client who committed suicide. This client said he was going to commit suicide, but because he showed no signs of a mental disorder his threat was deemed to be empty and of little substance:

> *We were there to assess him and had the power to commit him against his will if he were to be a danger to himself due to a psychotic or mental illness or danger to the community. But he wasn't. There was not a mental health status that we could commit him.*

Elaine had a similar experience with her client who committed suicide:

> *My boss and I went through the file and we could see that the risk assessments were done and that I had gone through the whole process* [paper trail of mental health assessment] *and that he was safe and sound.*

Aaron's experience is not dissimilar. He felt that his client committed suicide because he had misdiagnosed the client:

> *I had misdiagnosed or had missed something. I guess I was young and relatively new to the profession and as such you are full of book*

knowledge and you try to stick to the formats and forms and fill everything out.

The majority of therapists participating in this study were shocked and surprised to learn that their client committed suicide in the absence of signs and symptoms usually associated with suicide. Kane was confident in his understanding of his client until he committed suicide. He was also reassured by his client's behaviour of buying a house and starting his own business. Elaine followed the same procedure as Kane, and so did Aaron who had done things by the book. Aaron followed predetermined formats of understanding with confidence which reassured him that his client was not suicidal.

These therapists were shocked because they had encountered something which challenged their way of understanding their clients. The method and procedure of understanding their clients belongs to mainstream psychiatry and psychology in practice. Standard conclusions drawn from assessment findings are common practice for mental health professionals. Kane's colleague on the same case, a psychiatrist, arrived at the same conclusions Kane did and was therefore also shocked by the suicide. Elaine's boss at the District Health Board endorsed her assessment as standard and accepted practice.

These therapists were shocked because they felt that they had understood. They were shocked by their misinterpretation of what they encountered. The confidence and reassurance of their way of understanding was shaken by what really happened. How could this have come about? In the mental health profession practitioners assess for the likelihood of suicide by assessing for mental disorders that correlate with suicide based on research findings (Beautrais, 2000b; Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005). Practitioners categorise their observations and findings according to a system of knowledge, such as the Diagnostic and Statistical Manual of Psychiatric Disorders. This way of making something intelligible is what Heidegger (1962) refers to as a present-at-hand mode of understanding. It is a theoretical/scientific attitude towards phenomena. The disadvantage of this mode of understanding human beings is that it decontextualizes the life-world of being human and passes over the meaning and significance of how humans encounter and relate to things. A present-at-hand mode of understanding leads to a misrepresentation of the being that is human.

These therapists were shocked and surprised because their clients did not 'look like' they were suicidal. Kane, for example, said he was amazed by his client's suicide because he seemed fine, *he had bought a little house, he was working in the bush and had started his own firm*. Kane was shocked because he realised that he had misinterpreted what he saw by conflating the appearance of a phenomenon with its essence. These therapists understood what they saw literally. Heidegger (1962) argues that this kind of understanding belongs to natural science and that it is an inappropriate way of understanding phenomena as they appear to human beings. It is more appropriate to inquire through interpretation because phenomena are not always accurate in showing themselves.

It would appear that these therapists believe illness and wellness are distinct from one another. Biologically speaking they are, but human beings are more than biological systems. Aaron believed that his client committed suicide because she was ill and the only reason he failed to recognise her suicidal despair was because he failed to diagnose the signs and symptoms of a mental disorder. His interpretation excluded the possibility of his client being in suicidal despair in the absence of a mental disorder.

> *The secretary came in and told the group that CLIENT had committed suicide. That was one hell of a shock. I immediately went back to my notes, because I thought I must have missed something. Did I miss the suicidality? Did I miss or misconstrue the improvement I saw? Did I imagine that? I spoke to other people, to her friends, to her family. And everyone agreed that the depression had lifted by that time and that things were generally looking up for her. So still to this day it is one of the situations I recall very very clearly. To this day I still wonder what the hell went wrong.*

In Aaron's confusion lies a categorical error. According to Needleman (in Binswanger, 1975) the actuality, possibilities and limits of psychiatry in its practice is not sufficiently clear to itself because it rests upon two incompatible conceptual horizons. From its natural-scientific (mainly biological) horizon of understanding its 'object' of treatment is the 'sick' organism; and in its practice of psychotherapy it

views its object of treatment as the human being, that is, from an anthropological horizon of understanding. The situation can only be put right by going behind both conceptual horizons and grounding our understanding in the being of Dasein, says Needleman.

Kane and Aaron found themselves confused by these two 'incompatible conceptual horizons'. It would appear that this epistemological confusion fosters misrepresentation and misinterpretation of the being that is human, as Kane recalled *there was not a mental health status* [indicating the presence of a psychiatric disorder] *that we could commit him.* Their experience however proved the exact opposite of what they thought. This experience would suggest that an 'ill person' could also be well and that a 'well person' could also be ill. In other words, a biologically ill organism may be living a meaningful life or conversely, a biologically well person may be experiencing an existence of despair. For Maori, the indigenous peoples of New Zealand, the meaning of wellness does not mean the removal of symptoms. Being well means living a meaningful life with or without symptoms (Durie, 2004). This view accords with Heidegger's (2001) concept of privation. Privation implies the essential belonging to something is lacking. Privation is a negation of a phenomenon. We are tempted to define something by what it is not. During a crisis call Kane and his colleague refused to believe a client who said he was going to commit suicide. They refused to believe that he existed in despair because he was not psychiatrically ill. The absence of symptoms of a mental disorder designated this person as being well in their view, despite what he may have said about being in despair. The nature of a privation cannot be understood until that which it is a privation of is understood, says Heidegger (1962). Suicide, or illness, both privations, can not be understood unless the existence of that of which it is a privation is understood. Existence is more than its privation. The being that is human – exists – and is more than signs and symptoms of illness. Kane's client was understood as his illness (or lack of it) and not as his interpretation of his own state of being.

Aaron's experience shows how entrenched the conviction has become that a particular cluster of symptoms determines the likelihood of suicide and how seeing a person as being their illness causes one to overlook the being that is there. This faulty reality testing (Engler, 1998) is evident in Aaron's experience of shock and surprise. In

response to the question whether he felt that his professional training prepared him for working with suicidal clients he said:

> *At an academic level a resounding yes in terms of signs and symptoms.*

He has a vivid memory of his university professor talking to them about suicide:

> *He said that it is bound to happen when working with people who are emotionally vulnerable or with mental health problems and not anchored in reality as they should be.*

Those who commit suicide in Aaron's view fall into a category of illness based on observations of that which appears. When his client committed suicide he was shocked, because his client showed no signs or symptoms of being emotionally vulnerable, having a mental health problem or not being 'anchored in reality' as he should have been.

> *Things were looking up for her and everyone experienced this mood. Even colleagues and family thought she was much more cheerful, happy and filled with laughter. The old CLIENT was back!*

And when she committed suicide

> *It was irreconcilable with the picture of her smiling and her upbeat poetry. I struggle to reconcile these two pictures. There is no logic or reason to it.*

This experience left Aaron with self-doubt and uncertainty – the irreconcilable picture of a person who does not fit the diagnostic picture of a suicidal person. In this uncertainty he says:

> *But in that first year after her suicide I tested the hell out of anyone who mentioned depression or suicide. God knows how many tests I put them through to make sure about the diagnosis.* [This procedure] *is there for a*

reason and it has been around for much longer than I have. It is tried and tested. It has been researched and proven.

When I mentioned to Aaron that there is an irony in this, that he did exactly the same with the client who committed suicide, he acknowledged it. Even though the identification of signs and symptoms of a mental disorder and the diagnostic categories associated with suicide has shown just the opposite in his experience, Aaron returned to the notion that a person is his or her illness and he doubled up on his efforts at diagnosing more accurately after the event.

From these therapists' experiences one can see how their focus and attention were directed by a present-at-hand mode of understanding of suicide rather than understanding the person who was suicidal. The theory of mind philosophy behind scientific psychiatry and psychology develops an understanding based on an interpretation of itself rather than an understanding of the interpretation of the being that is human. It begins to understand itself rather than Dasein. The phenomenon – of being human – is uprooted from its origins and becomes detached from its referential context of meaning and significance (Cohn, 2002). Cohn argues that we have come to distrust ourselves by virtue of our own humanity. It is no longer good enough. The attitude behind scientific formulae, techniques and manuals of treatment is that we cannot trust what meets the eye and the ear; we can not trust our humanness. The problem, however, with the natural scientific view is that "Scientifically relevant 'facts' are not merely removed from their context of selective seeing; they are theory-laden, i.e., recontextualized in a new projection" (Dreyfus, 1991, p. 81). This is a projection which no longer belongs to Dasein's existence, but now belongs to the existence of science. The theory of mind philosophy behind science diverts its focus and attention to a phenomenon which no longer matters for the experiencing person. By *testing the hell out of anyone who mentioned depression or suicide* had proven to Aaron in the past that it said very little about the person. Aaron reverted to this way of understanding, despite the fact that it is a way which does not focus on that which matters to the person, but what matters to the profession. *It is tried and tested…has been researched and proven* and even though Aaron has living proof to the contrary, the procedure is repeated because it is saying something that matters to the existence of the profession.

Lisa says the despair which leads to suicide is

> *A lot clearer than the clinical picture…the way we read about it or observe it is distant, cold and clinical. The actual experience is more vivid, less detailed, but more understandable.*

Lisa is suggesting that a more comprehensive understanding of suicide lies beyond clinical appearance and distancing theoretical knowledge. In Lisa's experience suicide becomes more understandable once you see through the appearance of suicidality as a cluster of symptoms and go beyond the theoretical explanation to re-search what you encounter. Her comments suggest searching again by looking with your own eyes and hearing with your own ears. Elaine's experience with her client who committed suicide offers another perspective on going beyond the clinical picture, a picture which appears to conceal more than it reveals. Elaine recalls her experience of talking with a client who she sensed had decided to end his life, a client who also knew he had to provide the 'right answers' to avoid mental health services' intervention. It was a client who understood the currency of what Heidegger (1962) refers to as contemporary discourse:

> *In a risk assessment on paper you would not be able to predict his suicide. But through a personal and therapeutic experience you know. We both knew that. It was in that moment of holding eye contact that I knew. He knew that I knew without saying it. I think he knew that I recognised that the stuff he was saying was all the right things to say. But it was hollow and his way of getting out of the therapy situation.*

Here Elaine resisted going along with contemporary discourse. Elaine saw beyond the findings of assessment which then becomes contemporary discourse in mental health settings. She connected with her client subjectively, where truth is revealed in 'a moment'. Moments of sense, says Heidegger (1962), are concealed by contemporary discourse. Contemporary discourse is when a certain meaning is ascribed to a phenomenon which, with repeated use and reference, reduces the phenomenon to something self-evident. Meaning becomes part of contemporary discourse and gets

passed along in idle talk; the hallmark of inauthenticity (Crowe, 2006). It appears that words are not just words and listening is not just listening to words. It is this phenomenon that Lisa and Elaine are trying to articulate; there are listeners who listen differently and are better listeners for that difference. Following is Nancy's experience which reveals a kind of listening which is a levelling off of understanding the person who is there.

Contemporary discourse

This is Nancy's experience with what happened to her. This experience points at the phenomenon of contemporary discourse which allows for a better understanding of how the suicide of a non-symptomatic client causes shock and surprise.

> *I had a gut feeling from the beginning that something was wrong, but all the other staff said don't worry. Even though I would speak up and say what I felt, I often went unheard. I often wrote things in the notes and wondered why I bother because no one is going to read them. I get these intuitive feelings at times and I am sure it is a combination of experience and observation and all that. It is little bits that you can not put words to; I don't know but perhaps it is a level of distress that the person isn't articulating. I am not sure, it seems to be something just under the surface that you pick up on; we all do.*

Throughout the interview Nancy made reference to her feeling sad, powerless and that she and her colleagues in the in-patient unit failed the person who committed suicide. The main reason for feeling frustrated and powerless was that her concerns for the person *often went unheard*. Nancy said she found it difficult to get through to her colleagues; language failed to make her understanding manifest. What she sensed *just under the surface* of the obvious and how she was understood appeared to be at variance. "Both talking and hearing are based upon understanding. And understanding arises neither through talking at length nor through busily hearing something 'all around'. Only he who already understands can listen" (Heidegger, 1962, p. 208). The way Nancy understands talking and listening are, I believe, uncommon and refreshing. Nancy wants to explore the unknown, that which is possibly new and different, *just under the surface* of the self-evident. There are not words for it yet, but

she is willing to explore this with her colleagues, because it points towards a truth she senses is not self-evident. In response her colleagues said she worried too much and in this deft manoeuvre Nancy's telling transformed into idle talk. Her understanding was now idle talk. The unknown *something under the surface* became something known on the surface. It was only worry. The understanding that belongs to telling was lost the moment her telling became the language of worry. The unknown was transformed into the known. The original understanding was lost and got passed along as commonplace worry. This is the nature of idle talk which avoids real understanding.

Nancy was sensitive to something about the suicidal client which was not obvious to all, whilst her colleagues banded together and chose to see only the obvious. She found herself confronted by what Heidegger refers to as a falling existence and "absorption in being-with-one-another in so far as this is determined by the One" (Gorner, 2007, p. 111). In this accommodating and unburdening mode of understanding nothing is seen to be different or new and if something different thrusts itself to the fore, it is rapidly re-interpreted into the commonly known. In this inauthentic mode of existence "Everything looks as if it were genuinely understood, grasped and spoken, though at bottom it is not; or else it does not look so, and yet at bottom it is" (Heidegger, 1962, p. 173).

Nancy said we all pick up on things that are not articulated, it is *a level of distress the person is not articulating.* Nancy was in the minority in picking up on this. Her colleagues were too ready to ignore this and passed her concern off as her worrying too much. Perhaps it was the other way round. Her colleagues were the one's worrying too much and they unburdened themselves of this worry by clinging to the security of the collective. They may have sensed what Nancy sensed – she certainly implied this in her recollection of events – but they chose not to hear the distress concealed by assessment findings. Heidegger (1962) is of the view that conformism is a levelling off of our understanding, an understanding of our basic unsettledness. In conformism we avoid ourselves and the opportunity to re-interpret the world into which we are thrown (Gorner, 2007). Dasein is shot through with self-interpretation. Each self-interpretation rests on another self-interpretation right to the bottom where all began with nothing that is you. It may have been this which Nancy's colleagues avoided and they deflected their worry towards Nancy. Her reference in conversation

with her colleagues to the unknown *just under the surface* may have stirred the spectre of this unsettling existential reality.

> *I just knew, I don't know how but I just knew. I had been thinking about her after work because I thought she was high risk and the medical officer on duty did not think so. I can remember going on and on about it once during handover and the manager agreed with me. I just think that if there was agreement in the whole team about the level of risk that things may have turned out differently. And it is interesting because the staff she spoke to before she went on leave said she was much better. You know that often when depressed people show an improved mood that it is a dangerous time, because they have either decided that they are going to end their life and are at peace with that or they have the energy and motivation to do something about their life.*

In Nancy's experience her colleagues were not reading between the lines. They were only hearing words and not listening to her telling, and her telling was not discriminate enough. Her telling was too vague and ambiguous and in the zeitgeist of conformism that will not do. In conformism we forget that so much more is articulated than what is written and spoken. In an atmosphere of conformism language is no longer the echo of our discourse of the totality of meaning, according to Heidegger (Gorner, 2007). It becomes a formal communication in which the inner experiences and thoughts from one subject are transferred to another subject. Language is no longer a telling of understanding, but becomes the now familiar tick box mentality of exact and unambiguous explanation. The open spaces between words which articulate – which are not named – are lost in this kind of hearing. These open spaces between words are the joints which articulate understanding, according to Heidegger (1962). *I just knew, I don't know how but I just knew* were the 'joints of articulation' in Nancy's attempt to express her understanding. In these words nothing in particular was named but something was being pointed at. They were Nancy's words – however indiscriminate – attempting to articulate that which she sensed as true. But because her colleagues were only attuned to words that are unambiguous and explanatory, Nancy's articulation of understanding fell on deaf ears. In this kind of listening ambiguous words such as *I just knew* are not attended to. Consequently,

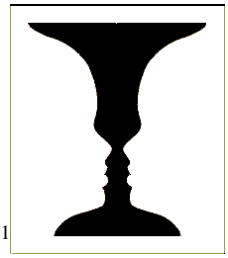
what Nancy spoke about became disjointed to her listeners and her telling no longer reflected the referential whole from which language springs and of which language is an approximation (Heidegger, 1962). Nancy was feeling frustrated and powerless because she experienced the degeneration of her language of articulation into the language of talking explanation. When we are attuned to listen to talking explanation we struggle to hear understanding. To her colleagues Nancy's telling of understanding sounded like common old worrying. When talking is conceived of as the transference of the inner experiences and thoughts from one subject to another subject and language no longer belongs to a telling of understanding, the human situation deteriorates into what Dreyfus (1991) describes as human beings understood as being occurrent entities (that which emerges from a present-at-hand mode of understanding).

A present-at-hand mode of understanding

Bray recalled his encounter with a schizophrenic client who, at the time of his discharge from an in-patient unit, displayed no signs or symptoms of active psychosis and was therefore deemed unlikely to commit suicide. The person was animated and smiling upon discharge. This is Bray's recollection:

> *The second thing was that I felt a hell of a shock because when he left me he was animated and smiling. This lady who was in the ward that night when I dropped him asked me the next day and said, how did we miss this? I said to her there was nothing to see. So she must have had a similar thought to me. When he left the ward he was animated, spontaneous and there was a laugh and a chuckle. The client we are talking about here is a 45 year old Maori male with a history of schizophrenia. Schizophrenics are more prone to commit suicide than others, he was a male and we know if he is going to do it, it will be in a violent way rather than with pills. I probably treated the confessions down at the police station as psychotic rather than saying to myself this guy has a history of parasuicide and is perhaps cleaning up before he kills himself. But that thought never entered my mind until afterwards.*

Bray said he treated his client's confession as psychotic and was unaware that the person was in despair of other possibilities of living. This person was admitted because Bray saw symptoms of psychosis and not because he saw a despairing person. Bray was open to the possibility of suicide, not because he saw despair, but because he identified a psychotic state of mind. Laing (1965) says that the initial way in which we see things determines all our subsequent dealings with it. For example, if we see a thing as a physical-chemical system, a behavioural entity or a thinking unit then we are determined by this intention to deal with it as such. However, it is not possible to respond to the whole person if one's intentional act is to see an organism. The theory and description of an organism determines a different relationship to the theory and description of a person.

 [1]

The Rubin Vase

"To look and to listen to a patient and to see signs of schizophrenia and to look and to listen to him simply as a human being are to see and to hear in a radically different way as when one sees, first the vase, then the faces in the ambiguous picture [Rubin Vase]" (Laing, 1965, p. 33). The client was soon discharged because the client did not show signs of a psychosis. Bray said there was nothing to see – nothing psychotic. Psychological practise in New Zealand is strongly influenced by the Vail Model characterised by treatment protocols derived from laboratory science. It is a model of practise which promotes the idea that practitioners should be good consumers of science (Evans & Fitzgerald, 2007). This is the current championed way of research in practice as understood by the practitioners in this study, referred to as evidence based practice in which practitioners are guided by natural scientific research 'evidence of best practice'. Based on correlation studies it is commonly understood in the mental health field that schizophrenic people are highly prone to suicide (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005; Harris & Barraclough, 1998; Kay &

[1] The Rubin Vase. Retrieved 12 January 2009 from http://www. dushkin.com/connectext/psy/ch04/rubin.mhtml

Francis, 2006). *Schizophrenics are more prone to commit suicide than others* said Bray as a consumer of science.

Bray's understanding is based on theory and statistics which show that schizophrenics are prone to behave in a certain manner. A theoretical and statistical mode of understanding is however a detached spectator mode of understanding and unsuited to understanding the being who exists, i.e. humans. When we take up a detached position towards a person and wonder about them theoretically they become objects with isolable and determinate properties, a collection of elements that are law-governed and we then attempt to explain human behaviour by strict rules (Dreyfus, 1991). What is looked at and what something in itself is becomes the same thing in this mode of understanding. This is a misrepresentation of what it means to be human because a human being is not a thing upon which our mental content can be projected. "Dasein's essence lies in its existence" (Heidegger, 1962, p. 67). To understand being human requires understanding of what it means to exist. This is a way of "understanding of that being" in its "interpretedness of its [own] being" (Heidegger, 1962, p. 36). Bray's shock is a manifestation of the realisation that a natural scientific mode of enquiry misrepresents how humans exist and understand themselves.

Here is another recollection by Bray in which his *inquisitiveness* reflects a present-at-hand mode of enquiry and the consequences of this way of being upon the enquirer.

> *The only thing about this client which remains unresolved for me is to know whether it was unintentional or deliberate. That still bugs me. It doesn't affect me or influence me on a daily basis but I do wonder about this.* [Why would that kind of information close it for you?] *Don't really know, perhaps inquisitiveness or morbidness. I don't know how you will explain it.*

Bray is unable to say anything about the meaning his inquisitiveness may have for him. He can not interpret himself in this way of being. This suggests that in being inquisitive Bray is unable to understand and interpret his being-inquisitive. Here we have to be reminded that as Dasein we have an understanding of who we are in our self-interpretedness. In a present-at-hand attitude an artificial dichotomy is created

and human relatedness is reduced to a subject-object transaction where people become like all other objects to be explained and you become an object of contemplation yourself. Categories of knowledge fail to do justice to an understanding of human existence. "Dasein must always be seen as being-in-the-world, as concern for things, and as caring for other [Dasein], as the being-with the human beings it encounters, and never as a self contained subject" (Heidegger, 2001, p. 159). A present-at-hand attitude establishes a subject-object mode of concern where one is able to distance oneself from that which one is concerned about and become inquisitive. In a being-with mode of care one is drawn into the experience. One does not have the experience as much as the experience has you. One is unable to stand at a distance and 'look at your experience' because you are your experience in being-with and in concert with who you are being. In a present-at-hand mode of concern it appears that one runs the risk of falling out of touch with your being. One becomes a self contained subject and that is when you discover yourself *unable to explain being inquisitive.*

Paul's experience allows another view into this mode of understanding.

> *When you get older you get a bit more mature in your practice and you realise there is only so much you can do and a lot of the responsibility lies with the person, unless they are absolutely psychotic. That is different. But life choices people make hasn't got anything to do with me. So, at the moment I feel quite comfortable and don't think I come across as robotic when I see people. I don't allow myself to get drawn in too much into a person's stuff.*

What people come to decide in consultation with Paul has nothing to do with him. Whatever they decide is something they do despite his presence in their lives. Paul makes a conscious effort not to be affected by them and he has no interest in how they may be affected by him. Stated differently, Paul has adopted a distance-theoretical mode of understanding in being-with someone. This attitude is often described as 'establishing clear boundaries' between you and your client in mental health services. Heidegger (1962) asserts that this deficient and indifferent mode of being-with is characteristic of our everyday human relationships.

"The world of Dasein is a *with-world*. Being in is *Being-with* Others. Their Being-in-themselves is *Dasein-with*" (Heidegger, 1962, p. 155). You can thus not have a world on your own. In the first instance, when we are in our world space, we are in that space as within a totality of others from whom we do not differentiate ourselves. *I do not allow myself to get drawn in too much into a person's stuff* has consequences for Paul which are no different than for Bray. One becomes a self-contained subject of theoretical contemplation over and against other self-contained subjects about who you wonder in detachment. Being with others without distinguishing between 'you' and 'me' is the condition for the possibility of sharing a human world. Being-with is the foundational condition for the possibility of the being which Dasein has. Paul is perhaps suspicious of this dehumanizing way of understanding when he defensively says *I don't think I come across as robotic when I see people.*

Being-in a mood

Paul's experience of shock and surprise hinges on his way of understanding what it means to be in a certain mood.

> *I went on holiday the next day and got a call that she had hung herself four hours after I had seen her. Disbelief really, because when I saw her there was no indication that she was considering suicide because I did ask her and her mood was quite pleasant. She was pleasant, chatty and seemed quite positive. It was a hell of a surprise.*

Paul's experience of being unable to explain what happened to him can be understood by considering the notion of expectation. Expectation is a kind of knowing that is founded on knowledge which presupposes something is likely to happen, given a set of factors and circumstances. Expectation is a kind of knowing which belongs to the cause and effect reasoning of a positivist and natural scientific mode of enquiry. Natural scientific orientated research results predict that someone is likely to commit suicide if s/he has a mood disorder (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005). In the presence of symptoms – such as a low mood or a changeable mood – Paul is not surprised if a person commits suicide because it is predictable and his expectation is satisfied with proof of the fact. But someone who was *pleasant and chatty* four

hours prior to committing suicide is beyond the knowing that belongs to prediction and expectation. That was why Paul was surprised. Paul seems to reason that everything we know about people, theoretically, ought to be consistent to a measurable extent, like all other things we have theoretical knowledge about. For example, Helium is known to be a stable natural element and Hydrogen an unstable element of nature. The level of stability for both elements is nevertheless measurable. But can the same be said about someone's mood?

Aaron's way of understanding is no different to Paul's. A week prior to his client's suicide Aaron found her in a happy mood and said *this is what is so idiosyncratic; there was no bloody reason for it.* Aaron, like Paul, is shocked by the revelation of a different truth beyond reason and logic. In the field of mental health we tend to think of mood on a calibrated continuum. In assessment we even ask people to rate their mood on a ten-point scale and interpret their ratings with confidence. In this attitude of understanding, mood is a definitive thing, an element or a factor. This implies that one is able to produce a mood by arranging the elements around it accordingly as we do with all other non-human things towards a predetermined outcome. This is not how Heidegger understands mood. "A mood makes manifest 'how one is, and how one is faring'. In this 'how one is', having a mood brings Being to its 'there'" (Heidegger, 1962, p. 173). We do not know the whence nor wither of our mood, we simply find ourselves there, says Heidegger. In Paul's company his client found herself in a *pleasant and chatty mood.* That mood belonged to their presence together and disclosure of the world between them. The client's mood said something about the significance and meaning of their being together for her and also gave Paul a mood of feeling at ease. To predict and draw conclusions on the basis of that manifestation of how she was in his company is to ascribe something calculable to spontaneity. When we ascribe reason to mood and ask the person to calibrate how they feel, we overlook what matters to the person because mood discloses Dasein "prior to all cognition and volition" (Heidegger, 1962, p. 175).

Aaron and Paul were unable to recognize what the mood of their clients disclosed in their attempts to explain what their client knew and believed at the time of a particular mood. Humans are affected in a dynamic and unpredictable manner as we constantly

re-interpret the disclosures of our being-in the world being-with others. Our mood and our self-understanding constantly shift with this ebb and flow.

Being-in-time

Aaron's experience of shock and surprise is also associated with his understanding of time and the same can be said about a number of the therapists in this study. Elaine's recall of her experience with a client who committed suicide is one example of how the therapists' experience of shock and surprise masks an assumption about time which is not the same as the time that belongs to being human. On the basis of linear time human phenomenon are distorted and misinterpreted for what they are.

> *It looked like he was responding well to medication and treatment and after four sessions he said he was all right and wanted to stop doing psychological work and continue working with the alcohol and drug counsellor. He went out with friends to the movies and dined out. His friends also thought he was doing so much better. Two weeks later he killed himself. My boss and I went through the file and we could see that the risk assessments were done and that I had gone through the whole process* [paper trail of risk assessment] *and that he was safe and sound.*

Elaine recalled her experience of working with a suicidal person who appeared to be responding well to medication and treatment. He said that he was all right and needed no further therapy. This appearance of being all right was not only affirmed by him in his inclusive and social behaviour, but was also confirmed by his friends. Yet two weeks later he committed suicide. After his suicide there was the usual procedure of checking his file for the results of periodic risk assessments. The documented results endorsed the view that he was 'safe and sound' and that he was not a suicide risk. It is generally accepted in mental health settings that a person should be fairly stable and consistent in behaviour, mood and thought over a period of time, unless they are exceedingly unwell, which he apparently wasn't. How then does a person change so rapidly and so dramatically in a 14 day period from a state of being all right to one of utter despair that ends in suicide? Perhaps it was an act of deliberate deception. Perhaps he and his friends were unaware of how unwell he really was. Perhaps the therapist missed the risk he posed to himself. Perhaps something had gone wrong in

Elaine's assessment. There are as many perhaps' as there are categories of knowledge about being human. Where does one begin to understand this? Which category of knowledge is best to consult? Heidegger (1962) suggest one begins with the person that is there; Dasein. Our understanding of what 'safe and sound' means ought to begin with the question; what does that which appears say about the self-understanding and self-interpretation of the person. An understanding of human existence begins with an appreciation of human time as transcendent (Heidegger, 1962). Elaine attempted to understand her client's actions by means of a natural scientific construct of what time says about a person. In this Elaine overlooked the person who expresses the significance of time in their being (verb). Elaine did not consider human time as transcendent, only as measured and was consequently surprised and shocked by his suicide.

Our relationship to time sustains our being in the world. What we do with time joins past, present and future. It temporalizes our existence (Heidegger, 2001). How we find ourselves is always at the junctions of past, present and future. It is fluid and cannot be captured and fixed in calibrated time as 'evidence' as to who we are. Measured time can say nothing about who a person is. Only a person's existence is able to comment on the mood the person finds him/herself in. By using measured time as a category to understand her client is a misrepresentation of the person's relationship to time and the basis of Elaine's surprise. In following Heidegger's arguments the departure point for understanding of another is not through measurement and factor analysis, but through an appreciation of the significance of an existence which is held together by interpretation at the confluence of past, present and future. These aforementioned factors belong to the 'time' which holds sway over us and give definition to who we are.

Conclusions

The experiences we have as therapists stand in direct relation to how we choose (not necessarily with conscious awareness) to see and interpret what we encounter in our everyday practices. The aim of this chapter was to explicate therapists' shock and surprise at the unexpected and unpredictable suicide of a client. What is the relationship between therapists experiencing the unexpected and unpredictable suicide

of a client and their way of seeing and interpreting what they encountered with their clients?

I have shown that all the therapists followed a widely recognised and professionally endorsed assessment process and yet their clients committed suicide. In following this collective and traditional way of seeing and interpreting what suicidal clients 'look like' lies the assumption, based on a natural-scientific way of knowing, that a suicidal person will exhibit certain signs and symptoms, warning of the possibility of suicide. In the absence of these known signs and symptoms of suicide risk, the possibility of suicide is greatly reduced and it will be an unexpected surprise if suicide should occur. In this chapter I have shown how therapists naturally react with shock and surprise when the unexpected and unpredictable occurs, because none of their clients, in their view, exhibited any of the traditionally understood signs or symptoms usually associated with suicide prior to committing suicide.

I have argued that the participant therapists' way of understanding what can be expected and predicted about suicide risk rests on the ascending theoretical-scientific epistemology in psychology and psychiatry. In this mode of understanding the emphasis falls on the 'what' that can be named and explained, and not on 'who' is experiencing. The emphasis is on identifying the signs and symptoms a client exhibits more that on the person exhibiting signs and symptoms. It has emerged from the participant therapists' experiences that by emphasising understanding of what a person exhibits in assessment can not be equated with or be generalised to understanding 'who' presents in a particular way. This differentiation needs to be born in mind in the assessment of suicidal clients. This differentiation brings to conscious awareness what one sets out to see and understand in the first instance and also avoids the tempting notion that one can know the other with certainty.

The strength of a natural-scientific way of understanding is that it enables the practitioner to name, categorise and describe what they encounter in an unambiguous way. This clarity and certainty facilitates common understanding, collegial familiarity and cooperation in the assessment and treatment of suicidal clients. However, in this strength lies a weakness which has been shown in this chapter. In emphasising understanding of 'what' is encountered over 'who', the meaning and significance of

how suicidal clients encounter and relate to the world is overlooked. It is in this oversight that the 'rules' of prediction and expectation that belong to a natural-scientific way of understanding fall apart and the participant therapists suddenly encountered the unexpected and unpredictable which belongs to the 'who' in the human equation. I have argued that phenomena are not always what they appear to be and the person with no signs and symptoms of a mental disorder is not necessarily living a meaningful and valued life, as the participant therapists experienced in practice. In a natural-scientific way of understanding 'knowledge about' accumulates upon phenomena and develops a common language and way of doing (equipment) that moves further and further away from the phenomenon itself. It is only when this self-evident way of knowing and doing breaks down in function that we discover how far away we have moved from understanding the phenomena itself. This chapter has shown how this comes about in practice, when what therapists know and do in assessment, with a confidence born in self-evidence, reveals something different and unexpected.

I have argued that from the perspective of human existence, time and the significance and meaning of 'being in a mood' is different from a natural-scientific perspective. From the latter perspective and its detached way of looking, time and mood is made significant and meaningful by measurement. For example, a rating of five on a ten point rating scale for mood is understood as an euthymic mood. But does a rating of five on a mood scale say anything about the mood which makes manifest the person's interpretation of who they are? Does it say anything about how the person understands and interpret the way in which they exist? The 'time' I went to the circus, for example, is not significant because the performance started at eight and lasted three hours. The significance of that 'time' at the circus is in the experience itself.

Nancy's attitude demonstrates what is required of the practitioner to understand a client in a more comprehensive way. She shows that it requires the practitioner to explore the unknown and that which is possibly different, despite what is being exhibited in observable and self-evident signs and symptoms. It means that to gain a more comprehensive appreciation of what and who they encounter in assessment and

treatment requires the therapist to straddle and unite a natural-scientific way of knowing with an understanding of human existence.

Chapter Six

Being Responsible

The aim of this chapter is to explicate the phenomenon of being responsible. Most therapists in this study felt they were responsible for life and limb; a significant burden. Often they felt that if they had done something different they may have saved a life. One therapist recalled *that is what people expect of you – prevent people from going to their death by whatever means*. This extraordinary sense of responsibility therapists felt in working with suicidal clients manifested in their care, and their fear and guilt after the suicide of a client. This chapter will attend to these experiences as they relate to the phenomenon of being responsible.

Care

> *We as psychiatrists always bear the brunt, or that is how we feel when someone does kill themselves in our care. We are seen as the responsible person and I do not think that is justified. I use to be very idealistic and wanted to do what is best for the patient always, make decisions that were in their best interest but not in my best interest. It would cost me hours of sleep because if the person did commit suicide I would be the person in front of the coroner. I don't do that anymore because I can not change the world and if society makes me responsible for people's lives in my care then I guess I have to protect myself. The way things are going in communities in this day and age is that we bear the brunt if someone commits suicide. It makes me really angry that our Western society expects of us to be able to rescue everyone. It is not right that people expect that all problems can be solved.*

The aforementioned account belongs to Anne. She said that the responsibility placed on her by her profession and society is onerous and unjustified. Anne feels that it is unreasonable to hold a therapist responsible for a client's responsibility towards their own life and death. It angers her to think that society can expect therapists to rescue people and solve all their problems for them. She can find no reason or logic in an expectation which exceeds her limitations as a human being. Anne's dilemma is that she feels compelled to live up to these idealistic expectations at times.

Occasionally Anne would catch herself *going along with these expectations and* [it] *compounds the problem* [because] *I tend to lose my boundaries and go over the top trying to rescue people.* Jung (1983) draws a parallel between the mythological figure of Prometheus and a similar human phenomenon encountered in his experience as a therapist. It is the phenomenon where people identify with a godlike way of being. This way of being exceeds the boundaries of constraint and modesty which belong to being mortal. In this mode of being, people like Anne, occasionally find themselves going over the top trying to rescue others. According to Levinas (Peperzac, 1993) this misinterpretation of the beings that we are has been nurtured throughout the history of Western thought and philosophy. He asserts that it is an atheistic tradition which has become its own God, a "fundamental narcissism of an ego which takes itself to be the centre and the all" (Peperzac, 1993, p. 49). This way of being 'beyond the being that one is' causes Anne untold problems in her life. It disrupts her sleep and impinges on her private life. Anne tries to protect herself from the turmoil and torment associated with this elevated way of being. She reminds herself; *I can not change the world.*

Marie's account shed a different light on being responsible and caring and raises another dilemma therapists experience in being responsible.

> *Whenever I would see him I would run it by one of my colleagues and say these are the buttons I pushed and this is how he presented and this is what I had done, how does it sound to you? Then I know I have been using my skills and I have done what I could* [checking for symptoms of psychosis and suicidality]. *That is all I can ask of myself. I feel more confident knowing that I have done a proper assessment and have looked in all the little spaces. Then I would feel more reassured about the decisions I have made with him, knowing how he was going to manage his medication and his life. It means getting them into a place where they can function at the highest level they can. And having the best quality of life they can. For me caring means that I want the best for someone, and I've put myself out there for them and put a package together. Hoping means that they could do this or maybe it will happen, but not doing much about*

it. Hoping is lacking the action. So caring is the action. Hoping is just the wishing for them, but not doing much about it.

Marie's account demonstrates an institutionalised and professionalized mode of care and responsibility. In discussing how she copes and manages her clients who are suicidal, Marie gives a description of what it means for her to care for someone. Marie has a very clear understanding of what it means to care for a client in a mental health institution. To care is to ensure that they exhibit no signs or symptoms of psychosis or suicidality. She needs to *push the right buttons* which is a mode of caring Marie defines as a thorough assessment. There are distinct advantages to this mode of caring:

1. It demonstrates that she is actively doing something and not *just hoping and wishing*.
2. It is a form of care that complies with institutionalised expectations and in doing so she feels confident and believes in herself as doing all that is expected of her.
3. To care is to be able to *put a package together* which will *put the person in a better place* where he can function better and have a better quality of life. 'Packages of care' is contemporary discourse in mental health to describe how we care. It is an expression that conjures up the image of an impersonal instrumental agreement. Packages usually consist of a regime of medication which the health professional monitors for compliance and effect and other evidence based therapeutic prescriptions, with expectations of compliance attached. Packages of care are neat and handy and caring in this manner is explicit and unambiguous for all to see and judge. This explicitness removes the mystery of caring for a fellow human being and becomes a science, based on rules and definitions.
4. Marie can document her findings of care which would safeguard her from any possible accusations or recriminations in future. In caring like this health professionals keep themselves safe, and at an objective distance.
5. This mode of caring is perfectly acceptable in mental health institutions and by following the institutionalized expectations, regarding suicidal and psychotic clients, Marie can demonstrate that she cares in accordance with the

institution's interpretation of care. And that is all that is expected of her. In institutions care is prescribed and circumscribed.

What else can be said about this mode of caring? This first thing to take account of is that culture and cultural institutions have existence as their way of being, just like human beings have (Dreyfus, 1991). Secondly, that existence is a way of being founded upon self-understanding, says Heidegger (1962). Like human beings, institutions base their decisions and actions upon their interpretation of phenomena and I have attempted to show how our mental health institutions understand what it means to care, and Marie shares that way of understanding which she demonstrates in what she does.

Anne's way of caring – when she goes over the top and tries to rescue people – could be referred to as a Promethean way of caring. Marie's way of caring can be referred to as an institutionalised way of caring. These modes of care are deficient modes considering Heidegger's (1962) view of what it means to care in an authentic human manner. According to him the nature of authentic human care, or the essence of care, is captured by a person's existence. We embody what it means to care. Care manifests itself in understanding – or attempting to understand – how a person understands him or herself, in reconciling what they do with how their world makes sense to them. Rescuing people, as Anne occasionally attempts to do, or giving them things such as 'packages' like Marie does, excludes the attitude contained in Heidegger's definition of care and are therefore deficient modes of care by his definition. These are modes of care which conceal the world of the client, and instead, reveal the world of theory and science and its institutions (Jung, 1983). Anne's way falls in with the tradition of Western thought and philosophy and Marie's way falls in with the culture of her institution. Neither of these ways is primarily concerned with the world of the person in their presence.

The way in which the mental health institutions go about caring perpetuates a concealing of our being in the world. It is a deficient mode of caring for another being that is human because

1. It leaps in and takes over responsibility instead of leaping ahead. It leaps in with packages of care. This form of care narrows the world of the person

down. It distorts the meaning of being responsible and understanding oneself whereupon a person creates an existence of their own. Leaping in with a package of care conjures up an image of instrumental and mechanistic concern and in this image there is little room left for the person to constitute a place that is theirs.

2. The giving of a package of care is associated with a contractual arrangement between two independent and self sufficient entities. It is not a relationship associated with the care and concern for another human being.
3. The institutionalised mode of care jettisons hope because hope is just wishing. But when hope becomes just wishing, it looses its courage to venturing forth and find different ways of being.
4. Living well and living without symptoms are not synonymous; one can live well and have symptoms at the same time, according to Mason Durie (Evans & Fitzgerald, 2007). The tradition of depth psychology argues that the possibility of living well becomes a human reality only in the presence of symptoms (Hillman, 1992).

Paul's account offers a further insight into what institutionalised care looks like.

> *You don't have to be emotionally attached to them but you have to care what happens to people and how they manage their lives and all those sorts of things. You need to make yourself available; they need to know where to contact you. There is a huge list of things you have to do. If they are on medication you need to know what effect it is having. There is a whole plethora of stuff you need to do. You have to be reliable, turn up on time; you have to be dependable, etc. The list is large; you have to be empathic, don't go to sleep when they are talking to you, those sorts of things, be prepared to pay attention to what they are saying, assess what is going on, listen to the family, and all that. It is a huge list.*

What is noticeable about this account of care is its mechanistic nature. The emphasis is on what Paul sees himself as having to do to a person. This list of things to do may fail to be concerned about the person who is there. This list of care can be applied to anyone, anywhere and anytime, no matter who is there. This mechanical procedure

does not invite the unfolding of the complex structure within which the person's existence becomes meaningful. The complex structure I am referring to is the junction of past, present and future where a person finds him or herself to be and from which they understand themselves, and from where they begin to exist the way they do. Being there in the 'presencing' of an existence is what Heidegger (1962) considers the essential meaning of care. Paul's care is the care that Levinas (1998) refers to as care with a vested interest in which the extent of Paul's care is confined to the continuation of the existence which is his and that of the institution. It is a mode of care which Levinas describes as the "care for self prior to worry over the death of the other" (Levinas, 1998, p. 216). The significance of the other is limited to what they do and not concerned with who they are. The nature of Paul's care is to *just carry on with my usual bloody job* and to ensure the continuation of his existence circumscribed by the demands of his job before being concerned for the humanity of the other. Paul's care responds to his job, a list on how to care for the other in what they are in their doing (distressed behaviour), regardless of whom they may be. It does not appear to respond to the vulnerable mortality of the other, the 'who' behind the face, or the 'nakedness of the face and its mortality', as Levinas puts it. Perhaps the emotional demands of mental health work have overwhelmed Paul and he has withdrawn from caring too much. The care Paul demonstrates in this case is what Heidegger (1962) refers to as dominating *fürsorge* (solicitude) which relieves the other of care. Heidegger also has another, more primary, understanding of what it means to care; *sorge* (care) which refers to the anxious, worrying and apprehensive concern for the future of Dasein whose existence is an issue for itself (Inwood, 1999). In its authentic form *sorge* releases the other to confirm who they are.

Laura's account of her struggle with issues of responsibility, fear and guilt is revealing. She describes what it meant to her to attend the funeral of her client.

> *I am not a religious person and it was not so much the prayer that helped but rather the fact that they felt with me. We supported each other. I felt ultimately responsible even though I had a co-worker. I am the psychiatric nurse and the responsibility rests with me. His father embraced me first and held me very tight. So when he hugged me I felt something in it, it wasn't feeble or anything, there was something in it. I felt that he didn't*

blame me or thought that I could have done anything more. He was grateful for what we had done, I don't know. I sat there but felt very different to everyone around me. I was sad and overcome. It was just such a relief for me to see his parents and feeling OK with that, and for them to be OK with me.

Laura talked about her experience of attending the funeral of her client who committed suicide. She arrived at the funeral feeling she is the one who *is ultimately responsible* for what happened to her client and his decisions whilst in her care. She found herself feeling different to everyone around her, filled with guilt and *quite nervous because you feel that you may be blamed as his nurse*. Then there came a moment where there was a distinct shift in how Laura found herself. The deceased's father embraced her and held her tight. She felt something in his hug; she is not sure what it was that she felt, but it was 'something'. This something Laura felt seemed to have released her of her burden and she felt forgiven. She no longer felt overcome and different. Her mood and understanding of herself transformed as a result of this 'something'. Whatever this something was caused her to reinterpret what she understood of herself. It was a movement from a Promethean mode of being in which she felt directly responsible for someone else's existence to a mode of being in which she remembered that she is a mortal being in communion with humankind. It was a movement of self-understanding from a being that is not human to a being like all other beings from which we can not differentiate ourselves. Heidegger (1962) reminds us that our death is ours to die and our lives are ours to live. To assume it can be done for someone is an elevated mode of being, removed from the beings that we are. That 'something' Laura felt when the man embraced her at the funeral may have been care in its ontological sense, because it seemed to have addressed Laura's self-understanding (existence) directly.

I have shown that that which looks like care for another is in essence something else. It is a concern which answers to Western tradition, the mental health profession and its institutions. It does not concern itself primarily with the problems of the existence of a client. It is likely that a more authentic mode of care hovers, silenced by expectations. The more dominant inauthentic care is associated with therapists' fear of

societal recrimination and reproach. The following two sections will consider how this kind of fear and guilt 'looks like' care and responsibility.

Fear

The following recollections are from two therapists, Matt and Lance who show how fear influenced their way of caring for their clients. This is Matt's recollection.

> *Shit what now? Is my neck on the line here? And I had these bureaucratic concerns about how responsible I have been as a clinician, appropriateness of treatment, etc. It brings an added pressure and I see this in all the District Health Boards, they are risk averse and you should protect yourself. Yet, in working with someone who is actively suicidal…I am trying to articulate this now. Again, it hovers in the background and there is always the possibility that they will go ahead and do it and then you are going to be investigated. How to open myself up to hearing the person without that interference creates conflict for me. It interferes with spontaneous practice. Why I say that is that moving from* [He names another country] *to this culture, and I have spoken to other colleagues about this, there is a lot of feeling of 'being safe'* [self protective] *here, and I said, right, I do not care about that. I am going to stick my neck out here for her and be myself and put on the file what needs to be on the file. That need to feel safe steers you in the direction of being prescriptive and covering your arse; and that is not care.*

In talking about a client who made an unsuccessful suicide attempt Matt says that his ability to care for suicidal clients is compromised. He says that in the background of his practice is always the possibility of being investigated if a client should commit suicide and that creates a conflict for him. He recognises that it makes it difficult for him to be open to the existence of his client. He feels unable to hear clearly what his client has to say and it interferes with him being a spontaneous practitioner who can rely on his own experiences and understanding of human existence in despair. He can not be-with. He has come to conclude that in the New Zealand mental health culture the priority for a clinician is to protect the District Health Board by protecting himself or herself first, to be cautious and not *stick his neck out* and be the vulnerable human

being that he is. The disadvantage of this organisational-cultural attitude is that it leads to prescriptive practices regardless of the person presenting. Matt says that this is not care. He can not associate care with having to be present to another human being without *being open* and listening as the spontaneous fallible human being that he recognises he is. To care for another as understood by Heidegger is not the kind of care the mental health service is expecting of Matt in his view. Care, as understood in the mental health services, is not the care associated with the being that exists. Matt is aware of this. He often finds himself in a bind as a result and the following account demonstrates this.

> *It is the whole issue of outcome based short term focussed therapies. That is the other thing that hovers all the time; that there needs to be so-called improvements seen. So on this particular occasion I stepped into that mode of solution focussed CBT* [Cognitive Behaviour Therapy] *way of working where the empathy is, I will not say lost, but to listen is lost because you are coming with these preconceived ideas of what the person should be doing and not hearing them. I slipped into the mode of the zeitgeist of the District Health Boards which is not depth orientated or wanting to embrace the other. That is where I failed her and I was angry with myself as well. It is an ongoing pressure which I slip in and out of and I catch myself doing it. There is the pressure to identify the problem and sort it out. So that if suicide was expressed, that I have addressed it tick, tick, tick. So then you are fine. I fell into that mindset.*

Matt is angry with himself when he discovers that he falls into the zeitgeist (mood of the time) of the District Health Board which is not orientated to embracing the other in his view. He feels that the orientation towards understanding people in District Health Boards is scientific-mechanistic in nature. As a clinician you are seen as a good consumer of science who should identify the problem, select the solution based on best practice principles, intervene as prescribed and make sure that you provide evidence on paper that on behalf of the District Health Board you have cared as expected, should the client commit suicide. This is the Vail Model of practice in New Zealand discussed by Rossouw (2008) who argues that it is an inappropriate mode of care if one is interested in understanding phenomena relevant to being human. The

reason for this is that scientific investigations are usually founded on a philosophy of mind which decontextualizes the lived world of Dasein. The phenomenon is uprooted from its origins and becomes detached from its referential context of meaning and significance from a human experiential point of view. In the Vail Model of care research and practice enter into conversation about matters that do not matter for the person present. It is this dialogue between research and practice that Matt is referring to and the reason he is angry with himself. Matt gets angry with himself when he cares as if he is an institution, instead of the human being that he is. He has come to the conclusion that mental health services' understanding of care runs against the kind of care he understands. His understanding of care requires the therapist *to stick his neck out*. In other words, it requires him to be vulnerable and to set aside concepts of pre-understanding, to relax the will in silent waiting as the poet Keats advises (Armstrong, 1993). Matt is in a dilemma when he chooses to care in silent waiting. In caring like this he has to face his fear of having no recourse to the institution and the profession, who choose not to contemplate this very risk that Matt considers to be the essence of care.

The culture of risk averseness in District Health Boards Matt referred to affects therapists in different ways. Following is Lance's experience of working with suicidal clients.

> *Strangely enough, if there is a high risk of someone doing that* [committing suicide] *I probably feel less* [anxious] *and go straight into management mode…I mean, sorry we can't let you do this…rah rah rah…and I go into a bit of a self protective thing. I mean, this could happen, not even authorities can prevent someone from killing themselves if they are hell bent on that. I go through the paperwork and the procedural steps. So it is not that distressing for me because you only have to do what you can do. I don't find it difficult when someone tells me they are going to end their life. It means informing the mental health authorities, there will be a team and it is handing responsibility over to statutory people with the authority to deal with that stuff. You use medication or you commit the person, or whatever the state feels they need*

to do to prevent suicide. I do not need to be responsible for that. It would be inappropriate in a sense.

Lance does not find it difficult to deal with someone who threatens to commit suicide. He enters into a management mode with predetermined activities and procedures to protect him from being implicated, should the person follow through with the threat. He manages the person by identifying signs and symptoms of suicide and then refers the person to the mental health authorities who *have the authority to deal with that stuff*. Lance does not feel he should be responsible and that it would be inappropriate for him to get involved. He steps back from getting personally involved and begins to assess and manage a set of suicidal factors according to protocol and tradition. The people who have the authority to work with the suicidal person are psychiatrists, psychiatric nurses and psychologists. This contradiction confused me. Lance is a psychologist working in a mental health service and no different to the psychologists *with the authority to deal with that stuff* also working in a mental health service; in fact they all work in the same service. But for Lance there is no contradiction. The reason for this unrecognised contradiction can be traced to the epistemological tradition of the profession which misrepresents the nature of being human by artificially dissecting a person into properties and functions. Lance's management mode represents this misrepresentation as it becomes operative in practice. Lance chose a theoretical-scientific mode of understanding and care in a tradition which accommodates this present-at-hand mode of managing a human problem. This epistemological confusion, which I have addressed elsewhere, is not confusing for the profession because the dichotomy of the being that is human is a valid construct of understanding in a natural scientific paradigm. It is however most confusing for those who do not live according to this theoretical construction of being human. Whilst it may be confusing for me – and possibly the client – Lance is clear about his actions. He assumes responsibility for assessing a behavioural-biological organism that exhibits signs of suicide and then passes the person over to another psychologist that will attend to the person in distress.

To pass a suicidal client on to *the authorities who deal with that stuff* is a mode of existence in which Lance continues to understand himself within the tradition of his profession. In this undifferentiated mode of existence Lance can avoid the possibility of reinterpreting himself by going along with tradition. Lance falls back into the

comfort of the collective – *I go into a bit of a self-protective thing* – where he will be unburdened and accommodated by a management mode of care. This resonates with Heidegger's (1962) notion of an inauthentic existence in which Dasein 'seems to win itself' as a way of avoiding one's basic unsettledness.

> *I also routinely give them a spiel that is quite condemnatory of suicide. I talk to them about the possibility of developing a code to just see their life through to its natural end, for better or for worse. One could see that it is a reasonable kind of social responsibility to the people around us. And I make sure that they are under no illusion that they can slip out quietly and everyone will be OK when they are gone. I want them to feel very uncomfortable and guilty about the notion of doing it. They have a responsibility toward people around them, even me. I am working with them and wow, they kill themselves and I have to live with that. I have had colleagues who have been unable to work after an experience like that.*

As part of his intervention in working with a suicidal client, Lance is condemnatory of the idea and lets the client know this. The condemnation comes in the form of suggesting the client develops a code to continue living for better or for worse. Lance makes sure that they feel uncomfortable about the thought of ending their lives and ensures that they feel guilty about having this idea. He informs them that they have a responsibility towards society in general, but also towards him in particular. It is their responsibility not to make him feel uncomfortable and nervous, and not to cause him the kind of personal conflict that could throw his existence as a psychologist into question, as it has done to some of his colleagues. Lance is afraid. He is afraid for his client and he is afraid for himself. Lance can see the spectre of his client's existential despair in himself. That his client contemplates suicide fills Lance with fear. Lance is afraid that the effect of his client's suicide on him may prevent him from doing what he is doing. It may prevent him continuing as a psychologist, because the effect on his colleagues were so encompassing that it disturbed their world and work as psychologists, to the extent that they were unable to function as such. We are in our doing. If we can no longer do, who are we? If he can no longer practice as a psychologist Lance's existence will lose some of its significance – or so it may seem. His 'world' will fall apart. If his client commits suicide in his care it may reflect badly

on him as a responsible and caring psychologist. Lance will then be confronted by the question; what kind of psychologist am I? And this is a potentially dangerous question which will take him upon a journey of redefinition and understanding. In this process things previously thought to be significant lose their status and things previously thought to be of no consequence become significant and meaningful, and it challenges the tradition which sustains his existence. It is a journey of understanding himself anew during which he may become entirely lost in confusion and self-doubt. If he chooses to confront this fear and face his anxiety – inherent in everyone who exists – he may have to find a 'new world' of significance. It is a frightening prospect he protects himself from when he goes into a management mode.

Guilt

> *I was angry with him, but that was a reflection on me. It was afterwards that I was angry with myself and questioning myself about what I did wrong, what could I have done better. The guilt was almost like a survivor kind of guilt, I don't know. In my intervention something went wrong and I lost a life. If you look at your role you are supposed to talk people off that bridge in a moment of crisis and almost heal them. That is what people expect of you; to prevent people from going to their death by whatever means.*

William felt guilty about failing in his duty of preventing someone from *going to their death by whatever means*. It is what society and its institutions expect of him and he has come to expect that of himself as well. He felt that he had done something wrong and had *lost a life.* Is it reasonable to expect mental health professionals and therapists like William to save human life? To answer this question we have to be clear about what is understood about human life in a mental health institution. In Hillman's (1992) view psychology misinterprets itself due to its lifelong obsession to be accepted as an adjunct to the science of medicine. The medical profession is concerned and cares about human life as a biological organism in the first instance. That is the medical profession's primary intention and it often succeeds in saving life with extraordinary feats of practice and knowledge of the neurobiological functioning of a living organism. However, the life which psychology is concerned and cares

about is that of a human being that exists. Elsewhere I have drawn attention to Laing's (1965) view that the initial way in which we see things determines all our subsequent dealings with it. For example, if we see a thing as a physical-chemical system, a behavioural entity or a thinking unit, then we are determined by this intention to deal with it as such. However, it is not possible to respond to the whole person if our intentional act is to see an organism. The theory and description of an organism determines a different relationship to the theory and description of a person. "My thesis is limited to the contention that the theory of man as a person loses its way if it falls into an account of man as a machine or man as an organismic system of it-processes [and] the converse is also true" (Laing, 1965, p. 23).

The answer to the question whether it is reasonable to expect mental health professionals and therapists to save human life is no. It is unreasonable because it is an expectation which rests on the conviction that a biological organism represents a being that is human. This misrepresentation according to Heidegger (1962) is a result of our tendency to understand ourselves as autonomous entities with functions and properties like all other entities of the natural world which conceals the true nature of human existence, which exists in a different manner than entities of the world exist. The notion that the human body as a biological organism is synonymous with an embodied existence has been entrenched by the human sciences which, says Heidegger, interprets the nature of being human via categories of knowledge such as our knowledge about living biological matter. William asked himself *what did I do wrong* and said *in my intervention something went wrong and I lost a life.* What went wrong for William was his unreflecting adherence to this tradition in human sciences. He intended to save a person understood as a biological organism which is different to saving a human being that exists. Human life and death, when understood as existence, always belongs to the client. Elaine's experience will shed more light on this.

Elaine understood being responsible as a therapist in a different way, compared to William. Her sense of being responsible was experienced within the limitations and modesty of her own mortality which brought its own kind of turmoil when her client decided to end his life.

But his mind was made; he did not want to live without his wife who was having an affair. This reality was just not acceptable for this man and it was sad to see that he could not change. In therapy that was not changing.

It was sad for Elaine to be with someone for whom the horizon of possibilities had fallen away. He found himself in a place where he no longer seemed to care about his existence. His future, his ownmost possibility, was no longer an issue for him and no matter how Elaine cared about him; he had decided to end his life. As a therapist Elaine understood that, as Mulhall (2005) puts it; the death that belongs to Dasein calls forth the life that belongs to Dasein. As a therapist one can not live or die for another.

I respect people's choices even though it ended like this. I remember looking him in the eye during the last session when he decided not to continue and I thought I will respect this thing. There was a mutual respect. That was valuable.

This was a difficult decision for Elaine but she felt it was important to respect the client's decision. She could have leapt in with care and she could have dominated him by taking his decision away from him. Even though the consequences of her decision filled her with sadness, she felt it more important to convey her belief to the man that she cannot live nor die for him. His existence belonged to him and she felt he respected her for caring about him like that. Soon after his suicide Elaine felt that others may blame her for not taking over and doing something for and to the man. She said *I know I was not at fault, but that initial blame thing…* yet she felt she was not guilty of not caring and being responsible. *When my boss tried to protect us* [from accusing enquiries] *I thought that he should not do this because we are not guilty.* Elaine's fear about how others may perceive her care was laid to rest at the funeral where she found no blame or ill feelings directed at her. She continued to wrestle with her conscience and one day she came to the final resolution; *I still respect people's choices even though it ended like this. It was a cathartic process for me.*

This is Kane's experience of guilt;

I don't find myself an academic or know lots. I have a lot of life experience and have a lot of things to share and give. I guess through this life experience and the things I have done, and the things I have learnt, that I have gained a lot of wisdom. At the same time there is also this vulnerability that there is so much more to know and much more to learn. I feel the more you know the more there is the need to know. If you open a door there is another. A lot of wisdom comes to you. That's what I mean by vulnerable. I simply missed it.

Kane was reflecting on how he felt about his client's suicide. He talked about understanding himself as a wise person with life experience in learning by doing. Nevertheless, despite this know-how and his familiarity of being a therapist, his client's unexpected suicide brought him to realise that he is vulnerable. No matter how much one learns one can never know the other completely. The suicide of his client caused Kane to remember the vulnerability of being human. Furthermore, I formed the impression during this conversation with Kane that this renewed recognition was not something which hounded him. It was not something he wanted to be rid of. This way of being vulnerable was something he recognised about himself and he could reconcile himself with it, saying *I simply missed it*. He simply understood himself as standing guilty in the face of his vulnerability and of never being able to know another completely. This way of being resonates with Levinas' views. According to him the "absoluteness and infinitude of the human other can never be disavowed…" (Peperzac, 1993, p. 61). He asserts that the concrete way in which 'I am' in relation with the infinitude – when traditional conceptualisations have been disavowed – is in vulnerability and weakness. This reflects Kane's experience and it suggests that one can never escape being always guilty of one's vulnerability towards another person. On the other hand, we may choose to believe that we can rid ourselves of this vulnerability, if we understand and project ourselves in the Western tradition of thought and philosophy, in "the comfortable consciousness that the Other is but a thought, belongs to it as a subordinate moment of its own universe" (Peperzac, 1993, p. 68). In this manner of being with another we may bring ourselves to believe we can escape this vulnerability, but it will be a self-deceiving concealment of, what Peperzac refers to as, the primordial experience of conscience (Peperzac, 1993).

William's uneasy conscience is similar in texture. This is his recollection;

> *There are times when you realise that everything has its limitations. You learn the theory of what to do; A B or C and then realise that it all becomes null and void. Then you realise that you have to dig somewhere where theory cannot help you. And then you realise that the rapport you build in that relationship is key. At certain times it could be the key between life and death. Yes, I do believe I have abilities to do this kind of work but as I have said you often deplete your own resources and come to the end of the line yourself. You realise that theoretical models can not help you now and it is only you and the person. It is more than a feeling but rather a sense of knowing that there is extra help here. I honestly believe that. It is a feeling of calmness and serenity; I feel we are doing something right. It is a feeling of calmness in itself that allows me to focus more on him and listen even more closely.*

The idea of the infinite is in the social relationship. It is where the altereity (indefinable uniqueness) of the other is encountered, according to Levinas (Peperzac, 1993). In struggling with his vulnerability, William discovered that he, his capacity for care and being a responsible therapist is not measured in facts. "For me to feel unjust I must measure myself against the infinite" – it is the infinite that is perfect, according to Levinas (Peperzac, 1993, p. 116). Being responsible is thus not measured against the finite, the already or immanently known, but rather against the infinite in the other. By this definition of responsibility one is never free from being 'guilty' of one's primordial vulnerability in being-with. My being responsible is not something gauged by the ego which appropriates with knowing. My being responsible primordially belongs to the other "who steals from me my time, possessions and happy solitude"; it discovers that goodness is not a "satisfied source of abundance but rather the exhaustion of someone who does not possess his/her own life because it is taken away by the other's existence" (Peperzac, 1993, p. 117). Being disburdened of the ego and burdened by the infinite is *a feeling of calmness in itself that allows me to focus on him and listen even more closely…it is as if there is extra help here*. It would then appear that the burden of never knowing another completely and being with them

in this vulnerable way is serene and expansive, but to stand there with 'hoarded realities', as Levinas says (Peperzac, 1993), is terminal for both. William's experience and conscious recognition of his 'always being vulnerable' in the face of the other seems to be the self-reflection and ownership necessary. It is necessary to set therapists free to 'exhaust themselves' in caring for the other the best they can, relieved of the burden and unwarranted sense of having 'done wrong' when things do not work out as hoped for.

Conclusion

This chapter set out to make the extraordinary sense of responsibility therapists felt towards their suicidal clients explicit by looking more closely at what it means to care and the fear and guilt they encounter in the process. It would appear that therapists face a number of dilemmas in their wish to be responsible and caring practitioners. No matter how they cared, people committed suicide.

A dilemma therapists faced from a professional point of view is that they often found themselves identifying with expectations which exceed their human limitations. In their professional ethic they found themselves caught up in the history and tradition of Western thought and philosophy, and the notion that mortals can know everything there is to know about another, that knowing is able to solve all problems associated with the difficulties of existing as a human being. But at some level therapists come to discover that this is an impossible way of being. This impossible way of being responsible draws upon expectations that are not of this world, and it exacts a heavy toll on their everyday lives. It is a responsibility which exceeds their human boundaries. Whilst therapists are drawn into this idealistic notion and feel compelled by it, they also recognise that they can not save people from themselves, that the idea is onerous and unjustified. They recognise that it is unreasonable to hold themselves responsible in this manner, responsible for the client's responsibility.

From an institutional point of view therapists find themselves thrown into a social-cultural milieu where the meaning of care and responsibility has already been defined for them. It is a mode of care and responsibility that is clear and unambiguous, there are rules and formulas. It is a recipe for aggregate responsibility and care, instrumental and mechanistic in nature. It is a mode of care which also reflects the

extent of institutional fear and anxiety about caring for suicidal clients. It tries to avoid being blamed for suicides. This institutional fear and anxiety about caring for suicidal clients flow through to therapists and compromises their wish to respond specifically to the needs of the person that is there and present in front of them. The dilemma for therapists in institutions of care is that they are not certain about whom they ought to care for and towards whom they are responsible – is it the institution or the client? William and Matt have shown how they are conscious of this dilemma and how they attempt to reconcile the opposing demands made by client and institution. It seems that their reconciliation became possible in self-reflection and affirmation of their vulnerability of never being able to 'summarize' their clients. It is a wisdom which comes from their practice and toil to unite the 'already knowing' present-at-hand mode of intelligibility with an appreciation of the infinite human being.

Professionalized and institutionalised modes of care cause therapists conflict and turmoil. It leaves them confused about whether they are responsible for the wellbeing of their suicidal clients or for the profession and its institutions. They often feel more burdened by caring for the profession and institution than the suicidal client.

When therapists adopt a mode of care in which the client's world becomes central to their concern, they face different dilemmas. In this mode of care, demonstrated by William for example, there is an acknowledgement of one's vulnerability and weakness in the presence of the unknowable other, acknowledgement that one can not control or govern the existence of another. The vulnerability and weakness of the therapist in this mode of care also opens new possibilities of being for the therapist. The dilemma they may encounter in this mode of caring is that it may challenge their existence in which they already live and do with unreflecting familiarity.

Chapter Seven

Being unfamiliar

> This very heart which is mine will forever remain indefinable to me. Between the certainty I have of my existence and the content I try to give to that assurance, the gap will never be filled. I shall be a stranger to myself (Camus, 2005, p. 17).

Whilst trying to come to terms with the sudden death of their clients, worrying about how their methods of assessment and care will be perceived and judged, and burdened by their felt sense of responsibility, these therapists also experienced personal doubt and uncertainty. Some of them spoke about feeling confused, having sleepless nights, questioning themselves and their decision to be professional mental health workers and therapists. 'I couldn't function properly' said one therapist and another; 'I started feeling incompetent in almost every area'. They no longer felt at home and familiar with what they did, their professional world of work and reference no longer seemed to contain them and give them the reassurances and direction they needed during those times. One therapist said 'You know shit happens; people do things there is no motivation for. We can't understand people'. This indicates the nature of the uncertainty and unfamiliarity they experienced; not only did they no longer understand people, but also suddenly failed to understand themselves. Perhaps William and Kane came to understand themselves. This chapter will aim to explicate the phenomenon of being unfamiliar.

Conflict of understanding

> *I know mental health is a tough job and it has a huge impact on my mental and physical health. It is good to talk to another professional about it, someone who gets it. I have wanted to leave this job, but it has now been twenty five years. And you ask yourself at the end of your life would you have been satisfied being a psychiatric nurse? Not really. I know a lot of psychiatric nurses who all want to do something else, who are all locked into it for different reasons, and then realise you are getting older and you*

may as well carry on until you retire. I am getting to that point now and it is difficult because I am the sole breadwinner. Perhaps I should do more talking like we did today to make my job more bearable.

Here Nancy was reflecting on her work as a psychiatric nurse with people who are suicidal. She says that working as a professional mental health worker with suicidal people is a tough job which has a big impact on her sense of wellbeing. It is a life she says that leaves her dissatisfied and if she could she would do something else. Her work causes her to feel at odds with herself. It is work which no longer instils a feeling of value and significance. Nancy says she feels powerless in her occupation because her colleagues pay little attention to her thoughts and observations. It is this experience of being overlooked, which causes her to be doubtful about who she is and what she does. It undermines her sense of wellbeing.

[You just] *shut up about things and get on with it, but it returns from time to time. It's OK now it doesn't bother me that much but at the time I really felt pissed off about the whole thing really. But I knew that… I suppose what I am trying to say is that not all the people on the team were bad, there were some good people. I want to talk a little bit more about that feeling of powerlessness. Often in psychiatry you do feel powerless because you can not control what clients do. You can support them and guide them but when they have decided to top themselves… what am I trying to say? You just have to accept that you cannot control another human being. You have to do all you can and if it is not enough you can't let it eat you up.*

When Nancy says that 'you just have to accept that you cannot control another human being' she is implying that there is this tacit idea in the profession that therapists are able to control other human beings. But Nancy has her own thoughts about this and they are overlooked in favour of the collective and idealistic notion that one can control another. This variance in world view causes Nancy doubt and confusion. It throws her sense of worth and significance as a therapist out of kilter. It amounts to a crisis in her existence. Most of the time Nancy just keeps her mouth shut and suffers in silence as she allows herself to be swept along by this common notion, and yet

there are times when she feels there is something wrong about this conviction in the profession. How do I understand Nancy's crisis and the unease she experiences with herself?

I understand this as her struggle to reconcile the two opposing world views in psychiatry previously mentioned and described by Needleman (in Binswanger, 1975); understanding someone as a 'sick organism' and then attempting to relate to him/her as a human being in treatment. Camus (2005, p. 19) says that from a scientific point of view we may feel that we can seize phenomena and enumerate them – control them – but cannot for all that apprehend the world "were I to trace its relief with my finger, I should not know any more". On the one hand there is the view endorsed by the critical mass of the profession that we can seize and enumerate another human being. Nancy was referring to this notion when she said *often in psychiatry you do feel powerless because you cannot control what clients do*. Nancy often feels that she ought to be able to, when she finds herself in the zeitgeist in psychiatry of taking control of 'sick organisms', founded on its natural-scientific (biological) way of understanding people. And when Nancy said *you just have to accept that you cannot control another human being* she was perhaps voicing Camus' idea from an anthropological way of understanding that human beings will forever be indefinable and strangers to themselves. Nancy's doubt and uncertainty of who she is, in what she does, is the embodiment of this conflict of understanding.

She says, *while I am a professional person doing an assessment...I am not listening to me.* This statement underscores how Nancy finds herself unfamiliar with herself as she struggles to reconcile two opposing ways of understanding being human. She says that *being professional* means that *my mind is going a hundred miles an hour to make sure that all the bases are covered*. She is being beyond the person who is herself. She is talking about being swept along towards that horizon of understanding in which human beings are conceived of as biological organisms, and the basis of professional knowledge about what to think and what to do with suicidal clients. Yet at the same time she says *I am not listening to myself*' and *that perhaps I should look at the basic things such as the person is still alive and now they are safe, instead of thinking I should have done this or I should have done that*. In other words, deciding what to do and think from an anthropomorphic horizon of understanding and the lived

world of the person there with her. This illustrates Nancy's confusion and doubt as she finds herself torn between the notion of being 'seized and enumerated' on the one hand and the notion of being forever indefinable and strangers to ourselves on the other. This is a reason for her professional dissatisfaction.

Camus (2005) is of the view that all thought is essentially anthropomorphic and that we arrange our world and understand ourselves according to what we sense is right for us. This resonates with Heidegger's (1962) view that we project ourselves – exist – in accordance with our mood and our understanding which are "*prior to* all cognition and volition, and *beyond* their range of disclosure" (Heidegger, 1962, p. 175). We are thus indefinable on the basis of logic and reason which is how I understand Camus's claim that human existence is absurd. To seize and enumerate a human being upon the reason and logic that underpins a biological-scientific understanding of a person, compounds this absurdity of human existence. Our natural-scientific way of thinking and our theory is not sufficient to recognise *what* and *how* the world is disclosed to Dasein (Heidegger, 1962). This is when Nancy just *shuts up about things and gets on with it* when she finds herself falling into the zeitgeist of psychiatry, but the absurdity of it all *returns from time to time.*

This absurd human world is a source of our basic anxiety which spurs our human endeavors (such as science) to resolve it. There is this persistent idea that there is unity and clarity to be found in our multiplicity, that there must be a singular principle of understanding which will reveal the worth and meaning of human existence (Camus, 2005). When Nancy allows herself to be carried along by this persistent idea she finds herself like Sisyphus forever pushing a boulder uphill, only for it to roll back again. It is impossible. Camus asks who can tell with certainty that human worth and value will be disclosed by singularity and clarity. Perhaps our worth and value is in our multiplicity and the way we are beyond cognition and volition. Perhaps our lack of definition and strangeness reflect the worth and value of being human. This may be what leaves Nancy so confused and dissatisfied with herself and her profession. Together with her profession she finds herself compelled to look for meaning and unity where none is to be found, since the very source of understanding defies logic – Dasein. She finds herself continuously unable to confirm the value and

meaning of her own existence on the basis of the reason and logic that belong to our cognitions.

I was interested to know how Nancy deals with the confusion and turmoil she experiences from time to time and how she goes about resolving her confusion.

> *I had a glass of wine, and to be honest throughout my career, that is how I have dealt with my stress. I have one or two glasses of wine and that helps me to slow down because I am usually going at 100 miles an hour. Yes it takes the edge off anxiety and allows me to think in a more measured way, instead of my brain going really fast and jumping around between things. It is like taking a deep breath and letting it out.*

Nancy admits that it is a very stressful and anxiety provoking experience for her, which she struggles to cope with. She said that discussing these matters with a supervisor can be very helpful but she seems to struggle to find the right supervisor, *it takes a long time to find a supervisor I can relate to* and that she never discussed these cases with a supervisor. Instead, Nancy drinks a couple of glasses of wine in search of tranquillity and to put herself in order. Experiencing a client committing suicide is clearly an experience that threw her out of order. Her mind is all over the place and she is going at a 100 miles an hour. I take it that Nancy is referring to her self-understanding (existence) being in disarray when she speaks like this, in need of a deep breath. I would like to draw attention to Nancy's experience of the interview and how she experienced the interview within the context of this existential crisis.

> *Discussing these things with a supervisor can be very helpful, but it depends on who the supervisor is and whether you are on the same wavelength. Some supervisors you can talk to about stuff, but others seem to know how you feel about things. Like before when we were talking about instinct and you said I know what you mean. Oh, I am not putting this very well. This process has helped me to examine myself more closely and that is what has been helpful because you have asked me questions about my feelings and where that comes from. I have done that in supervision but never to the extent that we have done today. And of those*

two cases we examined today, I have never done that in depth like this before. And the process today revealed my own stuff and how the job affects me. Perhaps I should do more talking like we did today to make my job more bearable. Yes, that was helpful. Thank you.

What is supervision for Nancy? She says it can be very helpful if you find a supervisor that is on the same wavelength and someone who seems to know how you feel as opposed to just talking about stuff as in contemporary discourse. In this kind of relationship she is able to examine herself more closely and gain some clarity of self-understanding. She found that the interview had helped her in a similar way that a supervisor does who is on the *same wavelength and who seems to know how you feel*. So what happens in a hermeneutic phenomenological enquiry that feels just like supervision?

According to Crowe (2006) Heidegger's project is to gain a deeper appreciation of life by a procedure called 'phenomenological-critical destruction' which enables one to reach 'moments of sense' that are concealed by contemporary discourse. According to Crowe, Heidegger's method of phenomenological critique (destruction) aims to get to the 'basis of enactment' which is 'factical life-experience'. One way in which to do this is to trace commonly used terms back to their origins in factical life experience. Stripping our understanding of its self-evident meaning brings one closer to the genuine 'moments of sense' in going about with self-understanding in everyday life. Having asked Nancy to say more about common expressions such as *I had a gut feeling, I felt sad, I felt powerless, alcohol slows me down*, etc. appears to have brought her closer to moments of sense – the basis of her experience – for which she was thankful and believed that doing more of it will make her job more bearable. In our interview Nancy's spoken word was understood and treated as trying to point towards what Heidegger (1962) refers to as the very thing which the telling is about. We revisited common expressions throughout the interview in different ways and each time we seem to have gotten closer to those moments of sense the telling is about. It revealed the stuff of her unfamiliarity with herself. Nancy said in supervision she has never discussed how she finds herself in mood and understanding to the extent that we did during the interview. It was a process that has helped her to

examine herself more closely and that is what has been helpful because I asked her questions about her feelings and where it comes from. It was a process which

> *revealed my own stuff and how the job affects me. Perhaps I should do more talking like we did today to make my job more bearable. Yes, that was helpful. Thank you.*

In a recent study, comparing New Zealand psychologists with their Canadian and United States of America counterparts, it was found that New Zealand psychologists consider personal therapy (the primary focus of personal therapy is self-understanding) as only a modest positive influence on their professional development. They regarded training and supervision highly influential for their own development however. This result is in keeping with the dominant theoretical orientations of cognitive behaviour therapy in New Zealand, which places a stronger emphasis on training and supervision in the development of psychologists. There is less of an emphasis on personal therapy as part of professional development (Kazantzis, Calvert, Orlinsky, Merrick, & Ronan, 2009). Perhaps this is why Nancy has had to struggle with her crisis on her own because supervision does not give sufficient weight to listening and attending to the wellbeing of the supervisee in its practice in New Zealand. It is a dimension inherent in a hermeneutic phenomenological enquiry which Nancy found most helpful.

The call of conscience

This was William's experience of unfamiliarity:

> [What does it mean and how does it feel for you to be shocked?]. *It is an emotional and physical reaction. There is that feeling of numbness and disbelief. It was a typical PTSD trauma kind of thing. It is very intense. You see a man jumping right in front of your eyes and you know he is going to die in a matter of seconds. I felt shocked, confused and disorientated. I felt helpless and thought what the hell is going on here?*

Here William was describing a moment of utter confusion upon witnessing the suicide of a client. He found himself in a certain mood; he said he felt disorientated and no longer knew what was going on around him. William lost his frame of reference by which his being and the world is understandable to him, the reference by which he exists in knowing what to do. In the blink of an eye this referential network fell away and William was confronted with who he is, how he is and what he understands of the meaning of life and death. These moments in life which take possession of your entire being Heidegger (1962) refers to as angst. It is a basic mood which discloses Dasein's being-in-the-world. "*Angst* strips the world of its involvement-totality, its significance, making the world as such all the more obtuse" (Inwood, 1999, p. 17). In this mood one feels uncanny, or unfamiliar and not at home anymore. In angst we come to face ourselves anew – from the beginning, so to speak – to redefine and understand who we are. William describes this occasion of angst as a Post Traumatic Stress Syndrome type of experience – he felt nothing, believed nothing – vulnerable and open to different ways of who and how he may be, a possible new beginning. Crowe (2006) refers to such experiences as a call to an authentic life and he draws a parallel with Paul's conversion on the road to Damascus. These experiences share specific elements; an interrupting experience leading to greater self knowledge. William found himself questioning his own abilities and he felt incompetent. His existence was in crisis and he sought help from colleagues and a psychologist – his supervisor.

> *You almost transcend yourself and when something like this happens you realise that you are only human. They allowed me to talk about it and gave me reassurance that I am still OK and that I did the best I could. They helped me to rediscover that I am a mere mortal human being. It was not an Aha experience but I do recall when it happened that I felt relieved and less tense. It was a release and I felt more comfortable with myself. It is part of the process of letting go; I remember asking myself what is it that I am trying to control here? What was I holding on to? And I think it was the thought that in this job I am not supposed to make mistakes.*

In supervision William was helped to discover who he had become and it was a therapeutic experience for him to rediscover anew that he is a fallible mortal being.

He felt relieved of thinking he is able to control the existence of another and that he can seize and enumerate them with knowledge. Supervision confronted him directly with the questions *what is it that I am trying to control…what was I holding on to?* From this recollection it is clear that William's supervision included an important dimension for him. He experienced care and concern in the process which developed his self-understanding in crisis. I should note, in view of Nancy's supervision experience in New Zealand, that William was not living and working in New Zealand at the time of this experience.

William also recalled a situation in which he felt that he had prevented a suicide. He managed to convince a client not to leap from a bridge during a crisis call-out. It was an experience he refers to as a *divine intervention* during which he came to understand himself in a different light. It was a transforming experience, similar to the one explicated above. It was a call to authenticity, an interrupting experience which leads to broader self knowledge. He said this life saving experience was a miracle.

> *In fact I believe it is a miracle in each case because I do not believe that I am that good. You often deplete your own resources and come to the end of the line yourself. You realize that theoretical models cannot help you and now it is only you and the person. Then you realize that you have to dig somewhere where theory cannot help you, and you realize that the rapport you build in that relationship is key. At certain times it could be the key between life and death.*

This 'miracle experience' is also an interrupting experience, something out of the ordinary, which confronted William with who he is and how he is. He came to realize theory and the models of care that flow from it have their limitations and that the unfolding relationship with the person present is often 'the key to life and death'. William said that these insights – and the relief they afforded him – were not sudden aha experiences, but a process over time. This resonates with Heidegger's idea of the 'call of conscience' which in essence amounts to a crisis of existence during which the ideal of living a more authentic life is brought into the foreground of consciousness. This is Gorner's (2007) view: Conscience summons us to carry out

this modification of the One-self. Who called and who is doing the calling in the call of conscience? The answer to this lies in Dasein as falling and its 'uncannyness' (not-at-homeness). It is from this mode of existence that the call of conscience emanates. It is a summons from the fallenness in the One to an existence that is mostly Dasein's. It is clear from William's account that he was summoned through these 'interruptions' to confront how he had fallen into the expectation of the 'One', that he be (verb) something other than himself when he attempts to control and seize his client in crisis.

William responded to the summons of conscience. He said he felt relieved and released. In other words, he felt freed from being lost in the anonymous 'one' when this experience disclosed his situation of going along with the traditional interpretation of being human. It was a life intensifying moment which interrupted the downward trajectory of inauthentic life (Crowe, 2006). William was set free to reconsider the possibilities of existence and this was therapeutic for him. The importance of choosing to respond to the voice of conscience as a therapist is that it lays down a personal blueprint of experience by which William may be therapeutic with his clients who find themselves in a crisis of existence.

William's realisation that theoretical models of care and suicide prevention create the illusion of being able to prevent suicide is also something Matt commented on in a similar vein of self-doubt and confusion. This is what he said.

> *It brings an added pressure and I see this in all the District Health Boards, they are risk averse and you should protect yourself. Yet, in working with someone who is actively suicidal…I am trying to articulate this now. Again, it hovers in the background and there is always the possibility that they will go ahead and do it and then you are going to be investigated. How to open myself up to hearing the person without that interference creates conflict for me. There is the pressure to identify the problem and sort it out. So… that if suicide was expressed, that I have addressed it tick, tick, tick. So then you are fine. I fell into that mindset.*

Here is Bray's encounter with the voice of conscience.

> *In psychiatric nursing there is a macabre humour. And in some way we do get a bit disrespectful and derogatory. It is one of the ways that I deal with it. I remember from an early age that I had a cynical sense of humour. I think it is a defence mechanism. I like to be different. I like to shock maybe. In some ways there is a bit of anger* [suicide goes against Bray's life philosophy] *but I do not focus on it and it does not last long. In this particular guy's case I suppose it helps me to rationalise and I say your life wasn't fucking great anyway and you didn't have much going for you. It makes it a bit easier for me* [to cope with], *so again, perhaps just a bit blasé.*

In the process of talking about the clients in his care and others who have committed suicide, Bray says that suicide goes against his life philosophy; *in my interpretation of my world every day above ground must be better than below… no matter how bad you feel, being dead must be worse*. That someone should commit suicide angers Bray because it challenges his philosophy of life, but he avoids entering the challenge and takes on a 'rational' view, a blasé attitude and uses black humour to cope with this unsettling experience. There is no doubt that he is disturbed by the experience; it stirs him (anger) and affects him. It is a moment pregnant with possibility which resonates with what Crowe (2006) describes as a moment of 'life-intensification' – the voice of conscience – which in a direct and disturbing manner discloses one's individual situation. The 'voice' doesn't belong to anyone nor does it have content; it is a moment of finding oneself already under way in a life with still more life outstanding, says Crowe. In that moment of anger, where Bray finds his world at odds with that of his client, he is summoned by the voice of conscience, but his response cuts this invitation short. It is much easier for Bray to be blasé and to use black humour. He shallows his experience of himself in this manner. Bray is conscious of this; he acknowledges that it is a defence mechanism. He is consciously protecting himself and avoids the potential to project himself into the future in a different way of being the person he is.

In support of his life philosophy Bray says that *I have had some rugged experience in life which may have contributed to my life philosophy. I think people who commit*

suicide are fairly selfish. Maybe this statement points us towards understanding why Bray becomes self-protective when he finds himself moved in a direct and disturbing manner. He becomes anxious and worried when confronted by the existence of a client which could possibly end in suicide, for it is not possible in Bray's way of existing and understanding. This 'anxious worry' that Bray finds himself in is what Crowe (2006) considers to be the font of an authentic life; it is a boundless state of being; it is free. There is no structure, no direction, nothing to steady one by. It is an open space. This self-experience is fraught with abrupt ups and downs; it is uneven and irregular, in a word; rugged. Uncertainty, we are told, evokes anxiety (Kierkegaard, 1980). Through this region one emerges transformed, it broadens consciousness. But, it appears that the possibilities are too unpredictable and anxiety provoking for Bray, to want to venture there. To contemplate and enter the alternate world of the other, and their turmoil, will require Bray to encounter the turmoil and unsettledness in him, and that is what he protects himself from. He prefers to adopt a stance where there is no ambiguity. He consciously estranges himself from his own inherent turmoil. He holds the unknowable other (and the unknowable self) at a distance with black humour and a blasé attitude. The encounter remains shallow, or to state it differently: Bray's response perpetuates the downward trajectory of inauthentic life (Crowe, 2006). The unknown is an invitation to discover the one you are among the many, according to Kierkegaard (1980) and Heidegger (1962). The suicide of his client affected him deeply, he is called in this experience to look at his life already under way with still more life outstanding, but he deflected this. Coping with suicide through black humour and a blasé attitude is the outward appearance. It defends the essence of Bray's experience with suicidal people, which summons him to the life still outstanding.

> *Yes I have a friend who is a supervisor and we have talked about it, but I perhaps do not use supervision as well as I could. In reality I only make a token gesture when I go to supervision.*

In response to my question whether he makes use of supervision to work through his experiences of his clients who commit suicide, Bray says he does, but that it is a token gesture. He is aware of not using supervision as well as he should and gives his reasons for this. What usually happens in supervision that Bray is avoiding? In

supervision invitation is often directed towards the supervisee's emotions and noncognitive experiences to help the supervisee identify how s/he is affected by another person. It is Jung who said you can not hope to affect another if you remain unaffected, and knowing how you are affected is to begin to know yourself. To know oneself – to live authentically – is a 'rugged experience', a summons out of one's lostness in the 'one'. It is a way of life that involves 'anxious worry' about the self as opposed to the abdication of responsibility, and that means taking responsibility for the 'history that we are' (Crowe, 2006). Living the 'history that we are' is undifferentiated and the primary mode of Dasein being immersed in the 'one' (Heidegger, 1962). Bray says he has had rugged experiences in the past which appears to have dissuaded him from venturing there again. I understand Bray's humour and attitude to be an abdication; this experience does not make him resolute to choose a possibility of existence derived from his own culture, and he thereby remains lost in the collective (Crowe, 2006).

This was Laura's experience of being confused as a result of her client's suicide.

> *This one affected me badly. I was just in a mess really, it was pathetic. I couldn't function properly. I was doing the job but to the detriment of my own health. Realizing that I had a problem for starters was a positive step because I was just going through this turmoil. When I woke up in the middle of the night with this anxiety I knew that this is what she is experiencing on a daily basis and I could really relate to how she was feeling. It was a good experience as far as that was concerned.*

Laura is a psychiatric nurse helping people in a crisis of living. In one particular case she found herself in a crisis similar to that of her client. She says she was in turmoil and could no longer function properly. She was badly affected and woke up in the middle of the night with anxiety knowing this is how her suicidal client is feeling. Significant here is that Laura says that this was a good experience for her in the sense that she was living it. She did not have to formally think and reflect how her client may be feeling. Living this crisis was a good experience for Laura and she is suggesting that without experiencing the crisis in person, she may not have really known how it is for the client. The existential turmoil of her client resonated in Laura.

This feeling of being pathetic and unable to function properly arrived like a thief in the night and is not dissimilar to the angst experienced by William or the life-intensifying moment in Bray's account. These are experiences, if we follow Heidegger's views, which call Dasein to a more authentic existence, to be the person one understands oneself to be among the many and their ways of being which are not one's own way. Another way of looking at Laura's experience of confusion and anxiety is to consider the notion of ontological guilt and nullity.

Initially and for the most part Dasein is lost in the One, its possibilities have not been chosen by it. It takes away the burden of choosing its own possibilities of being (Gorner, 2007). The manner in which this choosing for one is done is concealed. So it remains indeterminate who has really done the choosing. In contrast, in existing authentically, Dasein is choosing to choose its possibilities. This does not mean that authentic existence is a detachment from inauthentic existence. Authentic existence is a mode of existence of One-self. Conscience summons us to carry out this modification of the One-self. Who called and who is doing the calling in the call of conscience? The answer to this lies in Dasein as falling and its 'uncannyness' (not-at-homeness). It is from this mode of existence that the call of conscience emanates. It is a summons from the falleness in the One to an existence that is mostly Dasein's. For Laura this 'summons' arrived when she least expected it and resonates with Crowe's (2006) idea of a sudden and unexpected moment of life-intensification in which a person is confronted with their existence. In that confrontation we discover we are who we are by our own definition and yet there is no final definition. Each definition is open to reinterpretation and redefinition ad infinitum, which Heidegger (1962) refers to as nullity, existence beginning with a 'not'. It is the essence of what I understand as Laura's angst and the essence of what I understand to answer the call of conscience to live authentically.

Laura's angst is related to the fact that as Dasein she is determined by a not; Dasein is thrown into its there, its disclosedness. This is not brought on by itself. Dasein projects itself onto possibilities into which it has been thrown. Dasein does not create the world which defines the possibilities of existence open to it, according to Gorner (2007). Dasein is free to choose from the possibilities disclosed by this 'thrown world'. Whichever way Dasein chooses or not, is done within a context not of its

choosing. Dasein is thus permeated with nullity through and through and its ontological guilt is the existential condition of morality as such. To choose what is morally acceptable or not still leaves Dasein guilty of making choices within a context not of its choosing. What remains is for Dasein to choose to choose himself, i.e. to define the context that will define its being as an authentic existence. For Laura this confrontation with her 'thrown world' and her indefinable strange self was a positive experience. It was a therapeutic experience in a way that helped her to be-with her client in a similar 'pathetic state of being'. To be pathetic is to suffer on the way, etymologically speaking – much like Sisyphus' impossible task of rolling a boulder up the hill of self-definition. For Laura this realisation was a positive experience that enabled her to be with someone in their vulnerability of seeking self-definition, a human reality which often lies at the centre of the problems presented to mental health therapists in my experience.

Following is Elaine's experience of confusion.

> *I immediately realised the reality of it. There was a serious chance that he would do it anyway. So it was not totally unexpected but it was still a shock to get news like that from a telephone call. But for me I had to do it on my own terms.* [Say something more about that need of yours to do it on your own terms.] *That is just how I am; I wouldn't really talk about my insecurities with others. It is setting me free on my own personal journey and coming to terms with it on a spiritual level. And if I think of support for therapists then private time to reflect on stuff is much more valuable. It is the ability to be really bluntly honest to the core. It is a process of letting this man be there. It is more important to me than discussing it with someone or having the need to say it verbally.*

Elaine said that it was important for her to come to terms with her state of shock and confusion on her own terms. Her own terms require her to avoid others and be on her own at a spiritual level with God (Elaine is a self-confessed Christian). She finds this way more valuable to gain self-understanding. It is a way in which she can be *bluntly honest to the core.* Elaine clearly trusts that being with God is the only mode of being in which she can be profoundly honest with herself, where she can own up and face

the existence that is hers. Perhaps she wants to avoid others because she is wary of responding to her crisis of existence by reinterpreting herself once again in accordance with the social/cultural tradition of understanding of what it means to be human. This way of interpretation is fraught with misinterpretations (Dreyfus, 1991). Elaine is understandably grappling with the being she is prior to her being a therapist and she avoids talking with others in her profession about her crisis because she is afraid it may 'murder her with its hoarded realities' (Levinas, 1998) and she could end up 'loosing herself and never wining herself' (Heidegger, 1962) by reconfirming her socially sanctioned role as therapist. Elaine is convinced that being with God at a spiritual level is the only way for her as a therapist in crisis to reach a broader self-understanding. This conviction runs contrary to the Heideggerian notion of being-in-the-world. We are not self-sufficient and independent entities like other entities in the world. We are always out in the world with other human beings and things of the world. That is what grounds human existence. Self-interpretation emerges being-in the world, being active and dwelling among entities of the world. Even when being with God, on our own, we are not on our own without others, and here we have to be mindful of the possibility that humankind created God (Armstrong, 1993). Being with God is therefore another way of being with others, part of our history and tradition of collective self-interpretation. Being with God is a mode of being derived from always being with other human beings. One is not able to exist on one's own, to understand oneself on one's own. "The world of Dasein is a *with-world*. Being in is *Being-with* Others. Their Being-in-themselves is *Dasein-with*" (Heidegger, 1962, p. 155). It may be that Elaine believes that she will foil the misinterpretations which accompany the with-world, if she avoids others. This belief is, however, a denial of an existential reality and instead of broadening her self-understanding she may overlook the being she is entirely. In this self isolating way of trying to be herself she is compounding her lostness in the 'One' (Heidegger, 1962). Being alone among the many is a privation of the being one like the many. Elaine's crisis of existence thus requires resolution in the presence of the other, if we follow Heidegger's notion of being-with.

Is it conceivable that the profession and its institutions that tend to seize and enumerate clients with their hoarded realities do so in all forms of their practice, even in supervision for therapists? If this is the case then there is hope. There is hope that it can be different, because the profession and its institutions exist in the same manner

that humans exist, an existence grounded in self-understanding based on interpretation. Elaine's experience of her crisis and how she responded illuminates this possibility of being-with a therapist in crisis in clinical supervision. The possibility begins with clinical supervision taking a leap of faith. Clinical supervision can open the space for the unknowable beings that we, believe we can find a way of being more true to ourselves when we are in the presence of someone brave enough and honest to the core, to leap ahead with us when we are in crisis.

Conclusions

The crisis of existence suicidal clients talk about in therapy – not knowing what to do and how to live – often resonates within the therapist at a very personal level. Working with suicidal clients confronts therapists with certain professional, institutional and personal issues which bring them to experience their own crisis of existence during the course of therapy.

From a professional point of view therapists experience confusion and periods of being unfamiliar with themselves as they struggle to reconcile the certainty and predictability of human behaviour from a scientific (biological organism) horizon of understanding with the unpredictability and multiplicity of being human from an existential horizon of understanding. From a scientific horizon of understanding therapists conceive of themselves in their 'professional mode' as entities capable of seizing and measuring others with great precision and certainty, whilst as humans in their everydayness they encounter others and themselves in a very different way during the course of therapy. This conflict often leads to a crisis of existence for the therapist. The therapist suffers. But life is suffering and suffering teaches us the necessity of developing personal responsibility for our own subjective lives (Young-Eisendrath, 1998). In May's (1958) view human existence begins on the other side of despair. It would seem that in one's suffering lies hope and possibilities. If one is able to acknowledge and reconcile oneself with the notion that life is suffering, then one is also set free to pursue a more authentic way of being, which Young-Eisendrath (1998) refers to as authentic suffering. This chapter has shown that some of the participant therapists could find it in themselves to acknowledge that they suffered and consequently found that their suffering had meaning and purpose. This meaning and purpose was discovered by way of their acknowledgement and acceptance.

This crisis of existence is not unique to therapists. Their crisis echoes a similar crisis in the existence of psychiatry and psychology. Within the profession the crisis stems from setting out to diagnose people as sick biological organisms and then aiming to treat them as human beings who are no longer living well. Therapists find themselves embodying and living this professional crisis in the course of treating suicidal clients.

From an institutional point of view therapists experience confusion and periods of being unfamiliar with themselves as they struggle to reconcile the expectations of the institution with their limitations as human beings. Institutionalised models of care and suicide prevention strategies have become so 'self-evident' and mechanistic that they forget the limitations of the human practitioners who are required to implement them. The expectations attached to 'best practice protocols' are of an ambitious, unambiguous and mechanistic nature and leave the impression with therapists that they are infallible as long as they adhere to these prescriptions of treatment. In practice however therapists find themselves confronted by this institutionally endorsed misunderstanding of what and who they are. It comes as a great shock and this disillusionment throws therapists into a crisis. They are confronted by their own humanness and mortality which lies concealed under institutionalised models of care.

At a personal level therapists find themselves confronted with what they understand of the meaning of life and death, not only the life and death of a suicidal client, but also their own. This confrontation with their own humanity and mortality comes as a great shock and a source of confusion regarding their own existence and how they understand themselves. They find themselves unfamiliar with who they are, a crisis of existence, as their own life philosophy is brought into stark relief by the turmoil of their suicidal clients. It is an experience which brings the therapists' 'life already under way with still more life outstanding' to the forefront of their consciousness and raises unsettling questions about what it may mean to live as an authentic human being. William and Kane's experience of confusion and their responses show in practice what it looks like to 'choose to have a conscience'. Although the choosing involves emotional turmoil, it became evident that new possibilities of being oneself

are revealed in the process, as William said, you almost transcend yourself in that moment of remembering your fallible humanity.

It would appear within the context of this study that there are deficiencies in mainstream clinical supervision which fail to take the emotional impact of client suicide on the therapist into full account. In this deficiency there is hope because clinical supervision as a human endeavour exists just like humans exist – in self-understanding and self-interpretation. Clinical supervision as an institution of practice in psychiatry and psychology is thus capable of recognising how it exists with still more ways of existing outstanding. Clinical supervision's existence is characterised by its emphasis on evaluation, enhancement of professional competence and monitoring the quality of professional service offered to clients (Howard, 2008). In Howard's view one of the key functions of clinical supervision as practised by health professionals such as psychologists includes the restoration of wellbeing. A narrative method of supervision achieves this in her view, since the emphasis is on collaborative enquiry, where the supervisee is able to 're-author' or 're-story' their experiences in a way that allows more distance from the problem, enabling the supervisee to "reclaim their lives from their problems" (Howard, 2008, p. 109). This method of supervision offers the supervisee an opportunity to reassert their values, hopes and commitments towards the restoration of their wellbeing in times of stress and emotional turmoil. It would thus appear that clinical supervision can attend to both demands, the demand of professional effectiveness as well as enquiring about the experience of the one who is being effective. Being seen as effective does not necessarily equate to being effective. This study has shown that what something looks like is not the same as what something in itself is. Inviting a supervisee into this kind of reflection is venturing into more ways of existing in service of the wellbeing of the supervisee and their client.

Chapter Eight

Discussion

New Zealand has a disproportionately high rate of suicide compared to other OECD countries. The Ministry of Health has made some considerable efforts to address this problem in the last decade. It appears that despite their efforts to develop and implement more effective prevention and intervention strategies, suicide remains a chronic problem for New Zealand. The purpose of this study was to make a contribution by way of understanding what therapists experience in working with their suicidal clients, hoping that it may shed more light on the mainstream prevention and intervention strategies in response to research recommendations.

This study identified three themes in talking to therapists about their experiences. All the participants experienced shock and surprise upon hearing their clients had committed suicide without presenting with signs and symptoms associated with suicidality in their assessment. All the participants experienced the responsibility of assessing suicidal clients and intervening to be a burden. Further, most suffered from guilt and fear of punishment in the aftermath of a client's suicide. A few learned to live in the always-there vulnerability of possibly missing an impending suicide. It was common to find themselves in crisis at a professional and personal level as a result of their experiences and many struggled to come to terms with events.

How do these experiences comment on the mainstream prevention and intervention strategies towards suicidal clients?

This study has shown that therapists are 'thrown' into psychiatry and psychology's traditional way of understanding what suicidality is and that they practise in accordance with this way of understanding suicidal clients. Psychology, and the other disciplines represented in this study, appears to be dominated by research which explains what suicidality is by correlating it with how it manifests, i.e. what it 'looks like'. Bio-psychosocial factors are correlated with suicidal ideation and behaviour leading therapists to adopt a similar mode of enquiry in practice. Like the researchers in the profession, therapist practitioners in this study adopted a dispassionate and

objectifying spectator attitude towards their 'subjects' and understood suicide phenomena as they appeared, literally, without interpretation.

Therapists 'fall' into this positivist mode of understanding. They were encouraged by a critical mass of opinion to also be-with their suicidal clients in a subject-object relationship as they went about assessing clients for risk of suicide, 'measuring' and 'seizing' them with their 'hoarded reality' of 'suicidal factors'. Marrying a client to this 'hoarded reality' appears to be the day-to-day practice of assessing suicidality in institutions of mental health. There are standardized methods and procedures of doing this which gets passed along as 'best practice'.

The repetition of 'best practice' develops a language, a 'common discourse' which speaks about this way of being with a client and articulates their know-how; it affirms their purpose and meaning of being therapists. Everything these therapists encountered in this sub-cultural domain of know-how was passed along as self evident and already known. If there were signs and symptoms of a mental disorder then it increased the likelihood of suicide. If not, then the person is 'not at risk'. If they encountered something that did not fit their framework of understanding it was reduced or transformed. For instance, when a participant said she felt that there was a danger of suicide despite the absence of symptoms, her colleagues said it was just 'worrying'. In this undifferentiated status of being therapists, united in understanding and practice, participants often found that they were caring about matters that concern the institution rather than the client. Three of the participant therapists (Nancy, William & Matt), however, demonstrated a commitment to practice in a manner that focuses on the client. This manner of practice revealed difficulties for these therapists in the face of institutional fears and concerns.

This study has shown that when a client committed suicide in the absence of the self-evident and 'already known' factors associated with suicide, therapists were surprised and shocked. They were unable to articulate the meaning of phenomena that violated their pre-understanding. I have suggested that this confusion has its roots in a natural-scientific attitude of understanding which fails to reveal the life-world of being human. It is a mode of understanding which leads to a misinterpretation of what it discovers because it identifies properties and functions as if human beings are self-

sufficient and independent entities. I have argued that humans are not self-sufficient and independent entities who are constant and predictable in mood and time. We are unique beings who will "forever remain indefinable", and that "my existence and the content I try to give to that" is a "gap [that] will never be filled" (Camus, 2005, p. 17).

This study revealed that therapists can not live or die for another and that it is the client who decides to end his or her existence. No matter how therapists cared for their clients, they committed suicide. That they found themselves powerless to usurp this responsibility created turmoil and conflict for therapists. They felt burdened by a Sisyphean way of being responsible, with scientific faith convinced they could overcome the impossible with will and idealism, only to find the reality of their human frailty sometimes haunting them in guilt and fear. This belief of being able to go beyond their human limitations was how therapists found themselves 'falling' into the misinterpretation of the beings that they are. They found themselves swept along by the tradition of Western thought and philosophy – Godlike with a "narcissistic ego" which "takes itself to be the centre and the all" (Levinas in Peperzac, 1993, p. 49). Therapists in this study found themselves resonating with the traditional wish of psychology which, according to Hillman (1992), wants to be seen as a 'medical' discipline. Whilst the primary intention of the medical profession is to save life – often succeeding with extraordinary feats of practice and knowledge of the neurobiological functioning of a living organism – therapists encountered human existence which is different to human life as a vegetating biological organism. These two incompatible horizons of understanding are at the root of professional and institutional anxiety about caring for suicidal clients, which the profession attempts to resolve with interpretations as if human beings are constant and unchangeable substances, calibrating their moods on a ten-point scale in order to predict what they may or may not do in future.

In their everydayness of being therapists in mental health institutions the participants went about their tasks of assessing, intervening and filling in forms to demonstrate they were complying with 'best practice' methods and procedures. But when their 'equipment' of understanding and practice failed and a client committed suicide despite 'best practice' predictions the situation was 'lit up'. What is concealed by tradition was suddenly revealed. They discovered that the Vail Model (Evans &

Fitzgerald, 2007) of psychological care in research and practice in New Zealand enters into conversation about matters that do not matter for the person present. They found that the medicalisation and classification of psychological disorders could not account for cultural and spiritual factors associated with problems of living. The Vail model of practice, with its idea of practitioners being 'consumers of science', is similar to a production line and workshop in the automobile industry. The aim is to diagnose the problem in the field of operation, to order and replace what is missing by selecting the best part from the conveyor belt of technical laboratory research. As one therapist said, it is just a matter of *knowing which buttons to push.* This is where therapists can find themselves at the outset in their day-to-day work in institutions of mental health care. Therapists are reassured by this culture of care and responsibility where everything is clear and unambiguous. There are rules and formulas just like there are rules and formulas for managing constant and unchangeable substances. It is a recipe for aggregate responsibility and care, instrumental and mechanistic in nature. It is a culture of care in which the therapist can immerse him or herself and be relieved of taking responsibility for the 'history that we are' (Crowe, 2006). I have shown that this undifferentiated mode of being 'one' in mental health institutions reflects the extent of institutional fear and anxiety about caring for suicidal clients. Institutions, such as District Health Boards, try to avoid being blamed for suicides by having formulas and protocols with which they can comply as evidence of their concern and care. I have shown how this institutional fear and anxiety about caring for suicidal clients flows through therapists and can compromise their wish to respond specifically to the needs of the person that is there and present in front of them. Therapists are caught up in embodying the anxiety that lives between the two incompatible horizons of understanding in the profession, between a biologically 'sick' organism and being human. It leaves them confused about whether they are responsible for the wellbeing of their suicidal clients or for the profession and its institutions. It would seem that the burden of responsibility is out of balance, weighted in favour of the formulas and protocols of the profession and institution rather than the suicidal client. The 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. Therapists are probably aware of this reality but seldom become conscious of it due to the societal and institutional pressures to appease their anxiety and conform to their self-protecting expectations.

The three participant therapists mentioned above explicitly demonstrated being consciously aware of these pressures and the turmoil and angst associated with their acknowledged vulnerability towards suicidal clients.

In this present-at-hand mode of care and concern the majority of the participant therapists were not responding to the vulnerable mortality of the other, the 'who' behind the face, or the 'nakedness of the face and its mortality', as Levinas puts it (Peperzac, 1993). In concert with the institutionalised fear of caring for suicidal clients therapists often fell back into the comfort of the collective where they are unburdened and accommodated by a present-at-hand mode of care. This Heidegger defines as an inauthentic existence in which Dasein 'seems to win itself' (Heidegger, 1962). It is a way of avoiding our basic unsettledness. Therapists often sensed the spectre of their client's existential despair in themselves and became afraid for themselves. Most therapists found themselves in a dilemma; to challenge the tradition is to challenge that which sustains their existence. It was a challenge that required them to understand themselves in addition to who the profession may think they are, and this tension manifested as confusion about their meaning and significance as therapists.

Working with suicidal clients confronted therapists with certain professional, institutional and personal issues which brought them to experience their own crisis of existence during the course of assessment and treatment. They were confronted by their own humanness and mortality which lay concealed under institutionalised models of care, challenged with what they understood of the meaning of life and death, not only the life and death of a suicidal client, but also their own. Their 'life already under way with still more life outstanding' arrived at the forefront of their consciousness and raised unsettling questions about what it may mean to live as an authentic human being.

What was revealed when the 'equipment' of institutionalised care and responsibility broke down that was so unsettling for these therapists? I have argued that there is this tacit idea in the profession that therapists are able to control other human beings, a notion endorsed by the critical mass of the profession that we can 'seize and enumerate' another human being. But when their professional 'equipment' failed to

give proof to this they were faced by the facticity of existence that 'human beings will forever be indefinable and strangers to themselves'. These therapists were now confronted by the possibility that the meaning and worth of human existence is to be found in our multiplicity and the way we are beyond cognition and volition, in our lack of definition and strangeness. This revelation runs contrary to the zeitgeist of mainstream psychology and psychiatry that there is unity and clarity to be found in our multiplicity, that there is a singular principle of understanding which will reveal the worth and meaning of human existence.

Suddenly and without warning therapists found themselves in an 'obtuse world', one 'stripped of its involvement-totality' as they encountered an existence that was different to their way of existing. In this mood of 'angst' they felt uncanny, or unfamiliar and not at home anymore. In angst they came to face themselves anew – from the beginning, so to speak – to redefine and understand who they are. I have shown that in this moment of unfamiliarity therapists experienced a 'call of conscience' as they struggled to reconcile this anxious and unfamiliar situation. I have shown that for some it was a 'life intensifying moment' which interrupted their 'downward trajectory of inauthentic life' where they seemed to have won themselves by merging with the zeitgeist of the profession and its institutions. They were summoned by their experiences to carry out a modification of the 'One-self' they were being (verb), their 'falling' momentarily arrested by different possibilities of being therapists.

One therapist was able to reconcile himself with the meaning and significance of this 'life intensifying moment' through supervision which *helped me to rediscover that I am a mere mortal human being* as he confronted the question *what am I trying to control …what was I holding on to.* The importance of choosing to respond to the 'voice of conscience' for him was that it lay down a personal blueprint of experience by which he could be therapeutic with his clients who found themselves in a crisis of existence. The majority of therapists in this study were left floundering in their own personal crisis in the aftermath of their experience of working with suicidal clients. They found that supervision and debriefing consisted of going over their assessment findings and the associated forms and procedures to ensure that they were 'safe' from retribution and that the institution was not liable. How their experiences affected them

personally was not attended to in supervision. This is in keeping with a recent study (Kazantzis, Calvert, Orlinsky, Merrick, & Ronan, 2009), comparing New Zealand psychologists with their Canadian and United States of America counterparts. It found that New Zealand psychologists consider personal therapy (the primary focus of personal therapy is self-understanding) as only a modest positive influence on their professional development. The dominant theoretical orientations of cognitive behaviour therapy in New Zealand place a stronger emphasis on training and supervision in the development of psychologists' technical skills and there is less of an emphasis on personal therapy as part of professional development (Kazantzis et al, 2009). It is perhaps for this reason that the participant therapists had to struggle with their crises on their own because supervision in New Zealand lacks this dimension of attending to the 'voice of conscience' in its practice. Our practice is an extension of how we choose to look at things at the outset. This study has shown that the misinterpretation evident in the ascendant positivist mode of enquiry of what it means to be human flows through all its practices of understanding and into supervision. The notion that therapists exist in self-understanding and self-interpretation is overlooked in supervision which primarily attends to the technicalities of professional development. However, Howard (2008) has drawn attention to how it is possible to attend to the wellbeing of the therapist supervisee without violating the primary concern of clinical supervision with professional effectiveness and technical rigour.

One participant found the interview itself most helpful and said *the process today revealed my own stuff and how the job affects me. Perhaps I should do more talking like we did today to make my job more bearable. Yes, that was helpful. Thank you.* In our interview the spoken word was understood and treated as trying to point towards what Heidegger (1962) refers to as the very thing which the telling is about. We revisited common expressions throughout the interview in different ways and each time we seem to get closer to those moments of sense the telling is about. It 'revealed the stuff' of unfamiliarity itself.

This study has influenced my own practice as a psychologist working in a District Health Board. I comply with the operational procedures that are associated with the assessment and intervention of signs and symptoms of 'mental illnesses'. It is one way in which I keep the organisation's anxiety at bay and also allows me to be-part-

of the community of mental health workers, from which I can not distinguish myself in the first instance. However, I am conscious that what encourages the organisation is not necessarily what engages a client. I am not convinced that a client approaches me for a diagnosis (even when they say they do) and 'coping skills' (i.e. standardised treatment) as much as being vulnerable about no longer knowing what to do and how to live as a result of the circumstances they find themselves in. I no longer trust that a diagnostic impression and its associated treatment options can comment comprehensively on a client's wellbeing and, instead, ask the client to talk about their life circumstances and their symptomatic responses in detail. I make a point of asking them what matters to them, that we are here to talk about that. I seldom hear a client say that a symptom in itself is what matters to them. In the course of therapy we find ourselves circumambulating 'places' and moments of despairing confusion because I make a point of encouraging the client to differentiate between what 'they' say and think and what the client thinks and feels. It is this act of differentiation which seems to bring us back to those 'moments of sense' in the client's telling, again and again, and with each 'passing' we get closer to how the client understands what s/he does when life is like that for them. With each 'passing' the client reveals more about their situation, it confirms who they have become. In every confirmation there is an invitation and I make the arrival of this invitation explicit. That is the place where therapy 'happens'. There is no method which can tell you where that place is; the existence of each client unfolding in our presence reveals the place of what matters to them in need of their care.

Relating my findings to research in the field

The findings of this study reflect some of the research findings and recommendations regarding suicide in New Zealand. In the Beautrais et al (2005) report prepared under contract for the New Zealand Ministry of Health there are a number of recommendations stemming from their review of suicidal risk factors. One of their recommendations is to focus on better recognition, treatment and management of depression and alcohol and substance-use disorders. My study has shown that people committed suicide in the absence of these disorders. The study by Beautrais et al also recommends "the better recognition of the life event, social, family and related factors that may contribute to the development of depression in older adults" (Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005 p. 47). In this recommendation lies the

suggestion that a more comprehensive understanding of a person becomes possible within the context of their life-world as being 'thrown', falling' and 'projecting'. But I have found an over-emphasis on the illness model of suicide in clinical practice and a neglect of the structural aspects of human existence just mentioned. Relational therapy is a therapeutic discipline that appears able to address these existential matters, but the traditional mode of therapeutic practice in New Zealand is cognitive-behavioural therapy. This dilemma resonates with another New Zealand based study into clinical practises towards suicide in CAMHS (Child and Adolescent Mental Health Services) (S Fortune & Clarkson, 2006). Fortune and Clarkson's thoughts prepare the ground for a discussion of my findings and the implications for research and practice which I will attend to shortly.

Fortune and Clarkson draw conclusions that support my own findings. For example:

- In their campaign to destigmatize mental illness, mental health professionals have contributed to the public opinion that suicide is a complication of an illness, namely depression, and that depression is treatable. The result is the public expectation on the one hand and the clinician's fear of suicide on the other is producing some irrational and impractical responses which impact on clinician's ability to function effectively and on managers' ability to maintain a high quality service. I have shown that 'irrational' and 'impractical' responses include the misinterpretation of what clients experience during assessment. Therapists assume a responsibility towards the client that go beyond their human limits. I have shown that therapists tend to mechanically apply rigid practice protocols which aim to match a client with a syndrome such as depression. This is done to protect themselves and the service they work for from recrimination which detracts from rendering a service to the client present and in despair.
- The theory and practice of suicide risk assessment distorts clinical practice when suicide is seen as an illness. Therapists and services use this procedure to make 'predictions' about a person's decisions about suicide, but decisions can change in a instant and it is "little wonder, then, that risk assessment has shown to add little to our ability to predict repetition of DSH [deliberate self-harm] at the clinical level" (S Fortune & Clarkson, 2006 p. 370). My study has

revealed this phenomenon in practice. These authors recommend that clinicians focus their skills on developing an 'interactive and dynamic' relationship which offers some hope for a better future instead of checking items off on a form and trying to measure 'risk'. I agree with this recommendation and will attempt to give it more detail shortly.

- When CAMHS set themselves up as 'proxy suicide prevention centres' in response to public expectations, clinical practice become distorted by focussing on protecting the clinicians and the service rather than attending to the person in need. I have shown how this distortion and confusion is a prominent theme in my study.
- Clinicians must be encouraged to engage fully in the task of "responding flexibly and genuinely" with a client and those who enquire about the adequacy of clinical services after a suicide "need to be careful not to encourage too much defensive practice in front-line clinicians" (S Fortune & Clarkson, 2006 p. 372). I have shown how defensive practice is a prominent theme in my study with reference to therapists' guilt and fear.
- To improve clinical skills these authors recommend, inter alia, attention to the impact on the clinician of their client dying by suicide. My study and the unpublished theses on the same topic mentioned previously identify this omission of care as a constant theme. These studies show how the wellbeing of the therapists coping with client suicide is not attended to in clinical practice and therapists have to, by-and-large, struggle with their confusion and doubts on their own.

I have referred to unpublished theses of therapists' experience of client suicide in the literature review chapter of this study and have indicated that they arrive at findings similar to mine. Here I would like to return to the thesis of Wells (1991), which is of particular relevance to my study regarding the use of a phenomenological method and that which was uncovered. Wells uncovered three prominent and seemingly related themes; therapists' failure (to detect signs of suicide), therapists' omnipotence and therapists' responsibility. These themes resonate with what I have uncovered, namely, therapists being shocked and surprised (suicide in the absence of signs and symptoms), therapists being responsible (often from an omnipotent point of view) and

therapists being confused during and in the aftermath of their experiences. The difference between Wells' work and mine is that I have taken a further step and explored how these themes are related to the 'who' that is experiencing, giving meaning and deciding what to do. My approach was motivated by Heidegger's view that to understand how human beings make their world intelligible requires an understanding of the being that is making meaning and deciding. Whilst my study and Wells' study uncover similar experiences, my study attempts to also uncover the existential structures of being human in our everydayness, which underpin the meaning and significance of therapists' experiences. And, I have shown how these structures can foreshadow therapists' experiences and their consequences. Another study which arrives at similar findings and also employs a phenomenological-hermeneutic method is by Talseth et al (2000). They interviewed 19 physicians at a Norwegian psychiatric hospital about their lived experience in caring for suicidal psychiatric patients. Their findings resonate with my own. Two main themes emerge from their narratives. One theme is where the physicians exhibit 'power over' suicidal patients and the following emerges. They focus on the patients' disease and need for medication, do not listen and do not take part in the experiences that the patients express. They do not accept their own mortality and do not acknowledge their own lived experience with death. They do not accept their own vulnerability and fallibility, and by implication that of the patient. This, says Talseth et al, conveys the impression that the patient does not exist as a human being, but is an object; the person is a treatment problem rather than significant in their uniqueness; the physician's lived experiences of the world is more valid than that of the patient. In the stories where physicians exhibited 'power to' the opposite of the aforementioned emerges, thereby demonstrating a greater capacity to dwell in mystery and apply the knowledge of that which is unique to the person present in their care. Suicide is both problem and mystery for the therapist and in practice it is the art of applying knowledge based on natural science as well as the knowledge about a unique person.

Implications for research & education

The findings of my study suggest a continuation of the shift in emphasis in psychological research and how psychology prepares practitioners for practice. Psychological researchers are challenged to find ways to avoid perpetuating the problem of developing theories about humankind (Kruger, 1979) and pursuing

matters that result in our misrepresentation and misinterpretation of the problems associated with human existence (Heidegger, 1962). This study has shown that positivist orientated research aimed at identifying the bio-psychosocial appearance and manifestations of human existence is insufficient to understand the experience of having to reconcile the existence 'which is mine' with the undifferentiated existence of being 'thrown', 'falling' and 'projecting oneself' in a world not of one's choosing. It is at this junction of the possibilities of human existence where research into suicide prevention and intervention could show promise. It is at this junction of existence that the textures of how one cares can be glimpsed and understood in terms of human despair. I have shown how natural-scientific orientated research results in practices that do not address what matters to the client, showing how therapists focus on the signs and symptoms of suicide rather than the plight of the individual present. I consider it evidence of a misalignment between research and practice when clients committed suicide in the absence of signs and symptoms of suicide. The findings of this study are in support of Todres (2002) and Giorgi (1970) who argue that phenomenological orientated methodologies guard against the danger of defining human beings in reductionist and utilitarian ways. Such studies preserve the essence of the uniquely human dimension of human identity with a (nontechnical) language which cares for the human order. My study has shown how a reductionist way of understanding a suicidal person results in deterministic assessment methods and procedures which close possibilities for the client and the therapist in treatment.

My study has further shown how a natural-scientific mode of enquiry "forms perception(s) which loses sight of its origins and believes itself complete. The first step would then appear to be to return to the world of actual experience which is prior to the objective world…" (Giorgi, 1970, p. 152). The world of human beings begins at the phenomenal level where meaning for the person that is there, is revealed. My study has shown that when the participant therapists adopted a positivist world view and a natural-scientific way of practise, they develop methods of inquiry in which the researcher, subject of inquiry and the participant are considered to be independent of the other (McGrath & Johnson, 2003). The subject of inquiry is seen in isolation from his/her context, whereas in a qualitative approach it is recognized that researcher, subject of inquiry and participant are interdependent. The subject of inquiry is seen to be in dialogue with its context. It is a non-linear pattern of relating in which meaning

emerges as dialectic, something that relational therapy attends to as a priority (Rigazio-DiGilio, 2000).

I have shown and argued that measured phenomena are not equivalent to essential phenomena or the phenomena as they are experienced. In a unilateral understanding of persons (quantity over quality) psychology, from the outset, shows that its "commitment to science was stronger than its commitment to man" (Giorgi, 1970, p. 63) which has left serious gaps in psychology's endeavour to establish a theory of mankind. I have shown how therapists did not have a valid and coherent point of reference against which they were able to account for their experiences because, as Giorgi (1970) points out, *Homo natura* is a phenomenon without consciousness and devoid of human selfhood and, when conceived in this way, amounts to a study of human function and not human existence.

Phenomenological research lends itself to the creative use of language in a field of practice (psychiatry and psychology) where technical language has become the dominant discourse. This sophisticated, often esoteric, and highly conceptual jargon does not touch one as does the language that we use in our daily conversations and in our personal reflections. Phenomenological research by its very nature creates the opportunity to use language which animates and brings to life human experiences in a manner that fosters a deeper connection and understanding of the experiences of living, thereby broadening insight and consciousness. As Halling (2002) notes, well chosen examples and quotes of human experience during the analyses of phenomena, brings the reader and practitioner into a closer relationship with the subject matter. Halling's (2002) criticism of traditional psychology, as opposed to a phenomenological psychology, is that the former gives priority to theory over experience and fosters an overvaluation of 'expertise'.

The findings of this study point in two directions worthy of further research in my view, and there may be others. The one is to research how therapists from different cultures and universities with different philosophic/theoretical orientations experience working with suicidal clients, to understand how those factors influence their experience of suicidal clients within the zeitgeist of mental health practice in New Zealand. The other area to explore is how managers of mental health institutions

experience the requirement to assess and treat suicidal clients. Expanding this study into the areas I have mentioned may reveal different meanings to the 'experience of working with suicidal clients' and perhaps offer a more comprehensive insight into the phenomenon that may augment or influence the current suicide intervention and prevention strategies in ascendance.

Implications for practice

My study has shown how traditional methods of assessment lead to misinterpretations and raises the question: how can a therapist come to know a client in the context of a psychiatric and clinical assessment that would avoid these misinterpretations? How are therapists able to engage with suicidal clients in an 'interactive and dynamic' relationship which offers some hope for a better future instead of checking items off on a form and trying to measure 'risk'?

Traditional psychiatric assessment is linear with its own dynamic of logic and reason. The first step is clarification of the problem with regard to the signs and symptoms of known mental disorders, followed by a systematic inquiry into specific domains of the individual's life that would identify predisposing, precipitating and maintaining factors associated with the presenting problem. The aim of this way of understanding is towards a hypothesis the clinician uses to determine a therapeutic course of action and to what ought to be attended to in treatment. Once the problem is understood and 'psychiatrically known' within this context, the clinician will offer the individual a treatment program which has been shown to be effective for people who have experienced similar problems. I argue that it is as a result of this deterministic epistemology that phenomena are misinterpreted as they are reduced to the clinician's fore-structures of understanding. The emphasis in this mode of inquiry is on clarity and singularity. A hermeneutic phenomenological mode of inquiry provides a concurrent epistemological framework for the psychiatric interview. A phenomenologically orientated psychiatric and clinical assessment requires the clinician to adopt an 'invitational' stance (Bradfield, 2007). An invitational stance offers the clinician the opportunity to attend to the lived world of the experiencing client. It is an attitude which welcomes the ambiguity and ambivalence that unfolds in the client's narrative of experience, an "important constituting factor in the individual's narration of his or her being-in-the-world" (Bradfield, 2007, p. 1).

Ambiguity and ambivalence are those 'moments' where clinician and client are being-with another, examining the meaning and significance of a client's experiences. An invitational attitude is better able to tolerate ambiguity and it guards against the imposition of 'one reality' over another. It is in ambiguity that possibilities come alive and heralds transformation.

It follows from the aforementioned that a hermeneutic phenomenological mode of inquiry is a cyclical process, rather than linear. Traditionally, questions that lead to the identification of a psychiatric disorder are emphasized and given priority during assessment. Bradfield (2007) notes that a linear approach is a fairly rigid and structured attempt on the part of the clinician to formulate an understanding of the individual. It is a linear process with an end objective; it serves the understanding of the clinician in the first instance. I argue that a hermeneutic phenomenological psychology aims to make the meaning and significance of the client's thoughts, feelings and behaviour explicit for the client. A hermeneutic phenomenological psychology creates the opportunity for the client to reflect and re-interpret him or herself within the referential network of their world. Sutton (2008) refers to the activity of a therapist engaging in the referential network of the client as 'opening the interplay of being and world'. In practice it requires the therapist to engage in the activity of reflection and the examination of thoughts and feelings of a client about experiences within their referential network of understanding, says Sutton. With the active involvement of the therapist in the client's interpretation and understanding – which grounds the client's doing – the client develops an awareness of his/her doing which can alter the experience of meaning and engagement in their world.

The aim of a hermeneutic phenomenological approach is to 'disrupt' the taken for granted. Disruption is a condition necessary for transformation and new meaning (Crowe, 2006; McManus Holroyd, 2007). In this manner of being disruptive, 'assessment' and 'intervention' become a cyclical therapeutic endeavour. In a cyclical process there is a fusion of the familiar tradition of the therapist with the unfamiliar history and culture of the client, and visa versa. In this disruption is "the beginning of hermeneutic understanding" (McManus Holroyd, 2007). When someone experiences disruption and disappointment in their understanding they are called to interpretation. This is a learning experience and the person undergoes a radical shift in their

consciousness (McManus Holroyd, 2007). This cyclical process is maintained through narrative where emerging patterns of meaning act as the intersection of two subjectivities (Stanghellini, 2004). It is through this method that Fortune & Clarkson's (2006) idea of an interactive and dynamic relationship can be operationalised, where hope for a better future can emerge instead of checking items off on a form and trying to measure 'risk'.

I support Stanghellini's (2004) assertion that, in addition to their psychopathological knowledge, clinicians give the narrated lived experience of a client informative priority if they aim to attain the goal of a meaningful psychiatric and clinical assessment. As the client's lived world of experience is invited to unfold in narrative, their projected vision of the full range of possibilities of self-understanding becomes manifest. This becomes possible only if the clinician gives equal weight to the phenomena disclosed instead of emphasising only cognitive/emotive/behavioural phenomena which informs the clinician's preconceived categories of understanding (Bradfield, 2007). Narrative is the natural form through which a person attempts to communicate the meaning of his or her experiences. A narrative approach challenges the technical approach in psychiatry where clarity and singularity reigns. The ambiguity and ambivalence inherent in narrative is the 'stuff of psychiatric practice', says Stanghellini (2004), because it animates debate and the opportunity to examine the meaning of different perspectives. The hermeneutic phenomenologically orientated practitioner may want to be mindful of certain 'signposts' in the client's narrative account of being-in-the-world. In Sutton's (2008) view there are some 'fundamental dynamics' that are central to how a client understands him or herself. The 'fundamental dynamic' signposts to being-in-the-world I consider of particular value for the hermeneutic phenomenologically orientated practitioner are care, commitment, time and returning again.

What a client cares about, or says matters to them, gives form and coherence to human life. It animates and gives direction and meaning to doing. Even a statement such as "I don't seem to care about anything anymore", as we often hear suicidal clients say, is a form of care which begs for the active engagement by the mental health practitioner to participate in the client's understanding of how nothing matters anymore. That which a client is committed to belongs to a referential network of

understanding and engagement in the world, and has its own horizon of possibilities. Even when the suicidal client confesses having "no commitment to anything worth while" there is the possibility for the practitioner to participate in understanding how the client's doing is not worthy of his or her resolve. It is a given of existence that nothing is fixed or permanent in time which belongs to being human, even what we care about (or are careless about) or commit ourselves to (or have no commitment to at all) can change in a blink of the eye. It requires the practitioner to be mindful, patient and tolerant of this reality in order to be ready and present with the client and their interpretation of these moments I consider to be potential transformations. In my view 'repetition' is the most important dynamic Sutton (2008) identifies, which refers to the idea of returning again or circumambulating. It is the one which affirms my assertion that assessment and intervention are two sides of the same coin. By circumambulating – returning again – something else or something new is revealed in each passing. The accumulation of shifts and emphases in meaning and significance grow into turning points. The practitioner with patience and resolve will track the client in their transformations of understanding as clients are invited to revisit the dynamic elements which constitute that which they care about (or are careless of) and are committed to (or not committed to), because neither care nor things we commit ourselves to are fixed and permanent in time. It is for this reason that standardised treatment programs are inadequate and unable to meet the demands placed on the profession by people in need of help and support in the life that belongs to them. In the existential reality that nothing in human existence is static or permanent lies the therapeutic necessity to revisit and return to what clients care about and commit themselves to. This is therapeutic practice in the true sense of the word. Revisiting a client's experience of having nothing to care about, or feel committed to, eventually reveals possibilities 'on the other side of the coin' that are worthy of care and commitment. These two 'fundamental dynamics' (Sutton, 2008) of being-in-the world are ever-present and often in their privative modes with regard to suicidal clients.

Can a hermeneutic phenomenological approach towards the psychiatric and clinical assessment of suicidal clients guard against clinicians living out professional and institutional anxiety about suicide? I believe so. The traditional process of assessment opens (limited in my view) a horizon of possibilities for the clinician in practice, one of which, as my study has shown, is the fear about prosecution and recrimination (i.e.

anxiety) which cause therapists to overemphasise their responsibility towards the expectations of the profession and its institutions in relation to the client. Other possibilities of existence in the therapeutic relationship are overshadowed and lie dormant due to the professional and institutionalised anxiety therapists attempt to allay in practice with suicidal clients. In this defensive way of practicing the possibilities of relating with the client is dominated by "what shall I do with and to the client to prevent him/her killing them self?" In my view a broader horizon of possibilities of existence is inherent to a hermeneutic phenomenological psychological orientation. The vision in hermeneutic phenomenology is expansive and its gaze is into the future, concerned about possible ways of living in recognition of all the possible ways of dying (literally and figuratively speaking). With an invitational stance and the informative priority given to the client's story, and the animating intersecting points of two subjectivities, therapist are drawn towards being more concerned and caring of the person with them than falling into the profession and its institutions concern about itself.

Therapists are there to attend to and contain the radical shift of consciousness for the client, but who is present to attend to and contain the radical shift in the therapist? In addition to attending to the technicalities of assessment and treatment during supervision, this study has shown a need to also attend to the radical shift in consciousness that belongs to the therapist. Supervision has a decisive and important contribution to make in this regard and will require a reconsideration of the issues 'admissible' for clinical discussion. Clinical supervision is challenged to 'disrupt' its interpretation of itself as existing for the sake of professional development in the form of technical training and supervising the competent application of technical skills. The horizon of understanding of the members of the mental health profession will remain short and narrow if it cannot open itself to the radical shift of consciousness therapists experience in their practice with suicidal clients. Supervision is challenged by the findings of this study to go "beyond the scope of mere techne" and open the "space that allows the phronesis [wisdom] of practice to be revealed" and to "trust the 'play' of relationship in the supervision encounter (Smythe, MacCulloch & Charmley, 2009 p. 17). I submit that 'the space of wisdom' is created by the suggestions I have put forward to therapists in assessing and treating suicidal clients. A hermeneutic phenomenological approach in clinical supervisors is an epistemological tradition

which can reach beyond the 'scope of techne', since it is interested in the lived experience of human existence and aims to disrupt the taken-for-granted which tends to veil the meaning and significance of experiences. The principles that will best serve clinical supervision for a therapist affected by a client's suicide in my view are: to be 'invitational' in attitude, to give priority to personal narrative and to have a willingness to exchange world views. An exchange of world views opens different possibilities when themes that matter for the client/therapist intersect with the fore-structures of understanding the supervisor brings to the meeting.

Limitations of the study

The findings of this study are limited by the fore-structures of understanding that belong to Heidegger's philosophy and my decision to follow a hermeneutic phenomenological investigation into the experiences of therapists working with suicidal clients. An alternative philosophic worldview may have guided a different approach to this question, would have generated different questions and resulted in findings and conclusions commensurate with that particular philosophy of understanding and interpretation of therapists experiences.

I arrived at the question about therapists' experiences as result of my own fore-structures of understanding that have been shaped by things such as being a registered psychologist in practice in New Zealand, my experience of working with suicidal clients, here and in South Africa – the country of my birth, my training as a psychologist at a university with a psychodynamic and phenomenological orientation to its program, my culture and the traditions I grew accustomed to as a child. These are matters that have made 'my eyes' and 'my ears' see and hear the way they do and have a bearing on how I chose to conduct this study and the approach I followed, and what I came to understand.

A phenomenological enquiry has its own way of understanding which shape the questions asked, the interpretations made and the phenomena revealed. A different method would have posed different questions and uncovered different meanings. My enquiry started with a question that offered the therapist the opportunity to talk about their experiences of suicidal clients. I rarely intervened with inquiry and allowed their stories to unfold spontaneously, asking questions with the sole purpose to ensure that

we kept our focus on 'how' they experienced. There were many moments during our conversation where I could have initiated a different path, a different viewpoint and something else may have emerged. Those moments of decision are a limitation of this study which may have lead to matters of equal importance and relevance.

The scope of this study was also a limiting factor and it needs to be born in mind with regard to the findings and recommendations I offer. All the participants were European therapists working in District Health Boards, who do not reflect the multicultural society New Zealand has become, nor the various approaches and practices of psychotherapy elsewhere in New Zealand. Certain cultures and ethnic groups may experience working with suicidal clients differently, for instance, I am told, that in one particular culture therapists do not experience fear and guilt upon the suicide of a client because 'the person has been called' by ancestors to end their existence on earth.

Conclusion

In this chapter I discussed how therapists' surprise at the unexpected suicide of their clients, their sense of responsibility – in the form of guilt and fear – and their personal crisis in the aftermath are associated with structured and standardised prevention and intervention strategies that are unsuited for the purpose of helping suicidal clients. I have shown how these prevention and intervention strategies echo the misrepresentation and misinterpretation of the natural-scientific tradition of what it means to be human. The therapists' experiences in my study relate to this revelation in practice. Discovering that phenomena are not necessarily what they appear to be, or predicted to be, unsettled and confused therapists' understanding of their responsibilities and what it means to live and die as a human being.

My thesis is that a natural-scientific attitude of understanding in psychological research and practice fails to reveal the life-world of human beings and that suicide intervention and prevention strategies in this tradition of thought do not attend to matters of concern for those living with suicidal despair. I have discussed how the angst of suicidal clients resonates with the profession and its institutions' angst about the impermanence and unpredictability of human existence. There is an error of judgement when the profession attempts to overthrow this existential given with a

reason and logic in research and practice that does not belong to the human order. It hopes to appease its own anxiety by capturing and holding people with certainty and clarity like a specimen permanent in amber. And with that, averts its concern for the anxiety which belongs to the client and his/her existence. I have shown how a phenomenologically orientated epistemology guards against the danger of defining human beings in a reductionist and utilitarian manner and aims to preserve the essence of the uniquely human dimension of human reality. I have recommended that therapists participate in the interpretation of meaning and significance of phenomena that belongs to the person who is there, to adopt an invitational stance and give informative priority to a client's story, as opposed to the structured and standardised assessment and treatment procedures which belongs to psychiatry's categories and classifications. I have suggested that therapists be mindful of the existential dynamics of care, commitment, human time and repetition which will guard against being prescriptive and teaching clients 'skills and strategies' to cope and comply. Attention to these dynamics serves the higher psychotherapeutic aim of a meaningful life which is at the heart of clients living with suicidal despair.

Like natural-scientific understanding, phenomenologically informed research brings with it its own fore-structures of understanding. The difference is that the latter is explicit about what it understands and willing to reveal its vulnerability of 'never really knowing for sure' and thus dependant on the active participation of the other. Why is this vulnerability of phenomenology in research significant? When it enters into dialogue about what is true and real it rests on the affirming foundation that the meaning and significance of real and true belongs to the person, a truth and reality in which subject of inquiry, researcher and participant are interdependent. This character trait of phenomenology, I argue, is more suited to developing theories and methods that are 'for' the human order. In traditional positivist human research the ledger of reality and truth amounts to a calculation and enumeration about physical nature, as if it is human. Phenomenological research lends itself to the creative use of language in a field of practice (psychiatry and psychology) where technical language has become the dominant discourse. This sophisticated, often esoteric, and highly conceptual jargon does not touch one as does the language that we use in our daily conversations and in our personal reflections. A phenomenological approach places priority on the life-world, because it considers this the original order of existence upon which all

conceptual orders, such as logic, mathematics and science rest. Life-world is the "world as we live it prior to any reflection upon it as such" (Giorgi, 1970, p. 134). The life-world is the ground or foundation of all human knowledge and the significance of this is that psychology and other mental health disciplines as human sciences need to account for phenomena in terms of how they appear and not how they ought to appear. The experience of being a therapist to a person who then commits suicide has been revealed in this thesis to potentially leave a profound legacy of guilt, doubt and fear. It is time for the profession to care for its own that they in turn may not shy back from caring for and about the vulnerable other.

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Appendix A

Participant Information Sheet

For psychological therapists

Date Information Sheet Produced: 19 April 2007

Project Title: Therapists' experience of working with suicidal clients.

An Invitation

You are invited to take part in a study that explores the experience of psychological therapists' working with a suicidal client within a variety of health care settings, within the North Island of New Zealand.

Who am I?

My name is Gabriel Rossouw and I am conducting research on suicide in New Zealand. I have worked as a psychologist in the public mental health service since 1996. I have experience working in child and adolescent mental health, adult mental health, inpatient units and crisis intervention teams as a duly authorised officer. My main duties are to help diagnose mental health problems and treat them. I will be undertaking this research as a part time student as part of my PhD qualification at AUT.

What is the purpose of this study?

The central aim of the research is to develop an understanding of therapists' lived experience of working with those who have attempted suicide or have seriously considered suicide. The objective of the research is to recommend additional suicide intervention strategies for mental health services in New Zealand and to uncover any issues expressed by therapists related to their own well being.

The final research report will be available as a doctoral thesis in the Auckland University of Technology library. Articles relating to the research will be published in relevant journals and could contribute to a number of publications such as a chapter in a book. The research findings are also expected to be presented at seminars. The implications for practice from this study may be used in the development of information for managers and health professionals in health service settings.

How was I chosen for this invitation?

The chosen participant is a psychological therapist (which may include mental health nurses, psychiatrists or other related health professionals) who has received a professional education in providing psychological treatment to clients, and resides in the North Island of New Zealand, working within a range of health care services within District Health Boards.

I want to talk with up to twenty psychological therapists who meet the following inclusion criteria:

Participants will be drawn from psychological therapists who are actively working in clinical settings where their roles are primarily of a clinical nature or have a clinical leadership function.

Psychological therapists who are experienced in their practice, with five years or more recent experience.

Psychological therapists who are articulate and able to tell their stories in English.

Psychological therapists from any ethnic group providing they meet other inclusion criteria

Psychological therapists who work in the North Island of NZ

Many of you will be approached by colleagues who know me, or who are participants in the study. Others will hear about the study from me and my colleagues. When you have read this sheet and you have decided to participate, I would like you to contact me directly, or if you prefer I can contact you.

What will happen in this research?

We will arrange an interview, which will be approximately 1 to 1 ½ hours, at a time convenient to you. It is possible that I may wish to interview some of you a second time or have a telephone discussion with you to gather further information. The interviews will be at a place that is private, confidential and agreed on by both of us. You will be asked to tell me stories of your experience that relate to the research topic. For instance I will be asking for you to tell me about your experience of working with a client with suicidal intent or who was considered to be at risk of suicide.

The interviews will be audio-taped and then transcribed. Once the interviews are completed and stories have been drawn from the narratives you will be sent a copy of these. You will be invited to comment on them or delete aspects that you do not want included in the study. Your participation in the study is entirely voluntary and you can withdraw from it at any time until data analysis is completed.

What are the discomforts and risks?

There is potential risk of discomfort and embarrassment. There can be occasions when interviews, such as the ones that you will be involved in, raise past experiences that might be upsetting. If you find that this occurs as a consequence of participating in the research, a free counselling session can be arranged for you. The Adult Mental Health Service in Whakatane would need to know that it is necessary as a consequence of research being carried out through AUT.

What are the benefits?

As a psychological therapist there will be no direct benefits to you from participating in this study. However I have found that some people participating in research of this nature have found it personally helpful and empowering to have their story heard as part of a research project. Also through the research I hope to enlighten both health professionals and their managers about the range of experiences that are aspects of being a therapist to clients with suicidality.

Therefore as a research participant you will be part of a project that adds to the knowledge and understanding in a little researched area.

How will my privacy be protected?

Interviews will be in a place of your choice where you feel assured of privacy and confidentiality. The tapes and transcripts will be confidential to me and the typist who will sign a confidentiality agreement. A pseudonym, used on all material such as the tapes and transcripts, will protect your identity. Audiotapes of interviews and the typed transcripts will be kept in a locked cabinet which only the researcher and research supervisors will be able to access. They will be destroyed 6 years after the study's completion. Every attempt will be made to avoid identification of any person or place in reports prepared from this study.

What are the costs of participating in this research?

The cost for you will primarily be in terms of your time. This amounts to approximately 1 to ½ hrs for the first interview and could be up to another hour if there is a second interview, making a range of a minimum of 1 hr to a maximum of 2 ½ hrs. If interviews are held away from your place of residence, this will add time needed for travel.

Opportunity to consider this invitation

I appreciate you taking the time to read this information sheet and for considering being a participant in my study. If you would like to participate it would be really good to hear from you. Please contact me within 1 month of receiving the participant information sheet.

How do I agree to participate in this research?

If you have any questions concerning participating in this study you are welcome to contact me by phone or email. If you leave a message giving your contact details on the mobile number I can ring you back. You may elect not to go ahead, or I may find you do not meet the inclusion criteria. Once you have agreed to participate a meeting time and place will be arranged that suits both of us. At that first meeting we will go through the Consent Form which will be signed prior to the interview.

Opportunity to receive feedback?

If you would like feedback on aspects of the research, or the results, then we can discuss how this will occur at our initial meeting. At completion of the study a summary of the research findings will be made available on request.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, see below.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz*, 921 9999 ext 8044.

Researcher Contact Details: Gabriel Rossouw (*Registered Psychologist)*

Doctoral candidate
Mobile ph 027 4042 846
Email: gabrielrossouw@xtra.co.nz

Project Supervisor Contact Details: * Dr Peter Greener
AUT, Akoranga Campus,
Private Bag 92006, Auckland.
Ph (09) 921 9999 ext 7187

*** NB: Peter Greener was the primary supervisor when the ethics application was made**

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Approved by the Auckland University of Technology Ethics Committee on *4 October 2007*, AUTEC Reference number 07/128.

Appendix B

Interview Questions

Demographic information: Name, education, occupation, address, contact details and current circumstances.

The researcher proposes to use these questions directed at the feelings, beliefs, convictions and experiences about the theme in question and to guide a hermeneutic conversation (Cutcliffe, Joyce, & Cummins, 2004; Groenewald, 2004).

- Can you think of a specific instance of working with a suicidal person?
- Can you tell me about that experience?
- What were your feelings, your mood, your emotions, and your thoughts whilst working with your suicidal client?
- Are you able to comment on the nature of your experience and what you were taught about suicidal people?
- What are your thoughts and feelings now, upon reflecting back on these events?

Appendix C

Consent Form

Project title: Therapists' experience of working with suicidal clients

Project Supervisor: Peter Greener*

Researcher: Gabriel Rossouw

- ○ I have read and understood the information provided about this research project (Information Sheet dated 19 April 2007).
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that the interviews will be audio-taped and then typed word for word.
- ○ I understand that I may withdraw myself or any information that I have provided for this project up to a month following receipt of the typed stories from the interview transcript, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the report from the research (please tick one): Yes○ No○

Participant's signature:

.....……
……

Participant's name:

.....……
……

Participant's Contact Details (if appropriate):

……
……
……
……..

Date:

Approved by the Auckland University of Technology Ethics Committee on 4 October 2007,AUTEC Reference number 07/128

Note: The Participant should retain a copy of this form.

*** NB: Peter Greener was the primary supervisor when the ethics application was made**

Appendix D

MEMORANDUM
Auckland University of Technology Ethics Committee (AUTEC)

To: Peter Greener*
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 4 October 2007
Subject: Ethics Application Number 07/128 **Therapists' experience of working with suicidal clients.**

Dear Peter
Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 13 August 2007 and that as the Executive Secretary of AUTEC I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 12 November 2007.
Your ethics application is approved for a period of three years until 4 October 2010.
I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through http://www.aut.ac.nz/about/ethics, including when necessary a request for extension of the approval one month prior to its expiry on 4 October 2010;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/about/ethics. This report is to be submitted either when the approval expires on 4 October 2010 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.
You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.
Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.
To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.
On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.
Yours sincerely

*** NB: Peter Greener was the primary supervisor when the ethics application was made**

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Gabriel Johannes Rossouw gabrielrossouw@xtra.co.nz, AUTEC Faculty Representative, Health and Environmental Sciences

From the desk of …
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