Suicide and its Discontent: Practitioner Psychologists' Experiences of Working with Active Suicidal Ideation.

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This research report is my own unaided work

Shane Llewellyn

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Abstract

Suicide is often conceptualised as a harmful, frightening and a misunderstood phenomenon. Research has shown that the theorising of suicide is broad-ranging and complex identifying that working clinically with clients who present with suicide can be challenging for practitioners, and such challenges can interfere in the ways in which practitioners work with suicidal presentations. Building on existing research on the experiences of practitioners working with the phenomenon, practitioner psychologists appear unrepresented within the research. This study aims to qualitatively explore the experiences of practitioner psychologists working with active suicidal ideation. The study asks what the experiences of practitioner psychologists' working with active suicidal ideation are. The rationale for focusing on active ideation helped place a specific focus on researching the phenomenon.

Based on a review of the literature on practitioner's experiences, seven HCPC registered practitioner psychologist were interviewed using semi-structured interviews and participants explored their experiences of working with active suicidal ideation. Interpretive Phenomenological Analysis (IPA) was used to analyse the participant's narrative, and three Super-ordinate themes emerged, 1- Working in Multi-Disciplinary Teams, 2- Working with Suicidal Ideation and 3- Exploring Our Own Ideation. The findings explore the extent to how the participants draw on a range of experiences in order to work effectively with clients who present with active ideation and to what extent working with the phenomena impacts on their ability to work clinically with active suicidal ideation. On the basis of this, it is recommended that policy directives demonstrate awareness of the complexities of the phenomenon, which could have positive implications for positive risk-taking and

wider societal discourses on how suicide is conceptualised and understood. Reflective guidelines for practitioners are also discussed. Further research is needed to explore the Super-ordinate themes highlighted and how these impact on clinical practice and MDT working.

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1. Introduction

This research study qualitatively explores the accounts of seven HCPC registered Practitioner Psychologists' experience of working with clients who present with active suicidal ideation. Interoperative Phenomenological Analysis (IPA) was used to explore the participants account and analysis uncovered three Super-ordinate themes, the Super-ordinate themes are discussed with reference to verbatim extracts of the participants narrative and policy recommendations and implications for practice are discussed.

Previous studies have focused on medical and therapeutic practitioners' experiences of working with suicidal presentations, which go some way towards understanding how experiences can affect practitioners' ability to work with suicidal presentations. There remains, however, a distinct lack of research that focuses explicitly on the experiences of practitioner psychologists working with active suicidal ideation. The reader should refer to the literature review for further detail on this.

This research will seek to expand on previous research on practitioner's experiences and focus explicitly on the experiences of Practitioner Psychologists working with active suicidal ideation in light of how practitioner psychologists' make sense of their own assumptions and experiences in working with clients who present with active suicidal ideation.

It is expected that through understanding the complexities of the experiences of working with active suicidal ideation, Practitioner Psychologists may feel better

equipped to develop more appropriate, reflective and robust ways of working with clients who present with active suicidal ideation, offering personal, professional and organisational benefits. In addition, this research will add to the developing and extensive literature within researching and understanding suicide whilst providing an opportunity for discussion and reflection.

1.1 Terminology and Definitions

There appears to be no uniform set of terms, definitions and classifications for the range of thoughts, communications and behaviours that are related to self-injury behaviours with or without intent to die. Nor is there an agreed taxonomy that encompasses the full spectrum of what is clinically defined as suicide-related behaviours. As a result, it has been argued that researchers cannot effectively compare study populations or results, therefore creating further difficulty for clinicians in translating such research findings into practical applications when working with clients at risk of suicidal behaviours (Silverman, 2006: 9).

This section, therefore, offers an exploration of how suicide is both defined and understood and also attempts to provide clarity with defining the phenomenon of suicide. It also outlines the terms used within this project in relation to suicide and provides the definitions of these terms.

1.2. Suicide

The World Health Organisation (WHO) estimates that the total number of people to have died by suicide in 2004 to be 844000 and accounts for 1.3% of the total global burden of disease (WHO, 2008). In the UK, 6,233 people aged 15 and over died as a result of suicide in 2013, a 4% increase from the previous year. Of the 6233 deaths recorded, 4858 (78%) were male, and 1375 (22%) were female with the most common method of suicide being hanging, strangulation, suffocation and self-poisoning (ONS, 2015).

Suicide can be conceptualised as a harmful, frightening and often a misunderstood phenomenon, which can seem paradoxical appearing to go against basic human motivations of self-preservation and avoidance of pain (Selby et al, 2014). The term suicide, as defined by the Oxford English Dictionary, is the action of killing oneself intentionally. Suicide, therefore, is both understood and defined as death resulting from intentional self-injurious behaviour, associated with any intent to die as a result of the behaviour. Intent can be stated explicitly by the individual or inferred (Posner et al, 2014: 7).

1.3. Suicidal Behaviour

Suicidal behaviour focuses on the range of self-injurious behaviours that a person deploys that involve inflicting self-injury where the inferred intent to die is the reason for the self-injurious behaviour. This is not to be confused for self-harm or non-suicidal self-injury (NSSI), wherein the case of NSSI, it is assumed that the person engages in self-injurious behaviours entirely for a reason other than to end one's life (Posner et al, 2014:7). This understanding is based on the concept of intent and infers that intent becomes the motivator for suicide.

To support this, Crosby et al (2011) postulate that the intent to die and the behaviour must be causally linked, meaning, self-injury or potential for it, occurs as a result of at least a partial intent to die (Cited in Posner, 2014: 8). This point highlights that self-injury is not necessary for the potential to cause/ inflict harm on one's self; however, the driver of suicidal behaviour is the intent to end one's life and not the self-injurious behaviours. To further expand on this, authors of the WHO report,

Multicentre Study, attempt to offer a typology for suicidal behaviour and identifies suicidal behaviour as a function of agency, intent and outcome (De Leo et al, 2006).

Agency, in this case, stipulates that an act of suicide must be self-instigated or self-initiated but not necessarily self-inflicted. Agency must account for any outcome in which the person is directly or indirectly responsible.

Intent, although it is acknowledged that this has been a controversial and critical component of the definition of suicide due to its difficulty to measure and that action may have multiple motivators. Intent, in this instance, refers to the desire for a certain outcome, for example, without intent, it would become difficult to evaluate action as different from that of an accident.

The outcome, in this case, ascertains that suicide must have the actual or believed potential for death as an outcome. Within this understanding, outcome and intent are associated, be it not perfectly (De Leo et al, 2004), because, without intent, a suicide attempt cannot be distinguished from homicide or an accident.

Agency, intent and outcome as outlined by De Leo et al, continue to pervade the most current nomenclature and classification systems to assess and define suicidal behaviour more reliably (Cited in Posner et al, 2014: 4). They also provide a clear distinction between self-harm behaviours and self-injurious behaviours, offering an insight into the classification of suicidal behaviours that goes beyond observable self-injurious acts.

1.4. Suicidal Ideation

Although a generic term, ideation (with or without a plan) is within the commonly used terms that generally describe the range of suicidal thoughts or behaviours (Silverman, 2006) Although there are over 15 definitions within the literature of suicide, ideation in the case of this project, will be defined as a cognitive process and will be viewed as involving the thinking about, contemplating or planning of suicide (Crosby et al, 2011).

1.5. Active Suicidal Ideation

Suicidal ideation can be viewed as involving varying levels of severity based on notions of being passive and active. Beck et al (1979) defined passive ideation as a desire rather than a plan to take one's life and active ideation as a desire to make an active suicide attempt. This classification has helped rank categories in order of severity with active ideation considered more severe than passive (Posner et al, 2014).

To support this, longitudinal studies of suicidal behaviour (behaviour defined as a history of unsuccessful suicidal attempts) have demonstrated that suicidal ideation predicts later suicide attempts in diverse samples of adults and that suicidal ideation can prospectively predict death by suicide in both inpatient and outpatient samples (Koslow et al, 2011).

In the case of this project, Active ideation will be defined along the same themes as Beck et al (1979) and views active ideation as a presentation that involves the intent to make an active suicide attempt with the aim of ending one's life as a result. The

active refers to the energetic pursuit and intent to end one's life, and ideation refers to the ideas, beliefs and feelings (Reeves, 2015) that are bound within the energetic pursuit.

It is important to note that ideation is a cognitive occurrence which is separate from, but also predictive of, suicidal behaviour (Posner et al, 2014). Active ideation requires the intent to die as a necessary condition for suicide. It requires more than just cognition. Therefore, it is important not to render a person's capacity towards suicide down to cognitive states alone; rather, cognitions are a part of the process of suicidal behaviour.

This point has been highlighted because within the definition of active ideation. It would be plausible to assume suicide or suicidal behaviours, are as a direct result of cognitive processes. Such a view would also limit understandings around various other forms of suicide, such as social and collective suicide, these will be discussed later in the literature review. What is important, however, is that's Active Ideation helps distinguish between intent to act and intent to die, indicating suicide as an outcome.

It is of importance to note, that due to the lack of common nomenclature, classification systems and operational definitions within the field of suicidology we lack specific protocols and access to language to help define explicitly the terms we are using, i.e. suicidal behaviour, ideation and so on. We can, however, propose a set of theoretical understandings within the literature, to help narrow definitions and evolve understandings (Silverman, 2006).

We are, therefore, constrained by the existing language within suicidology research. It is hoped that the contributions of this project and further qualitative research can help promote language that is based on understanding suicidal behaviour by placing emphasis on both the complexity of the phenomenon of suicide and human experience. Forging insight in this way would bring further insight and clarity towards defining terms and further understanding of the phenomenon (Hjelmeland and Knizeck, 2010).

2. Literature Review

This section will outline various studies that have focused on medical practitioners' experiences as well as those of therapeutic practitioners. This has been organised in this way as it offers a comparison between experiences of different professional groups, of whom, often provide clinical contact to suicidal individuals. It also provides insight into how important it is to provide practitioner psychologists' experiences as a professional group, as practitioner psychologists' usually work within Multi-Disciplinary Teams (MDT) specifically in relation to working within the NHS.

MDT working for practitioner psychologists' forms part of the standard of proficiency as outlined by the HCPC (HCPC registration is an essential component to working within the NHS). It outlines that practitioner psychologists be able to work, in partnership with service users, other professionals, support staff and others, and understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team (HCPC, 2015).

The literature also identifies the gap in research in which this research is concerned as it is felt, practitioner psychologists' experiences of working with active suicidal ideation is an under-researched and underrepresented area.

Much of the research in the area of exploring practitioners' experiences working with clients with suicidal behaviour tends to focus more explicitly on self-harm in the context of clinical staff, predominantly Psychiatric Doctors and Mental Health Nurses and Medical Practitioners within general medical and Accident and Emergency

departments (McAllister, 2002, McCann et al, 2006, Timpson et al 2012, Crawford et al 2003, McAllister et al, 2002, Saunders et al, 2012).

In a systemic review of the literature, Saunders et al (2012) reviewed 74 studies based on staff attitudes towards and knowledge about people who engage in self-harm in medical settings where staff were involved in the provisions of services to them. The results highlighted the extent to which medical and nursing staff in medical settings viewed those who self-harmed in a negative way. Negative views tended to manifest in feelings of frustration and sensations of failure amongst medical staff with more negative attitudes being expressed toward individuals who presented with repeated instances of self-harm.

The authors highlighted that the restraints placed on medical staff within A&E departments are in large, based on limitations of resources, provisions and more specifically time, which could account for such negative attitudes. The authors are attempting to make links between resources and environment in an attempt to explain how such negative attitudes may arise. However, such an investigation fails to promote a reflexive insight into how such negative attitudes affect care and outcomes.

In a similar study that looked at practitioners' attitudes, Dressler et al (1975) postulate that negative attitudes are correlated to feelings of anxiety towards patients who present with a high risk of suicide. They expand on this further by highlighting that feelings of anger and frustration correlate specifically with feelings of anxiety.

Usually, in such cases, this is often due to when clients present with suicidal behaviours in the absence of recent precipitating events.

This latter point appears to offer an insight into the possible correlations between emotional responses and how these can impact negatively on practitioners' experiences. To expand on this further, Pompili et al (2005) explored emotional responses and identified that both nursing staff and Doctors within A&E departments reported not enjoying caring for clients who present with suicidal behaviours. This was in large due to the anxiety and fear about saying the wrong thing to clients that present with suicidal behaviours, which often leads to the stigmatisation of the suicidal individual.

This point highlights that it is perhaps the externalising of negative reactions, rather than organisational pressures, that may account for negative attitudes toward suicidal individuals. This is an important insight because feelings of anger and frustration should not be denied nor acted out, but rather, handled with specific resources such as further training, supervision or psychotherapeutically (Pompili et al, 2005).

Within the literature, the focus on emotional response appears prevalent and attempts to offer possible insights into how this can shape the experience of practitioners. This is also not specific to medical practitioners' that has only been of focus so far. Emotional processing is also prevalent within the literature on therapeutic practitioners.

Reeves and Mintz (2001) in their exploratory study that examined the experiences of counsellors working with suicidal clients highlighted the range of experiences felt by counsellors, from feelings of anxiety, fear, panic and feelings of doubt that counsellors felt made them question their professional practice and competencies in working with suicidal clients. A similar study by Rossouw et al (2011) who explored thirteen therapists (five of which were psychologists) experiences of working with suicidal clients.

Rossouw et al (2011) found therapists experience a range of emotional processing similar to that identified by Reeves and Mintz (2001). However, the authors also highlight the conflicts that can arise from working with suicidal presentations especially between prevention and intervention strategies in relation to the therapist's responsibilities and what it means to live and die as a human being.

To support this, in their study that looked at therapists' experiences, Gurrister and Kane (1978) interviewed 27 therapists regarding their different theoretical formulations regarding suicide and their therapeutic preference in working with suicidal clients. The interviews were centred on the therapist's view of suicidal clients, their therapeutic preferences and their agreement or disagreement with various views of suicide (Cited in Palmer, 2008).

Gurrister and Kane focused their summary of findings on therapists' idiosyncratic understandings of suicide based on their recognition of the severity of suicide in terms of mental distress and reported they felt as though they should prevent attempts of suicide for the needs of the client and that this can cause moral and

ethical conflicts. This is largely based on the therapists' ability to empathise and understand the client's distress, promoting a deeper understanding of the functions of suicidal behaviours.

This insight provided above is an interesting one as it highlights a sense of difference between therapeutic practitioners’ and both general medical and psychiatric staff working within mental health contexts. Highlighting that therapeutic practitioners demonstrate an ability to hold ambivalence with suicidal clients and appear to be able to attend to the clients presenting issue despite the emotional responses felt.

In their meta-synthesis of 13 qualitative studies of counselling and psychotherapy for the prevention of suicide, Winter et al (2014) made reference to the importance of the therapeutic relationship in working with suicidal presentations. They identified a consensus amongst therapeutic professionals that effective therapists are understanding, empathic and non-judgemental.

The therapeutic relationship, therefore, becomes an essential arena towards understanding and working with suicidal clients. It enables practitioners to concentrate entirely on the client as a whole and explore with them their understanding of themselves (Reeves, 2010). It prioritises idiosyncratic understanding based on the clients lived experiences and facilitates movement on behalf of the client so that they can explore other solutions other than suicide (Moerman, 2012).

The therapeutic relationship in this instance appears essential. To support this, Konrad (2011: 13) argues that without a robust and collaborate therapeutic relationship, practitioners by virtue cannot expect to be successful in their interventions with suicidal clients. The therapeutic relationship, therefore, becomes an indispensable vehicle for successfully engaging and working with suicidal clients, (Jobes & Ballard, 2011) and is critical in the achievement of positive outcomes when working therapeutically with suicidal clients (Konrad and Jobes, 2011; Schechter and Goldblatt 2011).

This is an important comparison because it promotes a difference in understanding, exploring and working with, suicidal presentations. These differences could be understood in relation to reflective practice and the use of supervision of which are embedded within the psychotherapeutic professions (including practitioner psychologists) and not within other professional groups in the same way.

The significance of supervision with its normative, formative and restoring functions of therapeutic practice (Reeves, 2010) promotes self-reflexivity and space for exploration and containment. It is perhaps this, that offers therapeutic practitioners' the ability to hold ambivalence with clients and ‘process'' this, as it will within supervision, enabling the therapeutic practitioner to work through the emotional processes in meaningful ways facilitating self-awareness and insight.

This insight facilitates a need to attend to the process arising in the therapeutic situation, more specifically, transference and countertransference responses with suicidal presentations. The process of transference involves reactivation of the

client's previous experiences, recollections and unconscious wishes regarding (often early) significant people. Countertransference comprises all of the practitioner's unconscious reactions to the client and the client's transference (Leenaars, 2004).

Suicidal client's, for instance, could feel angry and rejected due to their state of mind when coming into contact with professionals and may feel negative or ambivalent about their case. Suicidal clients may deploy the process of projective identification, a means by which unconsciously clients attempt to communicate their feelings and experiences to another person, as a way of expressing such feeling (Richards, 2000).

Suicidal clients are perhaps amongst those who rely heavily upon projective identification as both a defence and as a means of communication. It is from this process that the practitioner may experience arousal of intense emotion and the therapist, therefore, becomes a receptacle for the difficult feelings that form part of the client's inner world (Richards 2000). The client may provoke feelings of guilt, incompetence, anxiety or fear in the practitioner when these feelings are not worked through (Leenaars, 2004:101).

Countertransference reactions are frequently elicited within therapeutic work, especially in relation to suicidal client's, and it is perhaps such countertransferential processes that aid in our explanations when considering the experiences of practitioners' working with suicidal presentations. It adds further depth and insight into the phenomenon and also highlights the possible dangers of not attending to countertransferential processes.

Modestin (1987) proposes the notion of therapeutic constellations- (1, coping with client's aggressiveness 2, tolerating client dependency 3, adequate handling of erotic transferences and 4, preserving loyalty towards the client) and postulates that negative countertransference reactions and the therapists failure to work through such constellations, may contribute to clients completing suicide. Modestin raises an interesting point because she is highlining the necessity to both explore and understand the factors that may contribute to the phenomenon that are a direct result from therapeutic interactions. It calls for mastery of the countertransferential process and effective insight.

There is a sense that in order to effectively negotiate, explore and understand the clients suicidal ideation, there is a need for understanding that is based on the clients frame of reference to avoid enactment of such negative countertransferential processes. There is a sense that the fostering of a sincere, empathic and congruent relationship with the client enables the practitioner to explore the suicidal ideation from the frame of reference of the client and not the practitioner (Jobs and Ballard, 2011), otherwise known as empathic fortitude (Jobes 2016: 48).

The importance of transferential processes within the therapeutic exchange highlights a need to explore suicide within the client's terms whilst simultaneously being aware of the processes at play of both transference and countertransference. This it would appear, is embedded within psychotherapeutic work and the support systems of supervision and reflexivity facilitate safety and openness.

Given that this project is concerned with that of exploring experiences of practitioner psychologists, it is important, therefore, to explore literature specific to psychologists experiences whilst maintaining focus on the themes highlighted above regarding the therapeutic relationship, reflexivity, transference and supervision as these are also embedded within the profession of psychology.

There appears to be little research that explicitly focuses on practitioner psychologists' experiences of working with suicidal presentations as most research tends to focus on the experiences of a client being successful with suicide.

In a study that focused on psychologists' understandings and experiences of suicidal clients, Wreth (1996) argued that although psychologists reported that's they felt as though they had a professional and moral duty to preserve life, psychologists also reported exceptions to this. The psychologists reported an understanding of the function of suicide and understood suicide as being contextual and appropriate within certain contexts, specifically in relation to cases of severe pathological and life-limiting illness such as cancer.

However, despite these understandings, the participants explained that they would not allow these beliefs to interfere with their therapeutic work with clients and placed great importance on the therapeutic relationship (Wreth, 1996). The psychologists interviewed, appear to be open to the functions of suicide; however, they do not necessarily allow such exceptions to interfere with therapeutic interventions with clients.

To expand on this notion further, in a study which looked at Australian psychologists' attitudes toward suicide and self-harm, psychologists displayed positive attitudes towards working with suicidal client's and also expressed beliefs in the right of an individual to decide when to die (Gagnon & Hasking, 2011). However, this paper called for developing future research to explore the impact of psychologists' attitudes on their behaviour towards clients who present with suicidal ideation.

There is a sense of a humanistic value within our understandings here and that understanding the subjective worlds of self and other needs to be central in our enquiry (Woolfe et al, 2010). Although the authors do not explicitly focus on this, it could be argued that this offers an interesting insight into how psychologists experience working with suicidal clients as the research focuses more exploring on the functions of suicide rather than the emotional processes that guide understanding.

This then presents an opportunity to explore further practitioner psychologists' experiences in working with active suicidal ideation as they appear underrepresented in the literature and the explicit focus on active ideation it is hoped, would capture the psychologists' emotional and reflexive processes. It is felt that a qualitative method of enquiry would be best placed to encompass what it is really like for practitioner psychologists working with active suicidal ideation as it focuses on human experience to help foster meaning.

This has been mentioned because within the systematic review of the literature presented earlier by Saunders et al (2012), of the 74 studies identified, eight were of

mixed methods and only thirteen were of qualitative design. Of the thirteen qualitative studies examined, only one made reference specifically to psychologists experiences of working with clients who display suicidal behaviours (Saunders et al, 2012) and none have made specific reference to experiences of working with active suicidal ideation.

From this standpoint, the possibility of exploring and understating the subjective lived experiences of the practitioner psychologists' themselves when working with active suicidal ideation arises as there appears to be a lack of research that focuses explicitly on that of practitioner psychologists and more specifically, experiences of working with active suicidal ideation. This will also build on developing further insight into developing further clarity and understanding towards defining terms and further understanding of the phenomenon, which will be based on exploring human experience (Hjelmeland & Knizeck, 2010).

The research presented in this section offers compelling insights into the experiences of medical practitioners and therapists' when working with suicidal presentations. The work detailing therapists' experiences hold the therapist at the centre of enquiry. The inner world of the therapist is of central concern, and this provides insight and understanding into the practitioners' experiences of working with suicidal ideation.

It is from this practitioner perspective that this research qualitatively explores the experiences of practitioner psychologists' working with active suicidal ideation. This research seeks to expand on previous research on practitioners' experiences of

working with suicidal presentations and focus more explicitly on practitioner psychologists to provide a homogenous cohort within the context of this project.

2.1. Theoretical insights

Theories in suicide range from those involving biological causes (Mann, 2009), to internal conflicts that drive a desire for death (Freud, 1917, Klein, 1975), to societal structures that promote suicidal behaviour (Durkheim, 1897). This section will discuss theories of suicide in an attempt to explore the phenomenon further adding insight into the complexity of theorising suicide.

2.2. Biological Theories

Biological theorising of suicide depicts that increase risk of suicide may result from interactions between genetic, biological predispositions and life stressors. Diathesis, an inherent physiological risk component to suicide, can become aggravated through environmental factors (stress) and it is the combination of diathesis and stress that may result in suicidal behaviour (Selby et al, 2014).
Dysregulation of the neurological transition systems, including the serotonergic, noradrenergic and dopaminergic systems and the HPA axis are understood to been linked to family history of suicidal behaviours (Mann et al, 2009).

The concept of diathesis and stress is an interesting one from this perspective as it relates to a combination of factors such as sex, familial genetic components, childhood experiences and psychosocial support systems (Stanley et al, 2010).

Stress, in this case, is viewed as having dual perspectives. Firstly, exposure to stress in early life can have lasting potentially detrimental effects on the development

and function of neurobiological systems, which are thought to correlate with the effect and regulation of behaviour and cognitive function. Secondly, impairments in stress response systems may be directly involved in suicidal behaviour (Currier and Mann, 2008). In both contexts, the assumptions are that genes may contribute to altered neurobiological functioning.

Within this perspective, predispositions are viewed as interacting with the environment and offer insights into how our genes can affect outcome. However, such predispositions such as neurotransmitter dysfunction, although useful, it does not account for how such predispositions result in increased suicidal behaviour or indeed how environmental factors can trigger such dispositions (Selby et al, 2010). Furthermore, such a view would appear reductionist and fails to encapsulate a true ontology of self.

2.3. Psychoanalysis of Suicide

The psychodynamics of suicide hold their roots in Freud's observations of Melancholia and arose out of drive theory and the topographical model of the mind (1917) and has subsequently been followed by many psychoanalysts, from Klein (1957), Abraham (1924), Kernberg (1984) and Shengold (1993). Others, however, have conceptualised aggression as being reactive to the environment in the tradition of studying the impact of deprivation and trauma on children following Ferenczi's (1993) work, which focused on the effects of abuse on children (Perelberg, 1999).

Aggression can also be seen as a reaction to an experience of danger, such as breaks in attainment (Stern, 1985), impingement (Winnicott, 1971) or as a defence against threats to the psychological self (Fonagy et al, 1993). Aggression can also

be conceptualised as reactive. Kohut (1977) for instance, argued that aggression is related to the experience of empathic failure resulting in narcissistic psychopathology.

The term aggression, therefore, has been used in an attempt to cover a wide range of behaviours, from self-assertion to destructiveness. Despite the different use of the term, aggression across the plurality of psychodynamic formulations from drive theory to ego psychology and object relations (Perelberg, 1999), there appears to be a consensus regarding its importance in the understanding of suicide.

Freud's drive theory involved conscious and unconscious libidinal and aggressive urges that had to be defended against. Freud argued that if such libidinal and aggressive urges are not successfully defended against, this can lead to symptoms and suffering. In Mourning and Melancholia (1917), Freud suggested that in melancholia (where there is ambivalence toward a lost object), the ego splits and part of the ego becomes identified with the abandoned object, so that hostility related to the object continues and is directed onto the ego (1917). It is from this that the person is able to attack the self and kill the self in the process of killing the ambivalently held object (Goldbat, 2014).

In 1920 Freud described a second mechanism for suicide, which he linked to the death instinct (Thanatos), which is operative from birth and is able to undo connections and destroy things whose final aim is to lead what is living into an inorganic state (1920: 148). Freud is making sense, through his clinical observations of the unconscious, repetition of behaviours and experience that may be painful or

self-damaging (Sandler, 1997). From his observations, Freud contrasted the death instinct with the life instinct (Eros) whose aim Freud argued was to establish and preserve unities (1920).

Freud later elaborated on this in The Ego and the Id (1923) where he described that the superego becomes so harsh in its attacks on the ego that it abandons the ego and leaves it to die (Goldblatt, 2014). For Freud, melancholia includes the mechanism of introjection and suicide could be understood as being directed against the introject. To support this, Menninger (1938) elaborated on Freud's notion of introjection of the lost object with displacement of feelings that were initially directed toward the object, are now experienced in relation to the self.

Menninger emphasised primitive oral phantasies in formulating a suicidal triad consisting of three unconscious wishes. The wish to kill, the wish to be killed and the wish to die, all of which relate to the three areas of mental functioning the id, ego and super ego. All three related to the oral phase of development and correlate to aspects of taking in and spitting out aggressive feelings. The implication of the presence of all three, Menninger argued, resulted in the fatal outcome of death from suicide (Cited in Goldblatt, 2014: 257).

Although Freud's contemporaries distanced themselves from the notion of a death instinct (Kohut 1977, Bowlby 1984), Klein (1975) placed great emphasis on the death instinct into her theory of development. For Klein, the unconscious is universal and constitutional in that it involves unconscious phantasies and derives from the death instinct. The death instinct starts from the moment of birth and is linked to the trauma

and pain of birth itself. The external environment has a fundamental role in the amelioration of persecutory anxiety, and Klein emphasised that good relations to both the mother (object) and the external world help the baby overcome its early paranoid anxieties (Klein, 1975 cited in Perelberg, 1999: 19).

Klein was of the opinion, following on from Freud, that the infant is threatened by destruction from within immediately following birth (1975). Freud suggested that Eros intervenes and re-channels the death instinct through two mechanisms arguing most of the destructiveness is turned outward onto others (sadism) and some remains as primary erotogenic masochism (Greenberg and Mitchell 1983).

Klein, however, proposes a third mechanism emphasising that an additional part of the death instinct is projected onto the external world. In this account, Klein alludes that Eros actually phantasies' an external object, projects part of the death instinct onto it and redirects the reminder of the destructiveness outward onto the newly created object (Greenberg and Mitchell, 1983: 132). This insight enables the production of both good and bad objects and refers to the mental and emotional image of an external object that has been taken inside the self (Klen, 1975).

The mother'' breast is of primary focus as Klein views the development of infants as being governed by the mechanisms of introjection and projection (Klein, 1935). The ego is central to introjection as it has the capacity toward internalising both good and bad objects of which the mother's breast is central. The phantasies of introjection of good/ bad objects are distorted images of the real objects upon which they are

based; they become instilled not only to the outside world, through the process of incorporation, they also become instilled in the ego itself (Klein, 1935).

The importance of the environment for Klein highlights an interesting observation because although the life instinct counteracts the strength of the death instinct and to the continual process of interaction between projection and introjection. The environment or rather the reality of it has an impact on the infant's constitutional unconscious phantasies, and that good experiences can explicitly modify the persecutory inborn phantasies (Perelberg, 1999). However, the importance of the environment is further detailed when considering suicide.

Unlike Freud, who ascribed the meaning of suicide as a process of introjection ie, as being directed toward the introject Klein although acknowledges this, also alludes to the importance of external objects alongside the introjected objects.

Klein postulates that although while in committing suicide the ego intends to murder the bad object, it also simultaneously always attempts to save the love object, external or internal. Within this, the phantasies underlying suicide aim to preserve the internalised good objects but also destroys the other parts of the ego that are identified with the bad objects and the id. The ego is therefore able to unify with its loved objects. However, Klein also highlights that the same phantasies can also relate to the external world and real objects, partly as substituted for internalised ones (Klein, 1935: 276).

Suicide, in this instance, may be related to the hatred of not only the bad objects but also the id. The suicidal act therefore may represent a breach in the relation to the outside world due to the desire to rid some real object, or the good object which represents the whole world which the ego identifies with, or the part of the ego which is identified with the bad objects and the id (Klein, 1935: 276). Suicide, therefore, is a complex interaction between the ego, its introjects and external objects.

2.4. Beyond the Individual

The psychoanalytic perspectives presented very much locate suicide within the individual, participating in mapping a contemporary regime of truth viewing suicide as pathological and a matter for psychiatric concern. Such regimes force the trajectory of suicide from once being a moral, theological and criminal issue towards, in most part, to psychopathology and mental illness (Marsh, 2010). Within this understanding, Hill (2004) argues that the suicidal person becomes characterised as in some way morbid, isolated and driven to end one's life by some peculiarly internalised torment.

This apparent linkage of mental illness and suicide appears to be an uncritically universal regime of truth within psychiatry and mental health professionals. Suicide is seen as relevant and essential within mental health training from Psychology (Shneidman, 1996), Cognitive Therapy (Freeman and Reinecke, 1993), Dialectical Behavioural Therapy (Leinham, 1993), Mental Health Nursing (Anderson and Jenkins 2002) and Occupational Therapy (Gutman, 2005), all of which address suicide within profession-specific writings.

However, what appears common within these writings is the assertion of a psychiatric assessment and possible treatment for those who present as a danger to themselves (Marsh, 2010). Indeed, even within therapeutic contracting, risk to self or others is deemed worthy of breaking confidentiality (Bond, 2015). This it would appear is also inscribed in law, under the Mental Health Act 1983 Section 12 Approved Doctors have the power to detain and treat people deemed a risk to self or others. This it could be argued 'concretes' psychiatry's role in not only the apparent treatments of suicide but also our philosophy and clinical guidelines of practice. It also adds further support towards the pathologising of suicide placing it even further within the individual.

In an attempt to move beyond a sole individualisation of the phenomenon, sociological perspectives could facilitate a move beyond individual interpretations of suicide and allow us to broaden our repertoire regarding the systemic or societal factors involved when thinking critically about suicide. Emile Durkheim (1897), in his book Le Suicide (1897) provided a comprehensive insight into death by suicide by exploring how social forces can be the primary cause of suicide. Durkheim's theory was one of the first to address the societal level of suicide, demonstrating a shit from an individual perspective.

Although criticised for neglecting variables on an individual level, being unable to account for individual difference/ factors, Durkheim has created a foundation of understanding on a societal level based on potential explanations in shifts in suicide rates over time and being able to associate these shifts with important societal factors (Selby et al, 2014).

Durkheim suggested that suicide is a result of disturbed regulation of the individual by society and that society has two primary forces: social integration, the degree to which individuals are integrated into society (social groups) and moral regulation the degree to which society regulates beliefs and behaviour (societal norms and legal system). Durkheim argued that the more socially integrated an individual is, receiving their aspirations regulated through social norms, it less likely someone is to commit suicide (Durkheim, 1897).

Durkheim was eluding to the need for structure and regulation of social systems in a person(s) ability to exist in unison and should any deficits in structure/integration or regulation occur there is a greater chance of suicide. Durkheim identified four primary types of motivation for suicide, each of which results from either extreme on one of the two primary forces, egoistic (loneliness- low social regulation), altruistic (suicide benefit society- high social regulation), anomic (societal disengagement- low moral regulation) and fatalistic (societal oppression- high moral regulation).

Despite the projective quality of Durkheim's work, the sole idea of failings in societal, regulatory systems being responsible for the main motivator of suicide does appear to raise more questions than answers. However, it does highlight the importance of societal structures, regulatory or otherwise, on a person(s) functioning or indeed positioning within society. It could be argued that it places emphasis on the importance of society as an ‘arena' of negotiation and regulation.

Biological, psychoanalytic and sociological perspectives on the theorising of suicide have been presented in an attempt to highlight the broad yet complex nature of theorising suicide. The aim of organising in this way is to demonstrate the various forms of and motivations for suicide and how attempts of theorising can help inform our clinical insight.

However, upon reflection, it is felt important to note that such theories should be held lightly in their assumptions. This has been noted because it can be inattentive favouring one insight over another as this jeopardises
Dogmatising a person(s) account in light of theoretical prejudice. This is especially relevant when considering the clinical implications of assessing or working with suicidal presentations.

2.5. Interpersonal Theory of Suicide- Forging a Deeper Meaning?

The interpersonal theory of suicide postulates that people die by suicide because they can and because they develop both the desire and capability to do so. According to the interpersonal approach, humans are not designed for self-destruction and the only ones who are capable of death by suicide are those who have been through enough past pain and provocation and have habituated to the fear and pain of self-injury, that the self-preservation urge can be beaten back (Joiner et al, 2009: 5).

According to the theory, the most dangerous forms of suicidal desire are caused by the simultaneous presence of two interpersonal constructs- thawed belongingness (not feeling accepted or belonging to others) and perceived burdensomeness (belief

that one is a burden on society), and that the capacity to engage in suicidal behaviour is separate from the desire to engage in suicidal behaviour (Van Orden et al, 2010). There is scope within the theory to measure the sense of both thawed belongingness and perceived burdensomeness and this is on the basis of measuring acquired capacity for suicide (ACS) which have demonstrate construct validity (Rimkeviciene et al, 2016).

What the interpersonal approach highlights is an inter-relational aspect in attempting to explore the phenomenon of suicide. It locates suicide as interlinked between the individual and the wider social structures and postulates that the presence of both thawed belongingness and perceived burdensomeness correlates to a heightened desire for suicide. However, this alone does not account for the act of suicide, rather thawed belongingness and perceived burdensomeness are perceived as related constructs (Van Orden et al, 2010) that heighten the desire for suicide.

It is the overcoming of instinctual life-preservation systems that leads into the acquired capacity that increases the risk of suicide, and it is this that can account for the overcoming of instinctual self-perseveration systems leading to the death by suicide (Jointer, 2005). This is often reflected in the engagement of past suicide attempts, self-harm, frequent exposure to or participation in, physical violence and self-injecting drugs. All of which, act as indicators for the acquirement of suicide and are predictive of future suicidal attempts (Jointer et al, 2009).

The interpersonal approach offers an insight into exploring suicide and its intent that appears to focus on all aspects involved in a person's life. It does not favour

individual or social factors; rather, it provides a full, holistic stance regarding understanding the possible factors involved in those who attempt or are successful in their pursuit of self-destruction.

Although the interpersonal approach does offer compelling insights, specifically in light of thawed belongingness and perceived burdensomeness, it is important to hold these concepts lightly. This has been mentioned because the interpersonal approach is quite assumptive in that thawed belongingness and perceived burdensomeness are the ‘ingredients' essential for the desire of suicide to arise. This may not actually be the case however, for all suicides across all cultures, and therefore, we should remain critical of overemphasising specific approaches to understandings potential reasoning behind factors that contribute to suicidal presentations.

2.6. Theoretical Insights of The Therapeutic Treatment of Suicide

Dialectical Behavioural Therapy- DBT

To help broaden the understanding of suicide further, it is appropriate to explore theoretical understandings that may influence how suicide is both understood and worked with clinically. Marsha Linehan proposed a biopsychosocial theory of suicide (based on suicidal women who did not benefit from CBT) and theorised that biological deficits, exposure to trauma and the failure to acquire adaptive ways of tolerating and handling negative emotion all contribute to suicidal behaviour (Paniagua et al, 2010).

Within this understanding, an individual would engage in emotional regulation mechanisms in times of distress, and when these fail, the next step is to engage in

self-injury in an attempt to regulate emotions. When these mechanisms have broken down or potentially never adequately developed, the resulting outcome is emotional dysregulation that leads to the acquired capability to enact lethal self-injury (Paniagua et al, 2010: 9).

Clinically, Linehan (1993) argues that suicidal ideation should always be analysed in-depth and never ignored and that the treatment of suicidal individuals requires a structured protocol for responding to the suicidal ideation. Protocols in this instance are aimed at reducing malpractice anxiety of practitioners by providing standards of care in both assessment and management (Linehan et al, 2012).

The use of a protocol provides the practitioner with a defensive measure (Linehan et al, 2012) in that it equips the practitioner with an evidence-based approach to treatment. This, in essence, encourages the practitioner to explore the suicidal ideation using empirically grounded methods facilitating validation of the client's ideation whilst promoting confidence in the practitioner (Linehan, 1993). The notion of promoting confidence is an interesting one because Jobes et al (2008) highlight that clinicians report issues of competency around the thorough assessment of suicidal risk and highlights a lack of evidence-based interventions for the treatment of suicide.

The therapeutic task within Linehan's theory of suicide, therefore, promotes an active involvement on behalf of the therapist. The therapeutic task is concerned with responding actively enough to stop the client from inflicting serious harm or death

and doing so in such a way that will reduce the likelihood of future suicidal acts (O'Connor et al, 2011).

It is felt Linehan's theory of suicide encompasses both the difficulty and complexity of suicide and its discontent; however, it has been explored here in an attempt to bridge both a clinical and theoretical understanding of how suicide can be conceptualised and worked with. It has also highlighted the importance of the therapeutic practitioner being able to tolerate and validate the client's suicidal ideation, whilst seeking to replace suicidal behaviour with life-affirming coping skills.

Cognitive Therapy for Suicide Prevention (CT-SP)

CT-SP, is a brief, targeted and evidenced-based cognitive-behavioural psychotherapy that is specific to the treatment of suicide (Bryan, 2015). The primary focus of treatment within CT-SP is to reduce the risk factors for suicide to enhance the ability to cope through the elimination of suicidal ideation. This is often achieved through skills training by targeting specific patterns involving thinking, behaviours and interpersonal interactions that facilitate suicidal states (Jobes, 2015).

A central theme within CT-SP is that the client will continue to have stressors and problems linked to the triggering of past suicidal behaviours, but will develop more effective coping strategies and skills to help deal with historical triggers so that these no longer function as triggers for suicidal ideation (Jobes, 2015). In essence, through the challenging of interpersonal relationships and the fostering of more robust coping strategies, the client develops techniques that challenge historical coping strategies linked to suicidal ideation through developing newer, healthier strategies.

Within this understanding, suicide is categorised as an internal core belief system based on a sense of hopelessness and dysfunctional automatic thoughts (Klonsky et al, 2016). Through identifying and challenging maladaptive coping strategies and deficits in thinking, through cognitive restructuring, the client is able to conceptualise their suicidality in these terms and participate in problem-solving skills facilitating more adaptive ways of coping.

Although Randomised Controlled Trials (RCT) demonstrate clients who receive CT-SP experience greater reductions in suicidal thoughts and make fewer suicide attempts at 6 and 8 months follow up (Klonsky et al 2016), it is felt offering CBT in this way risks pathologising the client's experiences and individualises the issue. It also, similar to that of DBT, provides a protocol-driven structure that understands suicide within its own assumptions and fails to acknowledge and work with aspects that may exist and correlate to the suicidality that perhaps do not fit into this model.

However, CT-SP does provide a structured clinical insight into how suicide and its presentations can be conceptualised and worked within a clinical context offering interventions that target reducing engaging in suicidal acts thus offering a possible treatment intervention that reduces the mortality rates of suicide.

2.7. Risk and Risk Management

This section aims to give a brief overview and insight into the notion of risk and risk assessment by offering working definitions of risk in light of possible ways of working with and measuring risk and risk assessment

Risk management is often viewed as a core component of mental health care and often includes an awareness of the degree of risk that may present either in relation to self or others (Dpt. Health, 2009). What is interesting, however, is that the word risk appears to be a word whose meaning we take for granted as there appears to be very little attention given to its definition within the literature (Reeves, 2015: 10).

Risk assessment is inherently subjective and represents a blending of science and judgment with important psychological, social, cultural, and political factors (Slovic, 1999). The Department for Health (2009) views Risk assessment as involving working with the service user to help characterise and estimate each of these aspects. Information about the service user’s history of violence, or self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that’s available, and their more general social contacts could all be relevant.

It is also relevant to assess how a service user is feeling, thinking and perceiving others, not just how they are behaving. Risk management then involves developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include a set of action plans, the allocation of each aspect of the plan to an identified profession and a date for review (Dpt. Health, 2009: 15).

From this standpoint, risk and risk assessment is seen as fluid and ever-changing concepts which hold the client at the core of its understanding and interpretation. There is also scope here to reflect on the functions of positive risk-taking which is of course bound within the notion of people's right to live their lives to the full and that

risk cannot be absolutely eliminated. In this sense, Risk is unavoidable but also healthy (Roberts and Wolfson, 2004).

Risk management, therefore, involves elements of positive risk-taking within its application, as it is almost impossible to eliminate all risks, specifically when considering the human condition. Davis (1996) argues that the starting point for good risk management, which cultivates positive risk-taking, is being able to see the person and not just the mental illness. Risk should be seen as positive and should be normalised to allow the engagement with the stigma, discrimination and exclusion that may result from some healthcare practices (cited in Reddington, 2017: 30).

Within psychology, risk formulation tends to be the predominant form of risk assessment as a formulation is based on items of history and mental state and the formulation should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it (Lewis and Doyle, 2011).

There are however standardised measures that aim to measure capacity and likelihood of risk from Historical Clinical Risk-20 (HCR-20), Clinical Risk Management Tool (CRMT), Beck Hopeless Scale (BHS), Beck Scale for Suicidal Ideation (BSSI), Suicide Intent Scale (SIS) and Short-Term Assessment of Risk and Treatability (START), to name a few. Standardised measures however, must be combined and balanced with information on many other aspects of the person’s life and current situation (DoH, 2007).

3. Rational and Aims of Research

From the literature presented above, this project is concerned with exploring how practitioner psychologists', make sense of their experiences working with active suicidal ideation. It would appear, that this professional group has not been sufficiently researched within the literature presented, and it is felt that by focusing on practitioner psychologists working within a range of organisational settings from the NHS, private practice and third sector organisations, would build on the existing literature around exploring practitioner psychologists experiences of working with suicidal clients.

By focusing on practitioner psychologists from a range of organisations, it is hoped that the research would capture the whole range of experiences of working with active suicidal ideation across their professional development. This would, therefore, avoid only focusing on experiences in current organisational contexts. the rational for focusing on practitioner psychologists is also reflected in the context of professional Doctorate training within Psychology that this research thesis sits within, offering a meaningful and relevant sample applicable to the parameters of this research project.

The focus on working with active suicidal ideation differs slightly from what has been presented in the literature, as there has been a large focus on suicidal ideation and suicidal behaviours. It will be argued that focusing on active ideation will add further depth to the literature as it will attempt to explore the processes and experiences of how practitioner psychologists work with the active processes of suicidal ideation.

It is also hoped that by explicitly focusing on Active ideation and its definition, it will provide a specific reference point helping to define the presentation that is being researched offering a specific reference point for the participants to engage their experiences from. This has been mentioned because the study if focusing explicitly on experiences of working with active suicidal ideation (within the terms defined earlier) and not that of other suicidal or NSSI presentations.

Finally, it is anticipated that the insights developed from this research will go some way to the development of more effective and robust ways of understanding and working with clients who present with active suicidal ideation, alongside highlighting possible guidelines and recommendations for policy and practice.

3.1. Research Questions

1. What are the participants' perceptions, experiences and understandings of clients that present with active suicidal ideation?
2. What is their perception of regarding the therapeutic relationship in relation to active ideation?
3. What are the participants' perceptions and sense of active ideation?
4. What is helpful and unhelpful when working with active ideation?
5. What are specific therapeutic interventions used with active ideation?
6. What resources do the participants draw on when working with clients who present with active ideation?

4. Methodology

A qualitative methodology was used to explore the participants' accounts of their experiences of working with active suicidal ideation. A qualitative approach is appropriate for this study because it is committed to the exploration of meaning attached to actions, decisions, beliefs and values with the social world and understanding the mental mapping process that respondents use to make sense of the world around them (Ritchie and Lewis, 2003).

The use of a qualitative methodology for the purpose of exploring participants accounts of their experiences of working with active suicidal ideation was deemed essential due to the nature of the research, in that, the research is interesting in exploring experiences of practitioner psychologists' working with active suicidal ideation.

Given that the qualitative method aims to understand beliefs, attitudes and experiences (Bryman, 2008) it is felt that a quantitative methodology would not facilitate a richness of understanding and expression from the participants' account. The qualitative method also provides an opportunity to explore, analyse and interpret meaning, which is sympathetic towards the participants' account.

More specifically, this project adopted Interpretative phenomenological analysis (IPA) as its method of analysis because IPA is concerned with the detailed examination of human lived experience, which enables such experience to be expressed in its own terms, rather than according to predefined category systems

(Smith et al, 2009). The emphasis here is within exploring experiences both flexibly and in detail (Smith & Osborne, 2003).

4.1. Epistemology of IPA

IPA is a qualitative research approach that is committed to the examination of how people make sense of life experiences. The theoretical underpinnings of IPA has its roots within phenomenology, originating with Husserl's attempt to construct a philosophical science of consciousness, with hermeneutics (theory of interpretation) and Ideography (concerned with the particular) (Biggerstaff & Thompson, 2008).

IPA is phenomenological in that's its concern is to explore experiences in its own terms (Smith et al, 2009). With its roots in phenomenology, a philosophical approach to the study of experience, the emphasis is placed on how the world is experienced within particular contexts. The primary interest is the person's experience of a phenomenon and the sense they make of their experience rather than the structure of the phenomenon itself (Eatough & Smith, 2006).

The aim within IPA is to access and understand how participants experience and make sense of the world around them. By focusing more intentionally on the aspects of lived experience, researchers are able to access details that frequently go unnoticed or unexamined in daily life (Finlay, 2011). Smith et al (2009:3) propose that when people engage in an experience of something of importance in their life, they reflect on the significance of that experience. IPA research, therefore, aims to engage with those reflections.

The attempts of people attempting to make sense of their experiences highlight the descriptive aspects of IPA and movement towards an interoperative endeavour which requires a hermeneutic phenomenological stance.

Hermeneutics is the theory of interpretation and IPA views phenomenology as a hermeneutic enterprise, IPA is concerned with the examination of how phenomenon appears, and the analyst is implicated in facilitating making sense of this appearance (Smith et al, 2009). Given the researcher becomes central in the analysis IPA proposes that the researcher engages in a double hermeneutic precisely because the researcher will be trying to make sense of the participant trying to make sense of what is happening to them.

This, in essence, encompasses the dual role of the researcher because they are employing the same personal and mental skills and capabilities as the participant. The researcher in this instance employs these skills more self-consciously so that sense-making is of the second order as the researcher will only have access to the participants experience through the participants own accounts of it (Smith et al, 2009).

IPA, therefore, acknowledges that the researcher's understandings of the participants' thoughts are influenced by their own beliefs and assumptions, identifying that these are not bracketed easily and do have an effect and influence on the interactions between researcher and participant. Researcher and participant are in constant intersubjective negotiation and interdependence with one another and meaning is created in relation to one another (Graneck, 2011: 181). The

interoperative process within IPA is a reflexive one, and the interactions and meanings of the researcher are valid within this process.

4.2. Overview of IPA and Implications for the researcher

IPA explores participants personal perspectives/ experiences in its own terms rather than those prescribed by pre-existing theoretical preconceptions and situates participants in particular contexts as a result. IPA is therefore, explicitly Idiographic in its commitment to examining the detailed experience of each case in turn, prior to the move toward more general claims (Smith and Osborn, 2012). This is in contrast to most psychology, which is nomothetic as it is concerned with making claims about groups or populations with the aim of establishing general laws of human behaviour (Smith et al, 2009).

The philosophy of IPA is based on the notions that understanding how individuals make sense of their experiences is an interoperative activity and is best accomplished through the detailed examination of particular cases within phenomena of interest. The goal is to make sense of the participants making sense of an experience, i.e. double hermeneutic (Smith et al, 2009).

IPA is, therefore, a method which is both descriptive, because it is concerned with how things appear and letting things speak for themselves and interoperative, because it recognises there is no such thing as an uninterpreted phenomenon (Smith, 2014: 8).

This amalgamation of understanding assumes that the meanings that an individual ascribes to events are of central concern and are only accessible through an interpretive process. Smith et al (2009) present a series systematic steps to aid the researcher in applying the principles of IPA to the research and helping facilitate a meaningful analysis/ interpretation that follows procedural steps, a step-by-step guide.

These include in-depth single-cases analysis to identify emergent themes, leading to the identification of superordinate and subordinate themes followed by a cross-case analysis. The initial analysis is descriptive, and the secondary level of analysis is interpretative (Larkin and Thompson, 2011). The role of the researcher is an essential aspect of the analysis as preconceptions of the researcher are recorded within reflective journals and memos. Reflexivity read of data to illuminate and reflect upon, placing the analyst as central to the interpretive process.

The epistemological focus of this project views experience or narrative rather than a real, knowable world, as being subjective and involved (Langdridge, 2007). Experience is a description of an interface between the natural and social world, highlighting a fluidity of knowledge that can be both transformative and differentiated. This, in turn, proposes the notion that our knowledge of the social world is a social product because both natural and social objects both exist and act independently.

Within this epistemological position, I as researcher also acknowledge the inherent interdependence I as researcher and the participants as researched, have on one another. This interdependence has its roots within our subjectivity, which Granek

(2011) referrers to the epistemology of the hyphen. This involves acknowledging that the researcher and the researched are co-constructed with one another, which develops within our intersubjective exchange. It is the acknowledging of this exchange Granek argues, is what enables us to take up an empathic and hermeneutic stance.

It is essential, therefore that reflexivity and relational understanding of my own subjectivity be of primary focus within this project because both the participants and I are in constant intersubjective negotiation and interdependence with one another. This point has been raised because it is assumed that we are always being created in relation to one another (Granek, 2011: 181) and therefore, our interaction poises assumptions and associations based on our intersubjectivity.

4.3. Reflexivity

Given the nature of IPA in its method of enquiry, it is important to bracket my own assumptions within this work. I have, therefore attempted to provide a reflexive account of my experiences so far in an attempt to make these explicit.

As a trainee through both my training and clinical work, suicide is something that has always interested me in the sense that I feel intrigued by how someone has the capabilities of ending one's life. I have personal experiences of suicide within my own family and friendship groups, especially during my teenage years. It was almost common or typical to hear someone had taken his or her own life due in large to the socio-economic area that I was brought up in. Despite my personal experiences of suicide, I had not really given it very much conscious thought, especially not until I

started my clinical work because upon reflection, suicide was always something external to me.

However, my interaction with clients in my clinical work brought with it a different experience of suicide and its intent. Although I have not experienced a client be successful with suicide, most if not all of my NHS and some private clients (Similar in socio-economic status to where I was brought up) present with active suicidal ideation or history of suicidal attempts and working with suicidal ideation is an integral part of my work.

It is from this that I developed the idea of exploring practitioners' assumptions of working with ideation because I did at first find it slightly overwhelming in the sense that I had and still have not, received any formal or informal training on how to assess and work with suicidal clients. I rely deeply on the therapeutic relationship and my autonomy as a clinician to guide my practice as well as theoretical assumptions to underpin my choices.

However, I tend to find that I adopt a very individual stance when working with suicidal clients based on their own biography and humanity. I always attempt to validate the client's responses however there have been times in my work where perhaps I have not attained to someone's ideation as much as I possibly should have based on my own assumptions of risk, protective factors and intent.

This could I suppose be based on individual difference, however, upon reflection, this does leave me feeling slightly uneasy because it in some ways places me in a

position of control, which leads me to think does my apparent continued exposure to suicidal ideation leave me feeling normalised by its effect? And if so do I therefore only attend to what I deem high risk? This project has its roots in my own understandings and clinical experiences however I also think it is relevant for the entire therapeutic community as it hopefully will provoke debate and bring to light some of our own personal assumptions and responses to the phenomenon of suicide.

Throughout the interviews, I kept a detailed journal reflecting on my experiences of the interview, the content discussed and subsequent findings throughout the analysis of the data. A large function of this was to offer a place of personal reflection on the content explored and discussed by the participants. The writing of a journal was restorative in the sense that it offered an arena for exploration and sense-making. This was deemed as essential specifically in light of the highly emotive focus of the research topic.

I also had discussions with clinical and research supervisors in relation to the topics covered and found this to be a very effective process of engagement. Mainly, to help focus my own thoughts and assumptions around suicidal ideation and aspects of my own fragility. I also explored this within personal therapy and used this as an exploratory space as a way of connecting with and reflecting on my own vulnerabilities in light of suicidal ideation.

The main area of concern was the possible effects of beneficence, ie, the research being of benefit and not causing harm and of nonmaleficence, ie, potential risks to

the participants in light of the emotive nature of the research topic. Nonmaleficence, in particular, was of central importance and engagement with clinical and research supervisors helped conceptualise and reflect on, possible discomfort and harm, emotional and psychological discomfort, and potential risks of participation (Burns and Grove, 2005).

Engaging with supervisors was extremely useful and helped conceptualise the research in a more focused and self-reflective way on my behalf as researcher. It also aided in the containment, consideration and balance of the possible consequences of the research specifically in light of exploring the intermate lived experiences of the participants, and that of my own. I also felt that my training in Counselling Psychology and my clinical experience, aided in offering a safe and containing space for the participants and the participants appeared at ease throughout the interviews and all reported positive experiences from participation.

4.4. Rationale for Using IPA

It was evident from that start that a qualitative methodology was the most appropriate for the study due to its focus on the exploration of experiences and the study aims to explore precisely that, experiences. Despite considering two other qualitative methods, both of which are discussed in section 4.4.

IPA was deemed most appropriate for the aims of the study. This, for me, was in large due to the philosophical underpinnings of its approach and the emphasis it places on individual lived experiences. It also offers a systemic framework to follow, and IPA is a particularly useful methodology for examining topics which are complex,

emotive and ambiguous (Smith and Osborn, 2015), so IPA was deemed the most appropriate and sympathetic research methodology.

Therefore, it is felt that the use of IPA is appropriate in the case of this project because it enables the researcher to explore the real lived experiences of what it is like for practitioner psychologists' with clients who present with active suicidal ideation. Furthermore, given the researcher is undertaking training in Counselling Psychology, the philosophy and epistemology of IPA, reflexivity and the notion that the researcher is attempting to make sense of the participants making sense of an experience, seems a natural fit within the ethos of Counselling Psychology. IPA presents an opportunity for the researcher to deploy and develop his Counselling Psychology skills to the research process.

4.5. Alternative Methods

IPA although a new research methodology at the time of the project, was deemed most appropriate for the aims of the study because of its commitment to the exploration of meaning attached to actions, decisions and beliefs. However, two other research methodologies were considered during the drafting phases of the research.

Given that qualitative research is a research strategy that emphasises words rather than quantification in the collection and analysis of data (Bryman, 2008) both Discourse Analysis (DA) and The Free Association, narrative and the interview method were both considered as plausible research methodologies for the research.

DA emphasises the power inherent in social relations (Lupton 1992) and draws its methodological influences from critical social theory, the works of Michel Foucault, antifoundationalism, postmodernism and feminism (Powers, 2001). DA adds a linguistic approach to an understanding of the relationship between language and ideology, exploring the way in which theories of reality and relations of power are encoded in such aspects as the syntax, style and rhetorical devices used in texts (Lupton, 1992).

However, it was hoped that this research would offer a much broader aspect to the experiences of practitioner psychologists working with active suicidal ideation, and it is felt that utilising DA would potentially undermine the personal lived experiences of the participants, as the analysis would focus on the critical socially-constructionist aspects to the participants' sense-making. However, having said that, there is scope within IPA to pay homage to the sematic cues and discursive structures available in the participant account without it being the sole focus within its investigation. It is felt that IPA offers more flexibility as well as structure to include other philosophical insights; this view is also supported by Smith et al (2009: 197).

The Free Association, narrative and the interview method, similar to that of DA, relies on the use of language and its inherent relationships between language and ideology; however, the methodology goes beyond the analysis of semantic identification and proposes the notion of co-production of data between research and participant. This is based on the notion of the interviewee as a defended subject and that the use of the biographical-interpretive method facilitates the production of the

participants meaning-making frames. This is achieved through the use of eliciting stories and the free association method (Hollway and Jefferson, 2010).

The methodological underpinnings within this approach are that the participants lived experience can be explored through the use of interpretive strategies, manly psychoanalysis, to identify not only their positioning within discourse but also their defensive strategies deployed to negotiate their positioning or sense-making.

Although this method is highly insightful and broad in its endeavour, it is felt that the reliance on psychodynamic methods dangers individualising and to a degree, over-psychoanalysing the participants account and renders aspects of sense-making and biographical discovery as communications and products of unconscious dynamics and furthermore, motivated by defensive structures to fend off anxiety.

It is felt that such an investigation would limit the scope of this project to an exploration of unconscious processing and potentially over interoperate the participants' sense-making and experiences to the realm of the unconscious. However, that said, as mentioned above, there is scope within IPA to consider this within its investigation and aspects from a psychosocial perspective, regarding subject negotiation and discursive positioning, have been utilised to help explore further the superordinate themes identified in the research.

4.6. Data Collection

Development of research instrument and pilot

Exploring experiences of working with active suicidal ideation can be a complex and often emotive process, specifically in light of the research literature presented earlier. A range of data collection methods was considered. The use of semi-structured was used to facilitate a comfortable interaction with the participants, which in turn, provided a detailed account of the participants' experiences that is under investigation (Smith et al, 2009). The use of semi-structured interviews allows for the opportunity to build rapport and encourages the participants to talk at length.

A draft topic guide was developed early on in the planning stages of the project; this involved conducting two pilot interviews with Practitioner Psychologist's that were not included within the final data set. The conducting of a pilot study, in this case, was viewed as essential as it is not only a crucial element of good study design, it also enabled the researcher to test-out the appropriateness of the proposed research methods (Teijlingen and Vanora, 2002). It also enabled the researcher to practice following the procedural steps of using IPA to familiarise the researcher using IPA.

This involved conducting two pilot interviews with two of the researchers at the time, clinical supervisors. The rationale for this was that they both met the inclusion criteria expected of the participants and the main rationale for conducting these initial pilot interviews was to 'test out' the research interview process.

Feedback and reflection formed the main rationale for conducting pilot interviews, therefore the existing trusting and containing relationship the researcher had with the

two participants within the pilot interview, was viewed as essential and feedback was sought in relation to the researchers interview style, choice of questioning, length of interview, how the participants reacted to the material and experiences of the participants.

The feedback was centred around promoting the researchers interview style and ability to attend to the participants narrative with comfort. The timing of the interview was discussed, and highlighted interviews should last no longer than 60 minutes. Interview questions were also refined from this process as feedback suggested at times, they were too broad and directive. Participants also highlighted that they found benefit from framing the research within the definition of active ideation as it made them conceptualise and focus more specifically on active ideation as opposed to other suicidal presentations.

Academic supervision was then sought regarding the systemic and procedural steps regarding transcription right through to analysis and presentation of data from one of the pilot interviews. This further re-enforced the researcher familiarity with the research methodology and its application. The engagement in a pilot study re-enforced the feasibility of the research and in turn led to significant improvements being made to the final research process and
procedure.

The research instrument consisted of the use of semi-structured interviews. Care was taken to not be directive in questioning and facilitate steering of conversation and taking the conversational opportunity as it arose. The building of rapport was the

main objective to allow participants to feel at ease to promote expression to allow the research to be carried out as effectively and efficiently as possible (Fulcher and Scott, 2007).

Although questions were asked, these were guided by the participant's sense-making and were almost ‘weaved' into the interview process (See Appendix). The interview process was flexible; however, it did follow an interview structure to aid in narrowing certain areas and topics that were applicable to the research design. A completely unstructured interview, although rich in its narrative potential, runs the risk of not eliciting topics or themes more closely related to the research questions under investigation (Rabionet, 2011).

Open-ended questioning and prompts were used to help facilitate expression and narrative (see appendix). Questions were focused on the research questions:

1 What are the participants' perceptions, experiences and understandings of clients that present with active suicidal ideation?
2 What is their perception of regarding the therapeutic relationship in relation to active ideation?
3 What are the participants' perceptions and sense of active ideation?
4 What is helpful and unhelpful in relation to interventions?
5 What are specific therapeutic interventions used with active ideation?
6 What resources do the participants draw on when working with clients who present with active ideation?

4.7. Method

Participants

Given that the primary concern of IPA is to explore a detailed account of individual experience, IPA studies usually focus on a small number of cases (Smith et al, 2009: 51). Therefore, it is felt that that the nature of the study and the scope of a doctoral thesis, seven practitioner psychologists who meet HCPC criteria for registration under the heading practitioner psychologist were chosen for interview.

Smith et al (2009) recommend between four and ten participants, cautioning that it is more problematic to meet IPA's commitments with a sample that is too large, than with one that is too small (Smith et al, 2009: 51), making seven, in this case, the mean. The importance here is about the richness of material, and it is felt this was achieved with the seven participants recruited for this project.

The phenomenon of active suicidal ideation in a small group of participants is being studied, who from a demographical standpoint, is as similar as possible to one another. By focusing on criteria for HCPC registration, this ensured this demographical similarity of participants and also achieved as homogenous a sample as possible (Smith et al 2009). I wish to stress that I do not make claims outside of this group and do attempt to provide a representative mix within the sample of age, ethnicity, gender or divisional membership within the BPS.

I do, however, wish to gain an understanding which could be applicable to the 'wider picture' of working with active suicidal presentations. This could be achieved by exploring the possibility that experiences in one location could indicate the possibility

of experiences existing in other locations (Harre, 1979) hence the encouragement of participants to explore the range of their experiences across their professional and personal lifespan.

These included qualified practitioner psychologists working in an array of organisational settings from the NHS- working in forensic, inpatient, specialist, community and rehabilitation services, private practice and third sector organisations. Five of the participants were female and two were male. Post-training qualification of participants ranged from five years to a maximum of 20 years. All the participants had completed BPS and HCPC accredited university taught doctorate programmes in either counselling, clinical or forensic psychology.

Although qualified practitioner psychologists working across a range of institutional and organisational settings were interviewed, the aim is to explore the common experiences of how practitioner psychologists make sense of this phenomenon, which goes beyond their current employability. This will, therefore, not exclude or discriminate personal and professional experiences gained outside of their current employment. The aim is to draw on their range of experiences gained through their clinical practice and formalised training across the length of their professional career as well as personal lived experiences.

Transcription

Interviews were transcribed verbatim from the audio recordings of the interview. The transcription took place as soon as possible after the interview.

Recruitment

The participants were a self-selecting sample following attendance at a Psychology conference where the researcher presented the methodological implications of the current research when in its early phase of development. The conference was an all-Wales Psychology networking event, and the researcher presented the project to meet criteria stipulated as part of the taught doctoral programme in counselling psychology that this project is attached to.

Recruitment, therefore, was a targeted approach of engaging community gatekeepers within the Welsh Psychology networks. Careful consideration on behalf of the researcher was given regarding the possible limitations to recruiting participants in this way, more specifically in relation to the possible limitations regarding generalisability of the data to other groups or perspectives (Halej, 2017). However, recruitment was primarily focused on HCPC registered practitioner psychologists and does not attempt to make claims outside of this professional group.

Eight participants initially consented to participate in the study. However, only seven were included within the final data set. This was due to sickness on behalf of one of the participants, and this participant did not take part in an interview.

4.8. Procedure

Ethical considerations

Ethical approval was granted by the University of the West of England and was agreed before participants were selected for interview. The information sheet and consent

form clearly stated that participation in this research is entirely voluntary and that participants are able to withdraw from the research prior to and during the interview without having to give a reason. Participants also have the opportunity to withdraw all or part of their interview material from the study for up to one month after the interview has taken place.

Participants were given an information sheet, which explained what the study was about and what participation involved. They were also given the opportunity to ask questions. Participants were provided with a consent form to sign; which clearly stated that their participation is voluntary and that they have the right to withdraw from the study at any time without having to give a reason. Participants were informed that data could be withdrawn for up to one month after the interview has taken place.

Following guidelines from the Data Protection Act (1998), anonymity and confidentiality were maintained by changing all identifying information in the written reports and oral presentations of the research, and by giving a pseudonym to any data that is used. Participants were made aware of this arrangement to protect their anonymity before they consent to participate in the research.

All data collected was stored confidentially on an encrypted USB pen drive which will be used on a password-protected computer, which only my supervisor and I had access to. Data was audio-recorded using an electronic digital recorder. Participants were informed that the interview material would be used to write and prepare for multiple written research reports and oral presentations up to October 2018, and then the material will be deleted. All paperwork completed by participants (consent form

and demographics questionnaire) were stored securely in a locked filing cabinet which only my supervisor and I will be able to access and will also be destroyed after October 2018.

All participants were invited to read a written report of the research in the form of a journal article before submission for assessment and publication in order to acquire feedback. It was clear that if requested, participant data could be edited or removed to reflect what is felt to be appropriate before submission.

The participants took part in in-depth semi-structured interviews in which participants were encouraged to ‘tell their story’. The researcher aided in facilitating the discussion to promote in-depth exploration and unpacking of idiosyncratic meaning(s). The researcher, in this case, was guided by the participant’s narrative as the participants were viewed as experiential experts on the topic at hand (Smith et al, 2009). The interviews lasted for around one hour and took place in my own private consulting room.

As a result of this method, there were no set questions, as it will, as the research aim is to explore idiosyncratic meaning. However, questions followed a coherent format based around definitions of suicide, how ideation is understood and worked with (see appendix).

It was felt that a debrief on participation is not necessary. However, I had a closing conversation with the participants at the end of each interview where we discussed how the interview went etc. and they were all forwarded my research supervisors

details should they have any concerns regarding their participation. I also explore how I attended to my own wellbeing and how, within my capacity as a researcher, I attended to the emotional needs of the participants.

Interview Process

Participants were interviewed individually within my own private consulting room, and interviews lasted for up to one hour. The interviews were audio-recorded following obtaining informed consent from the participants. Participants were reminded of what their participation would entail and at the start of the interview, were given a cover sheet detailing the themes of the research.

At the start of the interview, participants were provided with the definition of active suicidal ideation and were encouraged to reflect on their experiences of this. This provided structure and focus to the interview. The participants were briefly informed about the expectorations and methodology of the qualitative interview process, and it was explained that the researcher might be quiet at times and that participants may be asked to elaborate on certain points of interest as the purpose of the interview is for the participants to tell their story. Participants reported they generally felt at ease during the interview process and questions were asked from the researcher to either add further context or explanation in relation to the participants' account.

The researcher is familiar with conducting qualitative research and has also been working within therapeutic contexts for over seven years, which it is felt, aided the researcher with conducting a sensitive, empathic and participant-led interview.

The researcher made process and observational notes throughout the interview aiding in information gathering and applying context to the researcher's thoughts during the interview. Reflective notes were also made after the interview had ended.

4.9. Data Analysis

IPA was utilised to analyse the narrative and meaning ascribed to the participants' account. The stages of analysis followed the methodology proposed by Smith, Flowers and Larkin (2009) and followed the steps detailed below:

Multiple reading and making notes

Data analysis firstly involved the accurate and matriculated transcription of the participants narrative from the audio recordings of the interview. Following an idiographic approach, the analysis involved focusing on each transcript at a time and paid specific attention to the word by word account of the participant. This involved the reading and re-reading of the transcript a well as listening to the recording in order to familiarise the researcher with the transcript as much as possible. Exploratory comments were then made relating to comments of interest, use of language, significant issues, conceptual and descriptive comments and primary interpretations (Smith et al, 2009).

Transforming notes into emergent themes

At this stage, the researcher worked more with their notes, rather than with the transcript, the notes being detailed and comprehensive they were also reflective of the source material. The aim here was to transform notes into emergent themes (Pietkiewicz and Smith, 2012).

There were attempts to formulate phrases and capture the essence of the quality of what was evident in the text. The rational at this stage was to find appropriate expressions to allow theoretical connection and association, these, however, are still grounded in what was actually said by the participants (Smith et al, 2003).

At this stage, the researcher was influenced by already having annotated the transcript as a whole, which is a good example of the hermeneutic circle (Pietkiewicz and Smith, 2012).

Seeking Relationships and clustering themes

Initially, emergent themes for the whole transcript were listed on separate pieces of paper before the researcher attempted to look for connections and clusters. This then facilitated the researcher to look for connections between the emergent themes. This then facilitated the researcher to explore connections between the emergent themes. This was achieved by grouping themes together according to conceptual similarities and providing each cluster with a descriptive label (Pietkiewicz and Smith, 2012).

This process led to a more analytical process of the themes identified, which led to the clustering of themes. The emergence of clustering prompted the researcher to refer back to the transcript, thus facilitating close interaction between the researcher and the transcript (Smith et al, 2009). Conceptual comments and phrases from the participants and reflective commentary were also utilised in this process.

A table of themes in line with the participants narrative was then produced to illustrate the appropriateness of the themes that most strongly fitted to the participants narrative/ sensemaking. Themes were constantly referred back to the original transcript. Emergent themes were often omitted for not being rich in content within the original transcript (Pietkiewicz and Smith, 2012). Abstraction (Identifying patterns), Subsumption (helps bring together a series of related themes) and Numeration (frequency in which theme is supported) were used to process the emergent themes. Within this table of themes, clusters of themes were then label and were representative of the super-ordinate themes

Each of the seven transcripts went through this process in succession, and each transcript was treated in its own terms and was therefore important that the researcher bracket any prior thoughts, ideas or emergent themes from other transcripts. This is consistent with the methodological underpinnings of IPA (Smith et al, 2009). Therefore, the researcher took a significant amount of time and commitment to each transcript.

Once each transcript had been analysed following the steps highlighted above, consultation with research supervisors was used as a reflective/ feedback space where the analysis to date was discussed. This facilitated a further step within the analysis process, as it aided in ensuring the quality and vigour of analysis. This also enabled the researcher to ensure that the identified themes were firmly grounded within the participants narrative and a final table of superordinate themes created.

Themes were then presented in conjunction to their positioning with each superordinate theme and were illustrated using verbatim extracts from the original transcript. This was presented in the final write up and illustrated what the participants actually said and what the researcher interpretation.

The processing and exploration of the researcher's epistemological assumptions were also of focus throughout the research and therefore, a reflective journal was used throughout the entirety of the research process.

4.10. Validity and Quality of Research

Validity in relation to qualitative research is not the same as when applied to quantitative research. Smith et al (2009: 184) postulate that IPA is a creative process; it is not a matter of following specific rules. Therefore, criteria for validity needs to be flexibly applied, highlighting that what works for one study will be less suitable for another. The authors do acknowledge, however, that qualitative research should be evaluated in relation to criteria recognised as appropriate to it.

Therefore, the authors suggest the work of Yardley (2000) who presents general guidelines for assessing the quality of qualitative psychological research that demonstrate a sophisticated and pluralistic stance (Smith et al, 2009: 179)

Yardley (2000) postulates four principles for assessing the quality of qualitative research sensitivity to context, commitment to rigour, transparency and coherence and impact and importance. Yardley's (2000) four principles were of great significance to this project as a way of providing quality to the research.

Sensitivity to context: Yardley (2000) argues that a good quality qualitative research study will demonstrate sensitivity to context. Smith et al (2009) postulate that sensitivity to context is demonstrated through both the interactional nature of data collection (the interview process) and through the analysis process that requires immersive and disciplined attention to the unfolding account of the participants.

This can be demonstrated through the researcher's appreciation and commitment toward the empathic stance the researcher took with each participant in the interview. The researcher has over seven years' experience working within therapeutic contexts so is accustomed to demonstrating empathy, facilitating ease with people, being able to recognise interactional difficulties that may arise and demonstrating awareness and negotiation of the intricate interplay of the dynamics of power (Smith et al, 2009).

This principle of sensitivity to context was also of huge significance during the analysis process as the researcher immersed their attention into the data and demonstrated disciplined attention to the unfolding accounts of the participants and what was obtained from the interaction and subsequent analysis. Verbatim extracts were also provided throughout the presentation of findings to demonstrate how the analysis stayed close to the participants' account. The researcher has also avoided making generalised claims and remained close to the participants narrative throughout the analysis. A comprehensive literature review was also completed helping to provide context to the study.

Commitment to rigour: Smith et al (2009) outline that commitment to rigour can be demonstrated by the researcher's commitment and investment specifically in relation to the interview, ensuring that the participant is comfortable, and the researcher is attending to the participant. This again, was central to the interview process as the researcher remained tentative and engaging throughout the interviews offering a depth of expression on important points raised, which followed the participants' pace. This was further supported by gaining feedback from the participants at the end of the interview regarding their final thought and reflections of their participation.

The importance of pilot interviews is also an example as to how the researcher attended to the commitment to rigour as it focused on ‘sampling' the range of techniques within IPA from questioning, interviewing and analysis. The collection of feedback and making changes where necessary is also an example as to how the researcher attempted to apply this concept to the research.

Commitment to rigour can also refer to the thoughtfulness of the study in terms of appropriateness of sample, quality of interview and completeness of the analysis undertaken (Smith et al, 2009). The participants chosen are as homogeneous sample as possible in line with the questions and rationale of this research. Also, the researcher's training in Counselling Psychology has facilitated the researcher to provide a balance between closeness and separateness and being able to pick up on important cues from the participants and be able to dig deeper and probe where possible, remaining sensitive and empathic toward the participants (Smith et al, 2009).

Transparency and coherence: transparency referrers to how clearly the stages of the research process are described in the write up of the study. Transparency can also be further enhanced by describing the selection process for participants, how the interview schedule was constructed and how the interview was conducted and what steps were used in the analysis (Smith e al, 2009).

The researcher has attended to the principles highlighted above by detailing recruitment of participants, detailing how the interview schedule (research instrument) was constructed highlighting the importance of piloting and how this informed the researcher's practical application of research methods.

An account of the interview process has also been detailed and the steps of analysis have been discussed. The write up references the sub-themes within each superordinate theme to illustrate how the analysis came to light. The project has also been consistent with the underlying principles of IPA and has not adhered to any other qualitative methodology in its analysis. There is also continuity between the research carried out, the philosophy of IPA and the vales of the researcher.

Impact and importance: Yardley (2000) argues that the decisive criterion by which any piece of research must be judged is, arguably, its impact and utility.

The energetic pursuit of this research was to provide something that was original, inspiring, interesting and is representative of practitioner psychologists. This project hopes to illicit debate and insight as well as being relevant, important and useful to the field of Psychology and the wider therapeutic field.

5. Findings and Analysis

The following section will give an overview of each of the Three Super-ordinate themes identified through the analysis of the participant's account.

Super-ordinate Theme 1: Working in Multi-Disciplinary Teams	**Sub-theme 1a:** Feeling Supported
	Sub-theme 1b: The System Conspires Against Us
	Sub-theme 1c: Barriers and Restrictions Involved in MDT Working
Super-ordinate Theme 2: Working with Suicidal Ideation	**Sub-theme 2a:** Exploring Meaning
	Sub-theme 2b: Suicide as a Communication
Super-ordinate Theme 3: Exploring Our Own Ideation	**Sub-theme 3a:** What it Means to live and die
	Sub-theme 3b: It's not talked about

Figure 1 Table of Super-ordinate themes

Direct quotes of the interview transcript have been utilised to help illiterate points and demonstrate the meanings drawn from the analysis. Some of the transcripts were

richer in content than others so some aspects of the analysis draw more explicitly on some participants over others.

Key

… indicates in change in course of the conversation

[ ] are used to explain who is talked about within conversation

5.1. Super-ordinate Theme 1: Working in Multi-disciplinary teams

A significant theme that arose from the data was concerned with how the participants felt that working as part of an MDT was a core competency of their work and that MTD working was perceived as crucial and essential specifically in light of working with risk in relation to suicidal presentations. I will examine this experience below, starting with the overarching theme within MTD working, Feeling Supported as offering a sense of containment and resource for support as well as a platform for the sharing of risk.

I will then examine the more negative aspects of MDT working as described by the participants, focusing on the overarching theme of The System Conspires Against us, which expresses feelings of responsibility, blame and experiences of personal and professional conflicts concerning MDT working. Finally, I will examine tensions experienced with positive risk-taking and reflective practice by focusing on the overarching theme, Barriers and Restrictions involved in MDT working.

5.1.1. Sub-Theme 1a: Feeling supported

The first sub-theme discussed relates to the participants' experiences of feeling supported within Multi-disciplinary teams, specifically in relation to how this aids in their work with suicidal presentations. In particular, being part of a wider team and feeling supported was perceived to be a source of help and support for the participants and formed an integral part in their ability to work with clients who presented with active suicidal ideation.

All participants discussed the notion of MDT working. MDT working was deemed as a core competency of the participants as practitioner psychologists. Participant F

highlights this point- "*... being part of a team there are other resources to call upon, this is defiantly beneficial, and it's what we do, we work with other professionals."'* A

The participants conveyed the importance of seeking support beyond their professional boundaries and this in large, was based around accessing appropriate support and interventions for both themselves and the client. It brings to light a sense of reaching out. This is highlighted in Participant A's account when discussing a recent client they were working with, "*they were getting more and more suicidal, that uncertainty, luckily I had a care coordinator involved, we then got the crisis team involved and crisis did take this person on for home treatment'.* Reaching out in this sense appeared to offer the participant a sense of containment while simultaneously, providing the client access to further support.

There is a sense that reaching out for the participants is a therapeutic process within itself and helps facilitate containment for both participant and client. It also highlights the importance of seeking support beyond the parameters of their therapeutic endeavour with the client that is done in a sensitive way. Participant C highlights this by saying-

"*I may need to call upon wider resources fairly quickly and then try and hold that and do it in a way that they still feel contained and supported. I said your care coordinator is here can I go and have a chat with them, we went out, the three of us had a chat about it."*

Reaching out in this sense also helps with the participants emotional processing, sense of isolation and ability to tolerate distress within the therapeutic exchange with clients and becomes an informative process. This point is highlighted by Participant G when discussing a historical case regarding a client presenting in session with increased ideation-

"No one else in the team was involved I was the care manager, and he [the client] said that he was quite low, I did get the Crisis team involved and actually I felt relieved to talk to the crisis team."

There is a real sense that reaching out and accessing resources beyond that of psychology aids in avoiding working in isolation with clients and also offers the participants the opportunity to explore any concerns that may arise. This also appears therapeutic and containing for the participants' as it acts as a form of support and aids emotional expression. This point is re-enforced by Participant B when discussing working with a client who was experiencing increasing suicidal ideation- "*You know you have back up, so the first thing I do when something like that happens, I will go and find support whether that's the crisis team or other colleagues".*

Wider Resources

The need to reach out was not just contained to that of MDT or professional contexts. Participant C highlighted this point-

"It's thinking about, to put it crudely, what pockets of good mental health can this person draw upon as well. So for me, yes working in a service and having immediate sort of you know, psychiatrists and crisis teams and other things to call upon, are all very useful but again sitting with the person I'll think 99.99% of their lives is lived out of this context, they live in the community. What resources out there could be good for their mental health."

This comment highlights that there is a need to perhaps be aware of the broader resources beyond that of professional contexts as it offers more holistic access to resources that can also be containing and expressive. It also places focus on the individual aspects of people's lives and appreciates the possible limitations to professional contexts. This is supported by Participant G when detailing admission processes to acute psychiatric wards - "*sometimes not bringing somebody in is the*

most useful thing therapeutically, it acknowledges their strengths and often as a team, we will work with them the family and any other support they may have."

Broader resources in this sense, imply awareness and engagement with resources beyond that of professional contexts that promote containment and expression that is idiosyncratic to the needs of the client while simultaneously, providing a supportive and expressive environment for the practitioner.

An essential aspect to reaching out was the notion of support through the sharing of responsibility specifically in light of risk and exacerbation in suicidal ideation. The sense of sharing responsibility was seen as an integral aspect of MDT working specifically in light of suicidal ideation as participant F highlights- *“There is no straightforward answer, I think it's about the MDT approach and people sharing that responsibility".* This insight highlights the complexities of working with suicidal presentations that are perhaps beyond the parameters of a single profession alone. Participant D expands on this point further when discussing working with risk in an MDT "It *becomes team sharing, rather than you holding that one client, so it benefits everyone.”* (Participant D).

Sharing of risk in relation to MDT working is understood to be fluid and multidimensional and is shared across the team- "*I think it's very much team ness that helps us hold risk." (Participant C), and acts as a means of communication, expression and discovery. This promotes a wider view understanding of conceptualising and understanding risk within the parameters of the MDT.*

MDT working also acts as a barrier and facilitates movement beyond individual responsibility. This point is highlighted in Participant B's account when discussing a client who "had the means with them to kill themselves"-

"There were lots of professionals working in the background, you've got one in the crisis team checking every now and then, someone else in the background looking at notes making sure we are fully understanding about the persons support networks."

There is a real sense that the client is held in the centre of enquire and that professionals in the team are working alongside one another facilitating containment and information gathering. There is also a sense that these processes help contain anxiety and help foster a dynamic team approach toward working with this client. The importance of this is further expanded on in Participant E's account of working with risk-

"It's not comfortable, it's not comfortable when you think shit, shit there is a risk here shit, and umm, I'm very fortunate in where I work I have a crisis team I have a ward so someone comes in this room and I think ow my dear God I'm pretty, you know I have very immediate options with what I do with that… it is not nice when you know that you are holding it."

Participant E highlights that there is an uncomfortableness and possible anxiety when faced with risk and indicates the importance of both communicating and sharing this across the MDT. It also implies the importance of not working in isolation due to the emotive responses elicited — the sharing of responsibility aids in this. There is a clear expression of the need for MDT working in light of risk and a move beyond individual responsibility. Participant C's account re-enforces this as they highlight the potential risks of this-

"*Sometimes people work in isolation with clients essentially, I've done it before, and then you wonder why staff have such burnout because they're holding that themselves, there's nowhere for them to take it."*

This point has been highlighted because some participants work in private practice as well as organisational contexts, and although some acknowledged that in their experiences they may not perhaps work with the same levels of suicidal ideation, there is a sense of vulnerability within some accounts relating to working outside of

MDT/ Organisational contexts. This is reflected in Participant B's account when discussing private practice-

"*In private practice, I have not seen the same level of suicidal risk…although weirdly, in a way, private practice is more frightening because there is not that support…how would I cope if that happened in the private world because of your own personal liability to think about."*

This also illustrates a sense of ambivalence and defensiveness with working with risk of suicide in private practice that is otherwise safeguarded within MDT/ organisational contexts. This ambivalence was also mirrored in participant A's account when discussing a client who self-referred privately with a long history of parasuicide, "*I did take a step back and say actually is it appropriate for me to get involved, or does this person need more of a team involvement… the wife emailed me a few days later, and he had been admitted to hospital."*

These accounts highlight the importance of reaching out and also being aware of the vulnerabilities of working in isolation without the support/ information sharing of MDT working. It also implies feeling uncontained and feelings of ambivalence to working with risk within settings outside of MDT working. The participants, in this case, appear less willing to engage with risk in environments outside of MDT support and seem acutely aware of this.

Sharing of responsibility implies a sense of containment but also professional responsibility in relation to how risk, particularly that of risk of suicide, is conceptualised, understood and worked with. The MDT provides a framework that helps contain and manage risk.

5.1.2 Sub-Theme 1b: The System Conspires Against Us

The second sub-theme relates to the negative aspects of MDT working experienced by the participants highlighting feelings of responsibility and blame in relation to their clinical work with suicidal clients. It explores both personal and professional tensions experienced by the participants about how suicide is understood within MDT and wider organisation contexts.

There was a developing sense of the notion that responsibility was implied in the services the participants work in. This point is highlighted by Participant G when discussing the structure of service provision - "*we are automatically given responsibility for somebodies actions, and that's not a choice we've got and if somebody makes that choice to end their life, it is seen as a failure on your part as a professional."* This insight by Participant G implies that responsibility is assumed and that professional integrity can be called into questioned in the event of a person being successful with suicide. This also highlights a sense of anxiety and fear of blame.

The sense of blame was also mirrored in Participant E's narrative when discussing a recent investigation into a death by suicide - "*There is this great kind of blame, it feels like a blame culture, your name is on the risk assessment, you are responsible for that person, absolute nonsense, how can you possibly be accountable for another human being."*

There is a sense of tension within this narrative because it highlights the difficulty with assuming responsibility for another person without account for the interpersonal experiences and process at play leading up to the suicide. It also highlights the

participants' ambivalence and uncomfortableness with assuming responsibility, which appears to be in conflict with their personal beliefs regarding responsibility. This is also evident in Participant B's account when explaining a similar investigative process-

"*They sit you down, and they walk you through every step, and they will come up with actions, and they will come up with who is to blame. They say it's just a feedback session for us to think and learn for the future, but actually, they are incredibly punishing, and they are designed to question every single one of you. You have to be confident of the decisions you are making, it's a horrible system to be part of, I understand why it's there, but in practice, it's very difficult because we encourage conversation and curiosity about suicidal ideation. You would then have to be very strong about how you would then defend that if somebody did actually complete suicide."*

There is a notion here that investigative process elicit defensive responses from the participants, which appears to focus on the content of a person's actions rather than focusing on the processes of understanding. The process also appears very exposing for the participant. It would appear that organisations prevent individual understanding in its aims to standardise understanding. This it would appear, goes against the participant's desire to promote empathy and curiosity with their clients. This point is supported by Participant G, who commented that- "*You don't have a relationship with that moment you have a relationship with that person."*

Within this understanding, systemically, professionals are viewed as being responsible on a professional level, practising in a system that does not appear empathic and does not truly allow professionals to be curious and open to aspects of positive-risk-taking. On a meta-processing level, it would appear that this is what the participants are offering to their clients, safety, empathy and containment. However, there is then this notion that professionals are not necessarily on the receiving end of this, specifically in light of investigative processes. It would appear that the

investigative process becomes individualised and creates a disconnect between practice and policy, leading to possible feelings of vulnerability and fragility.

This does then raise the possibility of interacting with clients from a defensive position, offering clients opportunities that are not available to themselves, which could affect how processes with suicidal clients are attended to and understood. Participant F highlights this insight- "*You become sort of anxious about everybody, trying to contain everybody, you become risk-averse immediately after I think, and then you end up over providing."* This insight postulates that practising in anxious or defended positions, or feelings of uncertainty have a direct impact of professional confidence in working with suicidal presentations, which could also perpetuate the client's suicidal ideation.

It also provides insight into the possible limitations experienced with positive risk taking as it would appear, the participants feel uncontained within organisational contexts, leading to feelings of anxiety surrounding blame and possible feelings of un-containment. There is a sense then that the participants almost become contaminated by risk and appear more risk averse in their endeavour to work with suicidal clients.

There appeared to be personal conflicts experienced with the participant's sense of layered responsibility, specifically in relation to expectations placed on the participants. This was highlighted earlier in Participant E's account in relation to blame. However, this is further elaborated when discussing expectations placed on professionals-

> *"Somehow, we should be able to prevent all deaths, and you know I do not see the same expectation on cardiology or oncology, death happens. We aren't allowed to have any deaths."*

There is a sense that Participant E is in conflict with organisational assumptions and that of personal belief systems; it would appear that the complexities of human lived experience are not appreciated within MDT contexts. This point is expanded further within Participant G's account-: "It's *a wide multifactorial systemic thing that can help us explains people's suicidal thoughts, we shouldn't take responsibility for that."*

There is a sense that suicidal presentations are complex and wide-ranging so notions of assumed responsibility can create conflicts for the participants. On a personal level, there appears to be an appreciation for such complexities, professionally; however, they appear constrained by MDT/ organisational contexts. This also raises the value position the participants are taking, which is bound within codes of ethics.

This point is highlighted by Participant F when discussing professional responsibility- "*If you look at the bigger picture, …somebody has made that decision themselves. Umm we've got responsibility over our own lives haven't we, and about how we want to live our lives…But we have got to preserve life as far as possible and a legislative duty to do that."*

The personal and professional values appear in conflict with one another in this account. There is a connection here between expectations and responsibility combined with feelings of restraint based on professional and organisational codes of conduct, which do not necessarily facilitate interactions based on personal value systems. The participant appears to negotiate this conflict; however, there is a sense of restraint that emerges in their narrative. Participant A explore this when discussing professional liability- "*I ask they agree to a contract with me if they then do that, it's their choice, professionally then I know I have things covered."*

The restraint in this case appears to be a defensive one, there is a sense of valuing individual choice, however there is a professional conflict that emerges in relation to preserving life. The introduction of a contract in this case attempts to defend against such conflicts and provides Participant A with a sense of containment within professional and organisational codes of practice.

5.1.3 Sub-theme 1c: Barriers and Restrictions involved in MDT working

The participants describe their experiences of being unable to have meaningful self-reflective and process led conversations with MDT colleagues. The participants highlight the tensions owing to this and attempt to make sense of this based on professional differences. This sub-theme also explores the challenges Psychologists can bring to the MDT.

One of the restrictions discussed in relation to MDT working was the inability to have process/ self- reflective discussions with MDT colleagues regarding a range of issues. Participant F highlights this saying, "it's *interesting to have the opportunity to talk about these things because we don't talk about it in our day-to-day day work really. We do have reflection sessions and things umm, but you know, life is very busy and sometimes we just don't have them."* Participant F highlights two things here, the lack of self-reflexivity discussions amongst staff and perhaps more importantly, the need for self-reflexivity in the first instance.

Participant B recognises this when discussing positive risk taking and management- *"...positive risk that it's not going to happen, if that relies on your staff in your professional team being self-reflective collectively enough to manage that, and be*

consistent enough to make it work otherwise you're just traumatising the persons. So, can we rely on staff who are not perhaps as transparent or overworked in the way that they are, to be able to manage risk and suicidal ideation in that population like we need them to. I do not know that."

There is a clear insight that is drawn here regarding the importance, from the experience of the participants mentioned regarding self-reflexivity. Participant F takes this notion even further by recognising differences between MDT colleagues while also acknowledging the anxiety difference can cause-

"I am aware that we are not trained in the same way …we're socialised into that way of working early on which can be quite stressful and anxiety provoking sometimes, and when you try to bring that into quite a medical model orientated service, which is quite linear in how it looks. You know, we were talking about diagnosis earlier; you know has depression, then they have citalopram to treat it or whatever. It's quite concrete quite black and white, and we bring the shades of grey to the table."

This theme of recognition of difference while recognising the difficulty of a psychologists role within MDT working is further explored by participant D-

"In my team, I work with nurses so I am the only psychologist so there are three nurses and me, and I think nurses are very stoic by nature you know especially because they have usually gone through the whole serving the time on the ward I've got a job to do get on with it, and then coming into the therapy side of it they're having to take a step back from that, and the more alongside the client in a different way. Not saying they don't do that when they are nurse, they do but it is a different relationship."

There is a clear link here regarding professional differences across services involved in the provision of mental health. What the accounts highlight is a deprivation of self-reflexivity across MDT working and how this can impact on how suicide is conceptualised, understood and communicated across the MDT.

The participants also appear sympathetic to the origins of this and appreciate the complexities they as professionals bring to MDT working. This is supported by Participant G- *"I think it's a challenge for other staff to work alongside us, people like certainty and if you have been trained in quite a medical/ directive way, you know somebody breaks a leg you have a cast, then this happens within the body and the person will recover that's it. Mental health its different, psychiatry and psychology its different, umm so I don't think it's easy on the other professionals I remind myself that (laugh)."*

This account demonstrates a possible understanding of professional differences and how mental health, and in this context suicidal ideation, can be complex and often difficult to conceptualise and make sense of specifically in light of uncertainty. There is also an acknowledgement that psychology can foster feelings of uncertainty and anxiety in other professionals, and this may go some way as to describing possible barriers or restrictions experienced by the participants in Multi-Disciplinary Teams. This is of particular importance when considering the participant's frustrations with not being able to have process/ self- reflective discussions with MDT colleagues.

What was striking throughout the interviews with the participants was the participants' willingness to engage with the subject matter. The participants narrative highlighted that the conversations explored within the research schedule, are not part of their every day-to-day experiences in relation to reflecting on the challenges and process involved when working with suicidal ideation.

Participant F - *"It's making me think I don't do an awful lot of thinking about this which is interesting given what I do (laugh) and also spending enough time towards processing and making the implicit explicit."*

Participant B was left with a sense of contemplation recognising the limitations of limited reflexivity in line with the interview schedule reporting, *"We all hear the theory, linking practice to the theory but think about it from this perspective, sadly rare."*

Participant D- *"It was fascinating actually, it's made me think of stuff that I probably don't pay attention to, and given the topic I work with day in day out, then it's really interesting to think about where my thinking comes from"*

Participant C- *"I've surprised myself, we're sitting down talking about suicide, how enthusiastic I've been, you know, it doesn't happen often."*

These narratives also highlight the possible lack of resources available to the participants in relating to accessing and participating in process/ experiential/ explorative type conversations without judgement. This is further supported by Participant D who felt access to such resources was also beyond the realms of supervision - *"Well You know what it's like, supervision, we need it of course we do, but I don't think there's scope for this there, there's just not the time."* Although this was not directly expressed by the participants, this does pose further questions about how much the participants are affected by not having access to such self-reflective processes that are so valued by the participants.

5.2. Super-ordinate-theme 2: Working with suicidal ideation

This theme relates to how the participants work with and understand the phenomenon of suicide within their clinical work with clients. It focuses on exploring the functions and communications of suicidal ideation and demonstrates the complexities of understanding and working with suicidal ideation. Firstly, the sub-theme Exploring Meaning will be discussed in relation to how the participants attempt to understand and explore the possible functions of suicidal ideation in relation to factors outside of the individual. Secondly, the sub-theme Suicide as a Communication will be discusses by focusing on how the participants attempt to understand the processes and possible communicative strategies of suicidal ideation, specifically in relation to distress.

5.2.1. Sub-theme 2a: Exploring meaning

The first sub-theme to be discussed relates to the participant's experiences of exploring meaning with their clients about the possible functions of their suicidality. In particular, exploring idiosyncratic meaning was viewed as an integral process when working with clients who present with active suicidal ideation. This theme highlights the complexities of working with suicidal presentations in line with the participant's sense-making and highlights that accessing a wide-ranging approach, helps the participants conceptualise and work with suicidal presentations.

There was a narrative that was developing regarding the role of mental illness or more specifically, a medical model understanding and its limitations regarding active suicidal ideation. There is a sense of moving beyond symptomology in order to help conceptualise the possible meanings behind the suicidal ideation.

Participant E explicitly explored this point by saying- *"I think it's, well no I do not think wanting to kill yourself is and of itself a mental health problem. I mean people can quite often come to a very clear decision, I am going to kill myself, you know people with lots of physical disabilities you know people with umm various stages of cancer may decide I have had enough now thank you very much*." There appears to be an understanding here that the wish to end one's life goes beyond a diagnosable condition and is perhaps too complex and multifactorial to understand within diagnostic criteria.

Participant E later goes on to say- *"I work with a number of people who there is you know, this is a very medical way of looking at it, but there is a chronic risk of them killing themselves and actually when you think well if I was in your shoes I can't actually think I'd be seeing, seeing much different really for various reasons."* This demonstrates further the complexity of suicidality, which appears to go beyond a diagnosable condition as it highlights the possible idiosyncratic functions linked to the processes of suicidal ideation. Indeed, Participant C offers a thought-provoking experience with a client who attempted suicide-

> *"It's definitely not just a mental health service issue you know umm and as I say I do have an example of somebody who umm I saw a good few years ago, left the house one morning, life was ok, a beautiful day and thought wow what a day to go out on if I'm going to end my life and yea, jumped off a bridge on a motorway (laugh), he survived thankfully, but not someone who you know mentally ill. There were little bits and pieces in there about belief systems and so on and yea but shocked themselves, just though it was a good idea (laugh)."*

These experiences highlight that there is perhaps a need to move beyond a pathologising stance when thinking about suicidal ideation as there can be experiences or 'beliefs' that can perhaps offer insight behind someone's ideation rather than a diagnosis of possible correlating symptoms.

This is expressed by Participant C, who works with active ideation on *"a kind of relational interpersonal immediate* level" highlighting a need to explore idiosyncratic meaning. The notion of mental capacity was also highlighted in relation to Mental Capacity and the medicalisation of active ideation.

> *"People have that mental capacity to make that choice even if it's a result of trauma they still have an element of choice about it and who are we to say they can't and again it's trying to weigh that up."* (Participant A)

This insight by Participant A offers a link between idiosyncratic meaning and moving beyond diagnosis because it highlights that although diagnosable conditions (trauma) may be evident, there is still an arena of capacity remaining, which 'mental health services' may take away and interfere with its exploration. This point is also explored by Participant G when discussing diagnosis specifically in light of personality disorder and comments that *"I think there is something about what each individual brings as well and what they are tied up in, I don't just think it's because they carry a diagnosis, it's a part of it, but not the whole thing."*

There is a developing sense here that suicide is something that is brought to services and is bound within expectations to preserve life. This point by Participant E was quoted earlier however has resonance within this section, *"we should be able to prevent all depths, and you know I do not see the same expectation on cardiology or oncology, death happens we aren't allowed to have any deaths".* This does tie into the themes discussed earlier (responsibility) however it also demonstrates the complexity within this section, as like participant E highlights, Mental health provision is placed within a 'health system' however the same pathological indicators (although used for diagnostic criteria) do not account for individual choice and reasoning.

Developing understanding that moves beyond pathology and a sole individual understanding explicitly focuses on the other factors that can aid in the understanding of suicide and represents a movement beyond the individual. Participant C makes an interesting comparison between community and services in light of suicidal ideation in relation to a recent conversation they were a part of with a Welsh Assembly Member-

"I work in mental health services and your thinking about mental health and your thinking about mental wellbeing your thinking about distress and the context for that. I say none of that starts in a mental health service, that's where it's treated. I say it all starts it all takes its routes outside of those services."

This compelling insight presents the stark notion that suicide is brought to services and involves a process of negotiation before it arrives. It is demonstrating a systemic view regarding suicidality as outside of organisation and individual. It also raises questions of accountability and communication as well as promoting thought regarding the communications of suicidality with cultural and political discourse.

Participant F highlights the further complexity in light of Participant C's point by exploring the interpersonal exchange between person and society-

"Ah well It's like an onion isn't it if you're thinking about systemic factors there is all sorts of factors that might feed into that cultural things, social things research shows doesn't it that suicide rates go higher in times of recession and if you look at what happened in Bridgend a few years ago when they called it the contagion where they had lots of suicides there's all sorts of social and cultural factors around that as well so I think it would be too simplistic to sort of place it within the individual."

There is a visible link here between the participants' narrative, highlighting the importance of looking beyond presentation and symptomology in favour of a more holistic and systemic viewpoint. This it would appear offers an enriched and complex

understanding of active suicidal presentations alongside an appreciation for such complexity. The experiences presented also offer an insight into the cognitive aspects involved in ideation as it builds on systemic aspects in an attempt to engage with the process of understanding and exploring investment and constraint within social and cultural factors.

This is supported when reflecting on Participant C when discussing the role of society in the mental health of individuals.

"Your neighbours are a resource for your mental health. Your garden is a resource for your mental health, dare I say the pub is a resource for your mental health."

There is a clear attempt here with Participant C to connect with their clients, however, this narrative goes beyond this and demonstrates a link and also appreciation of, the importance of systemic aspects to people's lives. Which, of course, are meaningful to the person involved. This account also demonstrates the notion that suicidal ideation and more broadly speaking mental health, is brought to services and it is important for services to be aware of the systemic influences involved in people's sense-making.

Participant C expands on this further by mentioning that suicide "...lives in the community, it lives within people within their context and the community, and that's where it happens of course by and large that's where people end their own lives, in their homes, in a field you know jumping off a bridge, it happens out, it's out there that's where it's all going on".

5.2.2 Sub-theme 2b: Suicide as a communication

The notion of suicide as a communication was conveyed in the sense of exploring possible meanings in relations to the client's presentation. It attempts to offer an idiosyncratic exploration of the suicidal ideation and facilitates insight into the possible functions of suicide. This insight is expressed in Participant C's account when discussing their insight into how they conceptualise suicidal behaviours-

"It's a communication of some sort. They might not have the words to express how they are feeling so they are doing it through action instead."

Expression, in some sense, is detailed as involving overwhelming feelings of distress and the suicidal ideation acts as an expression of this. This insight is also expressed by Participant G in relation to understanding the possible communication of active ideation- "*Active suicidal ideation yes it's people, maybe it's their way of expressing how much distress that they are in and don't know where else to go."*

Conceptualising suicidal ideation in the realm of a communication of distress appears to highlight a sense that the client is experiencing feelings of struggle, overwhelment and possible ambivalence. It, therefore, conceptualises the suicidal ideation as being linked to a process of struggle and expression of the struggle manifests itself through suicidal behaviours. This insight highlights a more inclusive model of working and identifies factors beyond that of the suicidal presentation itself.

This insight is reflected in Participant B's account when discussing how they conceptualise suicidal ideation- *"Ill say, let's look at your sense of umm belonging and whether or not you have a support network and how you're communicating distress to the people, how you manage your distress yourself."*

The main emphasis here it would appear is communication and possible identification of possible triggers regarding intent within an interpersonal subjective enquiry. The attempts at exploring distress within this narrative highlight the need to focus on factors that may help but also feed into the distressing features. However, it also frames the distress as a 'typical' response to life. Therefore, it does not limit the distress to just being expressed through suicidal behaviours. It frames distress in such a way that focuses on exploring its communicative and expressive aspects and not the distress itself.

The communicative and expressive features of suicidal ideation can appear to serve a function, which is perhaps beyond the limits of language and gaining access to idiosyncratic understanding beyond the suicidal presentation can aid in the exploration of its possible meaning. This is highlighted in Participant D's account when discussing a conversation with a client's care coordinator in relation to an exacerbation in her suicidal ideation and behaviours-

> *"She was like well all this kind of acting out behaviour it's just silly, and I'm like well it's a communication that things are not right and we need to understand what the client is trying to communicate in order to then adjust our care accordingly because if we just palm it off as being silly or dismiss it is not a real intent or whatever, then we will lose people." There is a* lack of understanding within a lot of people that work in mental health as to what those expressions are actually about*"*

This account from Participant D emphasises the importance of moving beyond focusing on observable behaviours and demonstrates the importance of exploring the processes of communication in relation to suicidal behaviours. There is a sense here that not attending to the expressions of distress risks dismissing the client's communicative strategies of distress and labels the client as a 'problem' without necessarily exploring or understanding the meanings behind the processes of

suicide. It is clear that this evokes a defensive stance from the participant, and this relates to the possibility of "losing people" due to a lack of understanding and appropriate treatment planning.

5.3. Super-ordinate Theme 3: Exploring Our Own Ideation

The theme of exploring our own ideation explores the capacity of the participants to sit with and explore their own sense of human fragility and ideation. It explores the possible universality of suicidal ideation in that the participants acknowledge that working with suicidal clients brings to focus, their own sense of mortality and their limitations to this. I will explore this theme by firstly focusing on the first sub-theme What it means to live and die, which focuses on the participant's limitations in relation to their own thoughts of suicide. Secondly, I will explore the second sub-theme it's not talked about, which focuses on the participants' awareness that as professionals, conversations with other professional colleague's around contemplating their own existence are not discussed.

5.3.1. Sub-theme 3a: What it means to live and die

This sub-theme explores the participants own sense-making around their own thoughts of suicidal ideation and explores their own sense of the limitation in relation to their own sense of mortality. Participant E presents a fascinating insight into the notion of their sense of limitations in relation to their own mortality and poses the importance of recognising and reflecting on this, specifically in relation to their clinical work-

"*Somebody who I was working with, who's eight children died in a fire, and you think how do you even get up the next day and put the kettle on. So, I think it kind of brings a focus on your own ideas, of your own, both the value of your own mortality and in a way, your own line of what would be enough for me.*"

There is a sense here that Participant E is attempting to normalise their personal experience in relation to their clinical work. It also highlights that interactions with clients can evoke feelings of vulnerability and assumptions that can feed into

processes relating to a fragile sense of humanness and possible acknowledgement of the limitations to this. This insight also subtilty implies that suicide can present as a universal thought in line with this fragile sense of humanness.

This point is further explored by Participant C when discussing a recent illness- "I had some weird health condition that no one could get to the bottom of, and thankfully it went away, but there was so much pain involved, and I kind of thought I've had enough of this. And you think I may as well call it a day, there's no point in waking up like this every day." Participant D offers an insight that is linked to feelings of vulnerability and distress. Their sense-making is bound within experiencing an event that facilitated contemplating what it means to live or do within this context.

Contemplation linked to specific events was also expressed in Participant D's account when discussing a recent relationship breakdown-

> "It's *life-changing, it's heart-breaking, it's like the worse thing ever I've experienced. You can see how, yes I'm a healthy individual, that does not really experience stress, particularly, does not have mental health problems, touch wood. I can see how something as stressful and traumatic as a relationship break-up, or it could be the death of a loved one, or it could be a huge RTA, and I can see how that may lead you to question life."*

This narrative from Participant D highlights explicitly experiencing distressing and traumatic events can provoke questions around the limitations and fragility of human experience. It also highlights that suicidal ideation is perhaps an expression of distress and not necessarily linked to pathology or 'mental illness'. It also implies again, a possible universality of the human condition, the experiencing and contemplation of, suicidal ideation. This is explored further by Participant E- "*These are part of what it means to be alive, you know these thoughts towards death and destruction".*

The notion of a universality was also understood in the context of fleeting thoughts of suicide and not necessarily being linked to specific situations or distress "We can all have fleeting thoughts, because we're fluid beings." (Participant A). These it would appear were unquestioned and assumed "I think it would be naive to assume we wouldn't get these sorts of fleeting thoughts, wouldn't it, I mean I'm not sure how far it goes, but yes probably all the time." (Participant G). Exploring the notion of fleeting thoughts did not necessarily give rise to the contemplation of human existence; rather, they allude to an assumption that it is perhaps part of human experience to experience self-destructive thoughts.

This is further supported in Participant F's account- "*In some ways, people have very different levels of self-destructive thoughts don't they. But yea, I am capable of having those thoughts, we all are I think."* Framing suicidal thoughts in this way facilitates a movement beyond pathologising the phenomenon and promotes understanding within a more humanistic and explorative arena that appears congruent to the possibility of suicidal ideation as a universal human experience.

This insight also implies a willingness by the participants to engage with their own sense of mortality, not only in line with their clinical work but also self-exploration. This is something that was expressed by participant B who also offers a direct link to human fragility-

> "*One of the most powerful things I have seen people react to in therapy is when we think about the fact that suicidal ideation can be ok. It is just a thought like any other thought, and once it's there in your head as an option its always going to be there as an option… That's what makes us human is that these options will present to you. And why would it not present to us as practitioners in the same way."*

There appears to be within the exploration of the participants narrative, a sense of the importance of self-reflection and insight, specifically in relation to their own

mortality. There is a theme developing regarding the possible universality of suicidal ideation towards the human condition, and the participants appear quite self-aware regarding their own experiences of suicidal ideation.

5.3.2. Sub-theme 3b- It's not talked about

Although the participants appeared open to the opportunity to reflect on their expressions of their own suicidal ideation within the interview schedule, a significant theme that emerged was that there is often no space for these type of conversations in their day-to-day work. This second sub-theme explores the participants experiencing a lack of opportunity to reflect, report and discuss experiences relating to their own ideation either with fellow colleague's or clients.

The processes of not talking about thoughts and feelings regarding personal feelings of suicidal ideation in the case of Participant F was linked to felling's of fear and possible rejection due to a lack of potential understanding from others-

> "Perhaps because of fear, a lot of fear isn't it, and general society and you know people, in general, are not understanding and are afraid of the issue because it's quite, it's such a huge thing isn't it. It's quite difficult to understand if you haven't been through something similar. But, like all of us are prone to having these thoughts sometimes, but then, we don't have those same opportunities to talk about it because it's not reflected or mirroring what is actually happening."

This insight from Participant F also demonstrates the wider 'systemic' issues at play. There is a recognition that on a societal level, possible discourses of understanding in relation to the phenomenon and do not appear to promote such levels of self-insight and reflexivity. This is expressed in Participant F's account detailed above and is also expressed within Participant E's narrative- *"I do think what is it that people do with these thoughts because I guess people by definition, not by definition,*

but it's not the norm is it to have this kind of awareness of your own internal processes that we are trained to do."

There is a developing sense here of feeling constrained by and vulnerable to, certain levels of self-insight specifically in relation to suicidal ideation, which it would appear, is not perhaps the case for other professionals. The sense of vulnerability with communicating deepened levels of insight is apparent in Participant B's account- "Is making ourselves to vulnerable by admitting that we are human and these thoughts have perhaps occurred to us as well, yea it's like that separates us from them- suicidal ideation ."

This account from participant B alludes to a conflict with appearing vulnerable in relation to appearing human. There is a sense that professionalism hides processes of human fragility, and in this instance, professionalism aids in separation, separation not only from personal human fragility but separation from the client. Suicide is perhaps conceptualised as being separate from themselves and suicide is framed within a context of a 'presentation', and a reason for discussing it becomes possible. Suicide in this instance is external to the professional and discussion, or communication is framed as having a reason or purpose.

This insight may go some way as to explore the possible reasons as to why the participants felt unable to communicate or discuss their own ideation. Participant C comments that "I don't know if we do just generally sit down and talk, we do with bake-off but not with suicide. It doesn't really come up in conversation, seems to me needs to be a reason." This very much frames discussions around suicide as being contextual, and there is a sense uncomfortableness and that it would never present itself like other topics of conversation.

This does pose a fascinating insight, especially in light of the contexts in which the participant work in. Participant E provides a compelling insight when discussing communication of suicidal ideas to colleagues-

"I think within the context of my own life, there are edges. I don't think that it's something people talk, well people don't talk about that because you would assume gosh my colleague is a risk to themselves (laugh), and yet we can quite happily say I would cheerfully kill such and such sometimes. I want to do such and such to so-and-so oh yeah, so maybe we're more comfortable with our own homicidal tendencies."

The narrative from Participant E highlights layers of comfortability in relation to exploring and communicating the more fragile aspects of human existence. It also highlights the possible vulnerabilities in having such conversations and poses an interesting comparison between communicating thoughts to harm others vs self. This insight was also reflected in Participant G's account- "*In DBT we have team supervision so the client's suicide is talked about, never our own though, I don't even know if that would be a thing. We do happily talk about hurting other people sometimes though (laugh*)."

There is a developing sense here around the processes of self-disclosure. Participant A acknowledges that possible limitations to communication or disclosure with professionals could be made sense of in relation to feeling contained, similar to the process of therapy with clients-

"If you're talking to colleagues you know, what we do to help people disclose their own suicidal ideation is you create a safe, structured therapeutic space around them. Are we providing the space in which practitioners can do that in an appropriate way, I don't know."

The limits to self-disclosure were also explored in relation to clinical work with client's as highlighted by Participant E- "*It makes me think of self-disclosure, and what would it sound like for a therapist to say to somebody, yea I have thoughts to kill myself*

(laugh). I don't know how that would do down". Although there appears to be an acknowledgement towards the possibility of self-disclosure, there is also a sense of trepidation to this specifically in light of communicating feelings of self-destruction with others.

This point by Participant E does pose further questions relating to congruence with both self and process as well as possible transretinal responses to what is not talked about. What is apparent, however is that the participants recognise the processes of their own human fragility and felt comfortable discussing in the interview schedule what is not normally talked about- their own experiences of suicide.

6. Discussion

Semi-structured interviews were conducted with seven practitioner psychologists with HCPC registration under the heading practitioner psychologist. Interpretative Phenomenological Analysis (IPA) was utilised in order to analyse the experiences of practitioner psychologists' working with active suicidal ideation. Three superordinate themes emerged.

This section will focus on the three themes highlighted through analysis in light of pre-existing research and literature. Given it is in the nature of IPA that the interview and analysis will have taken you into new and unanticipated territory (Smith et al, 2009: 113,) new literature, as well as literature covered in the literature review, may be utilised in this section as a way of further exploring the themes identified.

This section will draw upon psychosocial literature as a way of exploring meaning that is bound within discursive and subject positioning. Positioning in this case, relates to the importance of the social in explaining human choice, which is bound within the understanding that social discourses can construct an array of subject positions that can be negotiated and occupied, thus providing a non-individualist way of linking individual subjects and the social world (Hollway and Jefferson, 2005:149). Psychosocial literature offers an insight that moves beyond individualising and provides a space of interpersonal meaning that can be found in the themes explored throughout the results section.

I will present each theme in turn, starting with Super-ordinate theme 1: Working in Multi-Disciplinary Teams, then Super-ordinate theme 2: Working with Suicidal Ideation and lastly, Super-ordinate theme 3: Exploring Our Own Ideation.

6.1. Super-ordinate Theme 1: Working in Multi-Disciplinary Teams

Working in Multi-Disciplinary Teams (MDT) explored the participants' experiences of working within MDT and focused on both the positives and restrictions involved in working with other professional colleagues. The analysis brought to light that the positive aspects involved in MDT related to feelings of support and containment as well as the ability to share risk across professional. The more negative aspects eluded to feelings of frustration in relation to assumed responsibility, experiences of blame and punishment regarding organisational processes. Analysis of the narrative also brought to light the possible barriers and restrictions in relation to possible tensions experienced within MDT working.

MDT working was understood to be informative in relation to how risk is conceptualised and understood whilst also identifying the implications for this. Analysis of the participants narrative uncovered that the participants appear to be directly influenced by organisational processes aligned to MDT working specifically when considering how they conceptualise and attend to suicidal presentations. It is evident that from all the participants' accounts, MDT working was seen as an essential component to their overall professional identity.

MDT working does form part of the standard of proficiency as outlined by the HCPC indicating that practitioner psychologists be able to work, where appropriate, in partnership with service users, other professionals, support staff and others, and understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team (HCPC, 2015).

Within NHS contexts, psychologists are seen as being integral in team composition (Department of Health, 1999, 2001). Psychologists are advised to adapt their working practice to match the needs of the team according to their own style of working (British Psychological Society (BPS, 2007) and to adapt psychological interventions creatively to meet the needs of service users (Murphy et al 2013).

MDT working in healthcare generally appears as a generic term that tends to focus on the collaboration of varying professionals within specific contexts; however, the term does appear recognisable to professionals (Moss, 1994). Leathard (1994) identified over 50 possible meanings in relation to the term MDT indicating, wide semantic variance in relation to reaching an explicit definition (Mason et al, 2002).

However, in keeping with the participants' narrative, it is felt that defining MDT working as a team usually from both health and social care backgrounds that include those who have up-to-date knowledge of the individual's needs, potential and aspirations (NHS Wales, 2011), is sympathetic to the participants' narrative.

This definition has been chosen because it encompasses appreciation for what each professional discipline contributes to client care and also offers an awareness of the interdependency of practice. MDT, in this case, minimises liability and ensures care is delivered to optimise client safety (Grant and Lusk, 2015). This offers protection against risk as MDT working offers a ‘sharedness' of working that is both informative and containing. The role of Psychology within MDT working was viewed as something that was reflexive and containing whilst also at times in conflict with other colleagues specifically in light of medical model orientated service delivery.

This has been highlighted because although the participants reported valuing MDT working, team reflexivity was lacking within their experiences of it. This the

participants felt, formed a large limitation to MDT working. This could perhaps be due to the differences in professional training, as highlighted by Participant F. Reflecting on this insight from participant F, this could offer an insight into how reflexivity was seen as lacking within MDT working. Stokes (1994) suggests that the dominance of medical model understandings within teams may serve as a support to professionals who work with clients who present with high levels of distress.

Murphy et al (2013) postulates how psychologists are often sympathetic to medical model orientated attitudes to presentations and view this as having a place within the team. Participants do appear to demonstrate this, although it does not really account for the variance in reflexivity within teams, which the participants highlighted was lacking within their experiences of MDT working.

West (1994) defines team reflexivity as the team's ability to focus on its aims and objectives through feedback and evaluation mechanisms (Cited in Mason and et al, 2002). Within this, West identifies four positions that teams may occupy: fully functioning teams, within which there is high team and social reflexivity; cold efficient teams, demonstrating high task effectiveness with poor social reflexivity and mental well-being of its members; cosy teams, with high social reflexivity and mental well-being status, but low on task reflexivity and effectiveness; and dysfunctional teams that were low on all factors mentioned previously. Team reflexivity is suggested as one element of measurement to measure a team's positioning.

Within this understanding, it could be plausible to assume, in light of heavy medicalised orientated understanding, that the participants experienced cold efficient and dysfunctional teams. This could account for the limited experience of and ability to participate in reflexive practice. This point has been highlighted, not to assume

group dynamical structures of their organisational experiences, or to discredit MDT working, but rather to offer potential insight into the possible limitations within teams regarding reflexivity. However, nonetheless, the participants do appear sympathetic and understanding regarding the differences within MDT working.

This is evident when considering Participant D's account regarding collaborative working and treatment planning within a wider risk-sharing network. MDT working in this case, although having its limitations, appears fundamental in the participants' ability to work with and conceptualise active suicidal presentations.

When considering feelings of blame in relation to organisational structures specifically in light of the participants sense-making around conflicts within personal and professional roles, it would appear that separation of personal views to meet organisational requirements is quite difficult (Reeves, 2010). It would appear that organisational and legal frameworks hinder the participant's ability to be truly curious within their therapeutic endeavour with clients and interferes with the ability to develop positive risk initiatives based on a true interpersonal and idiosyncratic formulation.

This insight is supported by Flewett (2011) who postulates that value judgements are involved in risk assessing and that an undesirable outcome does not necessarily mean that a wrong decision has been made. Flewett also postulates that high levels of anxiety that are caused by increased feelings of accountability and attempts to prevent risk taking, will have a negative effect on clinical practice. Therefore, affecting how adequate responses towards risk could be compromised due to restrictive organisational frameworks.

This point also highlights the possible defensive implications of something going wrong, and how this could affect value and professional judgements. Reddington (2017) postulates that when considering defensive practice, client care can be further compromised because clinicians are protecting themselves from possible blame and legal action should an undesirable outcome arise. In support of this, Flewett (2011) also highlights that clinicians can often fear undesirable outcomes, linked to the loosing of professional registration or attending organisational inquiry, rather than over the outcome itself. Reflecting on this, it is plausible to argue that professionals therefore, become more risk averse in their clinical practices to defend against the anxiety of the possibility of an undesirable event occurring.

This point also brings to surface the possible countertransference responses at play, in that the conflicts described above, could potentially interfere with the practitioner's ability to engage with clients and their suicidal ideation. This therefore, could add further insight into the themes discussed in relation to defensive practice and being contaminated by risk.

Leenaars (2004: 101) postulates that countertransference reactions comprise all the practitioner's unconscious reactions to the client and these originate in the practitioners own conflicts and that more negative responses may prove to be both problematic and even suicidogenic. Such conflicts Leenaars argues, may lead to possible disregard for the client's experiences by not exploring or discussing the suicidal ideation with the client, allowing oneself to be lulled into a false sense of security by the client's promises to not repeat a suicide attempt (as highlighted by participant A with discussing contracting) and denial of one's own importance to the client.

There is a sense that organisational and legislative structures offer a framework that does not favour subjective lived experiences. A recent Welsh Government strategy for mental health and wellbeing, under the Mental Health (Wales) Measure (MHM), places a legislative duty on all health boards and local authorities in Wales to improve support for people with mental ill-health (WAG, 2010).

Although virtuous in its ambition, the MHM focuses on preventing mental health problems from developing in the first instance, preventing mental health problems from getting any worse by providing early interventions, and preventing mental health problems from having a long-term or life-long impact by supporting recovery (WAG, 2010). The summary of finding within this measure focuses on appropriate risk assessment and care and treatment planning (CTP) however, risk assessments and CTP's are based on generic pro-forma templates that aim to standardise and quantify information contained within them.

This highlights the potential issues in relation to assessing and understanding the phenomenon as ‘templates' fail to capture the true essence and complexity of what it means to be a human being. It also fails to capture the potential meanings or expressions of clients suicidal ideation and becomes too prescriptive in how suicide is understood and ‘measured'. To support this, Reeves (2010) postulates that there are inherent dangers to being too prescriptive in response to suicidal procedures highlighting that human beings are not that predictable or straightforward.

Working in this way presents a sense of negotiation in relation to personal, professional and organisational belief systems. It, therefore, becomes a complex interchange of understanding, expression and communication of which, appears

disconnected from what the participants reportedly strived to offer their clients, safety, containment, freedom of expression and empathy.

6.2. Super-ordinate theme 2: Working with Suicidal Ideation

Working with suicidal ideation explored how the participants worked with and understood the phenomenon. It focused on an exploration of the possible functions and communications of suicidal ideation and analysis of the participant's account, demonstrated the complexities of working with and understanding, suicidal ideation. It draws understanding to the possible communications and functions of suicidality in light of diagnosable mental health conditions alongside the systemic factors that both influence and aid in sense-making regarding active ideation.

This theme highlights the importance of recognising the communicative aspects of ideation that detailed a move beyond observable presentations towards more of a depth of understanding. Distress was understood to be a communicative factor of suicidal ideation as expressed in the accounts of both Participant G and Participant B.. There was a developing sense that focusing understanding of suicide being a communicative strategy was in conflict with other professions specifically in light of Participant D's account when describing how a client was labelled as silly and acting out.

There is a sense that not attending to the communicative aspects of suicidal ideation can facilitate ambivalence towards suicidal clients and risks dismissing the client's experiences. To support this, Kutcher and Chehil (2007) postulate that if a client repeatedly entertains suicidal ideas and frequently threatens suicide, it can occasionally invoke ambivalent feelings. The client, however, may be frustrated with

ongoing interventions or treatment and may be using suicidality as a way of communicating their distress. Distress was also understood as being linked to social factors, as demonstrated by Participant B.

Identifying the importance of social influences on suicidal individuals was understood as facilitating further reflection, insight and sense-making regarding ideation, facilitating a shift beyond pathology and observation. Suicide in this instance is not just determined by the present, it has a history (Leenaars, 2004), an interpersonal history.

The focus of shifting from medical model orientated understandings towards focusing on the client's inner experiences offers a shift in perspective from the professional as expert to the client as expert of their own biographical context (Konrad, 2011). It is interesting that participants take this position given that evidence from numerous empirical studies, mostly using psychological autopsy methods, suggest that up to 90% of persons who die by suicide have a diagnosable mental disorder. The most common diagnoses are affective disorders, substance abuse disorders, personality disorders and schizophrenia (Mishara and Chagnon, 2011: 610).

Despite this, however, there does appear to be variation, especially in light of Participant C's account of the client who jumped off a bridge and who had no diagnosable mental health condition. Within this same thread, diagnosis does not also account for those who wish to participate in euthanasia, like mentioned by participant E and also perhaps those who commit suicide on a mass scale on the grounds of political or religious ideology.

This point highlights the possible limitations to suicide prevention strategies to prevent or reduce suicide, suicidal ideation and self-harm such as The Mental Health

Declaration (WHO 2005, European Commission 2005), which view mental illness and suicide as significant problems in relation to mental well-being. Suicide in this instance is often viewed within the ‘lens' of a mental disorder or rather, suicide as being a treatable condition, which is then, often reflected in treatment planning recommending pharmacology and CBT (Wasserman et al, 20102, NICE 2015).

It is plausible to argue that such a position aids in individualising the suicidal client and creates a separation between practitioner and client rendering suicide as a ‘presenting problem' that is ‘treated' within a health care system, mental health. Although there are strategies and policy initiatives to destigmatise suicide through nation-wide campaigns, early intervention services and sensitivity to reporting of suicides in the media (Talk to Me, 2014) suicide is still seen as a mental health condition, despite it being acknowledged that there are many risk factors involved in suicide (Turecki and Brent, 2015)

Participant C highlights this point when identifying that suicidality is brought to services, and that is where it is treated. Developing this insight further, Participant E highlights that mental health is within the health services, and people die in the care of health services for many other reasons. However, acknowledging the contradiction within this, noting that mental health teams are and somehow should be, responsible for keeping people alive highlighting that perhaps the same expectation would not be placed on oncology or cardiology for instance.

This insight does pose questions regarding the positioning of suicidality within a health system but also wider questions regarding the classification and understandings of it. The participants appear to make reference to this in relation to valuing and exploring the interpersonal lived experiences of their clients and not

explicitly locating their active ideation in the realm of medical discourse. Mental illness is viewed as a contributing factor in some cases; however, it's not seen as the dominant theme.

This it is felt offers an interesting insight as it demonstrates not only the multifactorial and complex nature of suicidality but also values, gains access to and engages with a rich arena of intersubjective experience, biographical meaning and exploration that a diagnostic discourse ignores. This highlights the need to value the clients interpersonal and relational dynamics because it would appear their intersubjective positioning and experiences can offer insights into suicidal ideation that moves beyond pathology. This insight would be fitting within a psychosocial approach.

The psychosocial approach highlights that the individual and society are interlinked and that neither can exist in isolation of one another. That said, there is an arena of personal subjectivity that exists within the social, discursive realm, however, this does not exist other than as already inscribed in the socio-cultural domain (Frosh et al, 2003:39). This insight highlights that individuals are neither separate from the social world nor reducible to it, but rather always already psychosocial. Highlighting that attention should be paid to the histories of individuals and the idea of investment in discursive positions (Hollway and Jefferson, 2005). In relation to suicide, this 'focus on the psycho-social' could offer a compelling insight as suicide could be viewed as being constructed both through and within discourses where it is negotiated, sustained and renegotiated (Edley, 2006).

It is precisely this negotiation and positioning that could enable suicide to be both complex and contradictory because the social and cultural aspects of suicide is felt across societies and cultures and in fact has existed since the earliest records of

mankind (Mishara, 2006). This point not only highlights the complex and multi-layered aspects to how suicidality is understood and conceptualised but also how it is responded to and defined within sociocultural contexts, meaning that perhaps the dominant sociocultural discourses directly affect our understandings and interpretations of suicidality.

This point has been raised because it challenges dominant discourses that suicidality is linked to or part of, a mental health disorder especially when considering ideologically driven forms of suicide by individuals who willingly gave their own lives on the grounds of extremist religious ideology. There does however appear to be no evidence linked to extremism and mental illness rather, research does highlight that extremist individuals demonstrate high levels of acceptance of suicide and suicide is viewed as carrying a highly positive and moral status that is elevated by their commitment to their radical religious goals (goldsmith et al, 2002: 195).

This point, although highly controversial, does pose an interesting insight into the creative and constructive nature of discursive positioning whilst also offering the prospect to challenge dominant discursive themes specifically when considering mental health and suicidality.

It seems possible that the arena of personal subjectivity that exists within the discursive realm accounts for individual expression, choice or completion of suicide. Such an investigation or indeed positioning, would value the intersubjective lived experiences and possible unconscious processes of clients and not render their suicidality as an observable expression of an underlying medical condition. It would also value and be aware of the discursive positioning and negotiation involved not

only for the client but for self and organisation, promoting reflection of our own interpersonal negotiation and positioning around suicidality.

6.3. Super-ordinate Theme 3: Exploring Our Own Ideation

The theme of exploring our own ideation explored the capacity highlighted by the participants to sit with and explore their own sense of ideation in light of their own humanness and fragility. The theme also explored the possible universality of suicidal ideation as being integral to their sense of humanness. Clinical work with clients facilitated reflection of the participant's sense of human fragility and their limitations to this.

What is most compelling within this theme is the participants' recognition and contemplation of their own sense of fragility. This highlights the possibility that suicide is something that is within us all. This links into the psychosocial aspects discussed in theme 2, Working with suicidal ideation, as it demonstrates the discursive expression and positioning of suicidality but also links to our own intersubjective positioning of this.

For the participants, what this could highlight is a sense of extended reasoning based on the recognition of the limitations and constraints within discursive positioning. This was highlighted in Participant E's case where negotiation of our own suicidal ideation can be conflicting because there is not space, as practitioners and professionals, to discuss what is described as a common occurrence. It is important however to make the point that a fleeting or even persistent thought is different from an intentional self-injury or suicide attempt, and it is not the attempt that is of focus

here, rather it is the possibility that suicidal thoughts, fleeting or otherwise, could have a universal place within our makeup as human beings.

This is further supported by participant F, who not only highlights the potential universality of ideation but also identifies the limitations of effectively communicating this. It would appear here that the underlying communication is that of acceptance and exploration; however, the communication contains a filter regarding the practitioners' own sense of ideation. This filter could be counterproductive because there could be a possible meta-communication that is being communicated to the client in which the client is positioned as different from the practitioner because they are suicidal. Such positioning is absolutely not the case when considering the participant's narratives regarding reflection, awareness and acceptance of their own suicidal thoughts.

This further complicates the picture when considering that suicide is brought to the services in which practitioners operate because, within this perspective, the practitioner is not positioning themselves as different from their client. Instead, it is the negotiation on both societal and organisational platforms that promotes difference of positioning. This could aid in the understanding regarding the conflicts and limitations the participants expressed because it would appear that although they are in some parts shaped by this, they appear guided and influenced by their sense of fragility, which appears in conflict with the dominant discourses available, specifically when considering organisational structures.

The prospect of our own ideation is not a new one: Freud (1920) postulates the notion of Thanatos, the death drive. Within this understanding, the death instinct is a representative of a biological force, more powerful than the life drive. The instinctual

correlation that justifies the death instinct corresponds to the human tendency to repeat unpleasable experiences. This contradicts the notion that people only seek out satisfaction of the erotic drives and instead indicates the existence and activity of a drive towards un-pleasure and death in the unconscious (De Masi 2015: 96).

This can challenge the notion that people only seek to maximise pleasure and can furthermore highlight the sense of compulsions of repetition. However, locating the death instinct as a biological drive within the scope of this project does feel very problematic, in the sense that it individualises the phenomenon and somewhat pathologises the suicidal experience and positions it as something against the status quo. This insight also favours pathological/ biological dispositions over interpersonal socio-cultural negotiation and influence.

However, this is further complicated when considering that the participants are employed in organisations that are specifically indicative of suicidality being pathologised and against the status quo. However, the participants highlight a shift in understanding based on their own sense of fragility and upon and interpersonal and relational investigation representing a depth of understanding and insight, which goes beyond pathology.

A shift of understanding that encompasses the potential universality of suicidal ideation being an integral aspect of humanity appeared useful for the participants as they were able to reflect on their own sense of fragility, enabling them then to enter an interpersonal exchange with their clients. Within this understanding, it could be argued that thoughts of self-destruction and harm are perhaps a fundamental aspect to processing and investment within subject positioning. It is also useful to focus on how ideation interacts with the environment, which would help avoid individualising

the experience through discursive positioning that currently denies suicidal ideation as a potentially universal part of experience.

This sort of shift in thinking could aid in our ability to fully engage with the phenomenon of suicide on an interpersonal and relational level, facilitating a shift in current perspective and sense-making. This way, we would be able to engage in a dialogue that questions and challenges the over pathologising of a potentially universal experience common across humanity. It offers the possibility to extend our reasoning and sense-making in relation to how suicide and its presentations are conceptualised and understood.

Potential shifts in understanding would acknowledge and to an extent, respect dominant discourses (medical model) as highlighted by Participant C when explaining that suicide is brought to services and its where it is treated. However, as practitioners, we would not be constrained and guided by medical discourse; rather, we locate our understandings within interpersonal interaction and reflexivity. Value is placed on biographical history, subject positioning and potential universal experiences of suicidality.

Within this understanding, there is the potential to postulate the possible universality of suicide while accepting that the aetiology of its understanding are also bound within sociocultural positioning (Mishara, 2006). This point is raised because Mishara (2006: 1) argues that research into suicide and influence from the International Association for Suicide Prevention (IASP) has historically focused on the commonalities in suicide, with adaptations to specific cultures and settings, whilst either ignoring cultural differences entirely or focus upon a specific culture without examining possible commonalities across cultures.

To further expand on this, perhaps the commonalities within suicide are linked to the notion identified here that suicidal ideation is integral to our sense of humanness and therefore common across all humanity? Such a view, however controversial, avoids complete separation and classification of suicidality as a or part of a mental disorder and provides a baseline of commonality across cultures. That said, it is not to say that wanting to kill yourself is and of itself a mental health problem (Participant E) it is in cases linked to diagnostic criteria that applies to those at high risk of suicide, BPD for instance. However, it is about attempting to explore and connect with its possible universality across humanity that may or may not be, linked to a diagnosable condition.

Such an insight, if applied to legislative processes, i.e., Talk To Me (2014) would help frame the conversation around suicidal ideation in a more meaningful way promoting depth of expression without the need for reason as highlighted by Participant C. I am aware that framing suicidal ideation in this way can be seen as controversial as there is a distinction between thought and action, however it is felt that the focusing on the potential universal aspects of suicidal ideation would go some way towards de-stigmatising and medicalising of the phenomenon.

6.4. Interpretative Phenomenological Analysis

The use of IPA in this project was new to me, and I was at first unsure how to apply the methodological considerations of IPA to the research questions. The use of IPA however seemed very appropriate for the aims of the research as I was interested in exploring how people ascribe meaning to their experiences in their interactions with their environment (Smith, Jarman and Osborn, 1999), which for me, offered a movement from an exploration of the role of language in describing a person's

experience (Biggerstaff and Thompson, 2008) as within previous research I tended to focus on Discourse Analysis as a research methodology.

The prospect of exploring a person's ‘inner world' for me, encapsulated the rationale for conducting the research in the first instance and also offered a space to consider the mutual co-constructed space between myself and the participants where meaning is constructed. After carefully and systematically familiarising myself with the research methodology, and testing this out with three test interviews, I was able to appreciate the philosophical underpinnings of IPA and the subtleties involved in how to best approach the topics and interview schedule with the participants.

The meaning and sense-making from each interview offered a space of reflection and sense-making. The biggest task, however, was bringing into research the participants narrative as well as the meaning that is forged within the co-constructed space between myself and the participants. This was achieved through meticulously and accurately recording the content of the interviews, observations and of course, my own self-scrutiny as a way of distilling meaning and forging understanding within methodological research. This was also aided by the solid methodological considerations of IPA and also the practical and structured step-by-step iterative stages

Self-scrutiny, in this case, was essential to identify where I position myself with reference to truth, knowledge, meaning, and intersubjectivity. It is for this reason that three pilot or test interviews were conducted because this sense of self-scrutiny is critical to the conducting of interviews, analysing the data and presenting a credible, valid and informative account of what is being researched.

The use of a different research methodology would most likely have produced a different account however it is felt that the methodological rigor of IPA, its practical and philosophical underpinnings and my self-scrutiny that has provided a balanced and appropriate exploration of the participants' experience.

6.5. Reflections on My Reaction to the Research

A considerable amount of time has passed since I first started thinking about the research question and rational. The whole process has been one of stimulation, enlightenment and dares I say, enjoyment. I have found that my relationship to both understanding and working with suicidal ideation has changed since this research in a very positive way. My initial experiences of suicide as detailed in the reflexivity section, I feel have led me on to this path of discovery and I have had the opportunity to really reflect on what that has been about for me. Most notably, how my positioning in relation to how suicide is worked with and understood came from a very anxious and nervous place.

I have also been surprised by how the research has turned out, specifically when thinking about the idea of the possibility of our own ideation and how awareness of this can help in our therapeutic interactions with clients. I must admit I was not prepared for that level of insight however it has had an enormously positive impact on how I both work with suicidal presentations and how I work with other MDT colleagues in the acute mental health service I work in.

In recent months, I have been involved in developing an all-Wales policy on how suicide and self-harm policy is delivered across Wales, focusing on a Matrix-style system of assessment and intervention. I have also been involved in providing

training sessions across the Health Board I am currently employed in with in-patient staff on how suicide can be conceptualised and worked with in acute settings. All of which develops on similar themes highlighted in this research.

7. Future Research and Implications for Practice

I hope that future research would value and appreciate the importance at exploring individual lived experiences. As highlighted earlier, I would strongly advocate for MDT specific research that would focus on the experiences of other professionals as well as psychologists to help explore and expand on further, the themes highlighted in this research. This I feel would offer compelling and rich insights regarding MDT specific ways of exploring professionals' experiences of working with active suicidal ideation.

Future research could also attempt to expand explicitly on the superordinate themes highlighted in this research and possibly offer an enriched understanding and insight into how experiences of the superordinate themes identified explicitly impact on their working with suicidal clients. This would also entail qualitative research intending to validate my tentative results on a wider population.

The implications for practice from this research could be quite wide ranging and specific not only to the field of Counselling psychology but the Psychologies' more widely and also other therapeutic and mental health professionals.

An important implication for practice in relation to this project, is the possible issues that arise in relation to positive risk taking. This also has wide ranging policy implications as it brings into question factors that can disrupt effective clinical

practice that promotes and engages with, effective positive risk management strategies. The research highlights such limitations as being linked to high levels of anxiety, defensive practice and overwhelming feelings of blame. Szmukler (2003) highlights that blame culture, threats of legal action and complaints continue to be a distinct factor in clinicians' practice, despite The Berwick Review (DoH, 2013), that reported clinicians should take pride in their work rather than organisations distilling fear and blame. The report highlighted that fear can be toxic to both safety and improvement (Cited in Reddington, 2017: 31).

This notion therefore indicates a movement away from being risk averse to becoming more risk aware with organisational support that is expressive of, and supportive to, positive risk taking. This would perhaps bring organisations into a realm where positive risk management means being aware that risk can never be completely eliminated, and aware that management plans inventively have to include decisions that carry some risk. The risks should be explicit in the decision-making process and should be discussed openly with the client (DoH, 2007).

Despite this insight from the Department of Health, it would appear that the participants did not experience such containment within their organisational contexts. Following such insight would value communication and understanding whilst avoiding the focus of blame to be shifted onto practitioners. It would appear that the participants are negotiating what they feel is right for the client vs doing what is expected of them both organisationally and professionally. The effects of this appear to have a direct effect on how suicidal ideation is conceptualised, understood and worked with, specifically in light of positive risk taking.

Potential policy directives could focus understanding towards the communicative features of suicidal ideation, specifically in relation to distress, rather than viewing suicide as a mental condition where responsibility to 'treat' suicide is placed on professionals. Focusing on the communicative aspects of suicidal ideation would help steer the understanding of suicide away from dominant medical model orientated discourses, promoting resources that focus on idiosyncratic meaning and the possible functions of suicidal ideation.

Directing policy in such a way, could also help shape societal discourses and understanding towards the functions and communications of suicide, whilst also promoting more of a risk awareness rather than aversion of risk. This could help contextualise suicidal ideation as being expressive and would promote collaboration with the client and services that is supportive of the identified risks, which would enable clients to take the risks they need to live a life that best suits them (Reddington, 2017).

This would, therefore, avoid punitive and punishing organisational responses to when things go wrong, and help promote services that are open, transparent and trusting of professionals and clients alike. It would also promote containment for professionals avoiding defensive practice and risk could be conceptualised as transformative and insightful rather than static and measurable.

Another important implication for practice, I feel, is the need for self-reflection and reflexivity. Not only on an individual and professional level but also on a team and

organisational level. Specifically, in light of exploring the notion of our own ideation as a process of therapeutic exchange and formation of a therapeutic relationship. There is something here around providing an organisational and professional space, whereas clinicians, we can explore and reflect on, the process of our own vulnerabilities.

This has been said, because it is likely that the more in tune we are with our own internal and group processes, the less likely we are to perhaps work with clients and interact with colleagues in less anxious and un-reflexive ways. This in turn, promotes continuity, support and containment on individual, professional and organisation platforms. It also provides us as clinicians, the opportunity to approach different explanations and understandings of suicidality in light of exploring the interpersonal and relational aspects to people's experiences. This, would aid in the further challenging of medical orientated models of understandings for more interpersonal and humanistic ones based on elements of a universal fragility within humanity.

Furthermore, the processes of reflexivity could facilitate a shift in the felt sense away from fear and anxiety to ones of competence and skill. It would also help focus and explore, the possible processes of transference and counter transference It would seem a good idea to offer protected time, outside the parameters of supervision, reflective practice sessions where practitioners explore the interpersonal, organisational, systemic and personal aspects involved when working with suicidal presentations.

Furthermore, there is scope within the research presented to provide alternative ways of explaining, exploring and even conceptualising active ideation when working directly with clients. This of course would pay homage to the interrelated aspects to the superordinate themes presented in the research and would also impact on potential definitions and ways of therapeutically exploring and working with, clients active ideation.

The research highlights a movement beyond observable acts towards a more interpersonal and relational way of exploring the functions of somebodies' suicidal presentation. In relation to practice, this could mean as well as focusing on the suicidal ideation, also focusing on other factors that may contribute to the presentation, but also other aspects involved in that clients life. Such a stance would shift the focus from being explicitly on the ideation towards a more interpersonal and reflexive understanding. Such a position would acknowledge classification systems to understanding suicidality, whilst not allowing it to be the only focus within the therapeutic exchange.

Although small in scale, the possible guidelines for reflective practice in relation to the findings of this research could include:

- Weekly supervision/ consultation in relation to identifying areas of development in relation to their experiences with working with suicidal clients- This would involve exploration and reflection on, areas of success and also reflection on what has been difficult to source all opportunities for the positives of change

- Obtaining regular client feedback in relation to both client and practitioner strengths and weakness and also to track progress- This would also help with identifying transference/ countertransference response to be reflected on in supervision/ consultation
- Facilitating MDT reflective practice sessions focusing on the exploratory and communicative aspects involved when exploring a clients suicidal ideation to promote breadth and depth of understanding- This would also help focus discussion around positive risk taking
- Participation in joint reflective practice sessions with other practitioner psychologists as a way of promoting psychological understanding and formulation regarding suicidal ideation, as well as, facilitating conversation and discussion around our own sense of human fragility- This could also facilitate discussion around the limitations Psychologists experience in MDT working.
- The promotion of self-reflexivity and insight in the providing of supervision/ consultation to others to further promote discussion and insight
- Engagement in personal therapy the explore further, in a personal context, our own sense of human fragility to help build awareness of our own limitations as well as promoting a separation of personal experiences from that of clinical work.

8. Conclusion

The aim of the study was to explore the experiences of practitioner psychologists who have experience of working with active suicidal ideation. Seven practitioner psychologists with HCPC registration under the heading practitioner psychologist, were interviewed using semi-structured interviews. The focus of the interviews was to explore the participants' experiences of working with clients who present with active suicidal ideation and the data was analysed using Interpretive Phenomenological Analysis (IPA). The results offer a unique exploration of experience that is not present in other literature and offers an interpretation of the participants' experiences working with this presentation.

Analysis of the data highlighted three Super-ordinate themes. Working in Multi-Disciplinary Teams, describing the containing and supportive aspects of MDT working alongside feelings of blame and highlighted tensions and possible conflicts that arise alongside possible barriers and restrictions experienced from working within a MDT. Super-ordinate theme two, Working with Suicidal Ideation, explored the possible functions and communicative aspects of suicidal ideation whilst emphasising exploration of factors outside of the individual that may account for a richer understanding of suicidal ideation.

Finally, the third Super-ordinate theme, Exploring Our Own Ideation, explored the capacity of the participants to sit with and reflect on, their own sense of human

fragility whilst also acknowledging that such reflective processes are not freely discussed as professionals.

The research has contributed towards understanding the ways in which Practitioner Psychologists' work with and understand clients who present with active suicidal ideation. The research has focused on the experiences of working with the phenomenon and has highlighted the complexities of working with suicidal presentations on personal, professional and organisational levels.

Psychosocial literature was drawn on to help explore the participants accounts further and offered an exploration of the research that focused on the complexities of both working with and theorising of suicidality. The need to focus on and explore the interpersonal and relational aspects relating to suicidal ideation were of primary focus within the project, highlighting that suicidal ideation is too complex a presentation to understand within any one discourse or frame of understanding.

The research has also brought to light, in a new and unique way, the importance of self-reflection and self-awareness in relation to a possible universality of suicidal ideation. The importance of self-reflection and insight has highlighted that appreciation of our own sense of human fragility can have therapeutic benefit, in so far as, there is the possibility to enrich the therapeutic encounter with clients by acknowledging our own fragility as a way of connecting with theirs. Demonstrating a shift in understanding away from a pathologising and symptomatic one, towards a more relational and interpersonal one.

8.1. Limitations

Despite the research offering an in-depth analysis of practitioner psychologists' experiences of working with active suicidal ideation, a potentially significant limitation to this research is failing to recruit and include other professionals such as Nurses, Psychiatrists and support workers. This would have offered a spectrum of professional insight and perspective that would have further ‘beefed up' the analysis and provided an MDT specific insight into working with suicidal presentations.

Although other research has focused on Doctor and nursing staff(s) attitudes, there is an apparent lack of MDT specific research in light of active suicidal ideation. The scope for this is further reaching still, as there could also be inclusion of Home Treatment and Crisis Team staff(s) again to bolster further the insight explored in this research.

This, however, was deemed beyond the remit of this research project for reasons of scope, homogeneous sampling and the quantity of participants to recruit. However, I would both welcome and advocate for a research project exploring the experiences of MDT teams when working with active suicidal ideation.

Another limitation to this research could be my decision to recruit practitioner psychologists and not focus on or indeed include, other psychotherapy professionals in the project. This has been noted because the potential insight and implications for practice highlighted in this report are applicable to other professionals and not just that of psychologists. Inclusion of other therapeutic professionals it is felt, would have offered further insight and exploration of the therapeutic and relational aspects involved when working with active suicidal ideation.

The participants selected were all practitioner psychologists working within Wales at the time of the interviews. This could also be viewed as a significant limitation as

policy directives towards how suicide is conceptualised and worked with are different within the devolved nations. So, the recruitment of practitioner psychologists outside of Wales could have yielded different insight and processing based on the practitioner's experiences. This is in large due to recent policy changes within English NHS trusts regarding directing provisions and resources toward zero suicide prevention strategies that do not exist in Wales.

I also aware that that the conscious choice to recruit practitioner psychologists based on their HCPC registration is also a significant limitation as it fails to acknowledge the divisional memberships and trainings applicable to each branch of psychology training, more specifically Clinical Psychology, Counselling Psychology and Forensic Psychology.

This decision to focus on HCPC practitioner psychologists over BPS divisional psychologists was one which took significant thought and reflection. The main reasons for this was that I wanted to focus on the commonalities amongst psychologists', which was not divisive, or prejudice, based on divisional membership and training. Rather, I felt focusing on HCPC registration (which in large is also essential for working in NHS posts) offers a threat of continuity and provides a homogenous sample appropriate for the terms of this project.

Furthermore, the rational for this project was based on exploring the experiences of working with active suicidal ideation and not that of divisional membership within the BPS and differences between psychology trainings. It is important to note, that the participants did not raise any questions or concerns regarding divisional membership and the narratives of the participants do not elude to this either.

8.2. Methodological Reflections

This in-depth research of practitioner psychologists' experiences of working with active suicidal ideation has been presented with reference to psychosocial understandings as a way of enriching the data. The research provides a rich and detailed account of how the participants made sense of their experiences working with this presentation. Such depth would have been difficult to achieve with a larger sample size, hence following the recommendations of sample sizing in IPA research was deemed appropriate for this research project. However, it is worth noting that although providing significant depth, this project does provide a lack of breadth in its endeavour however it is felt using IPA in this project was best placed to explore the participants' experiences.

My choice, however, of limiting my methodological enquiry to that of just IPA has obviously affected how the data has been approached and analysed. The use of Discourse Analysis, for instance, would have explored the construction and use of language whilst also focusing on the hierarchy and power dynamics involved. Further still, if I had perhaps followed the free association, narrative and the interview method (Hollway and Jefferson 2010) then the defensive strategies deployed by the participants could also have been explored in light of using psychoanalytical thought to interpret the data further.

However, using IPA in this research has been appropriate and sympathetic to the participants' accounts. Whereas other methodologies may offer differing insight, it is felt that IPA not only enabled the research to seek understanding of the lived experiences of the participants, whilst simultaneously moving beyond an explanation as to why the phenomenon occurs, but rather seeking an understanding that

explored the conditions that triggered the experiences. The experiences of which are located in past events, histories and the socio-cultural domain (Tuffor 2017).

Furthermore, having followed the methodological underpinnings of IPA in this research, I am left with a sense of gratitude. By this, I mean, the philosophical assumptions within IPA for me, correlate to how I work with clients. My commitment to exploring experience lived or otherwise, has been central to my interchange within my clinical work and I am left thinking that the same commitment, intrigue and curiosity has been applied here in this research as it is in my clinical work.

It is from this perspective that using a qualitative paradigm, specifically IPA feels appropriate within this research because qualitative paradigms offer the researcher the opportunity to develop an idiographic understanding of participants, and what it means to them, within their social reality, to live with a particular condition or be in a particular situation (Bryman 1988).

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10. Research Paper

Journal Article

To be submitted to Psychology and Psychotherapy: Theory, Research and Practice

Suicide and its Discontent: Practitioner Psychologists Experiences of Working with Active Suicidal Ideation.

Shane Llewellyn, Dr Niklas Serning & Dr Nigel Williams

Word Count 5,562 (excluding abstract and references)

Suicide and its Discontent: Practitioner Psychologists Experiences of Working with Active Suicidal Ideation.

Objectives: The aim of the study was to explore the experiences of Practitioner Psychologists working with Active Suicidal Ideation.
Method: Seven Practitioner Psychologists with HCPC registration under the heading Practitioner Psychologist were interviewed using semi structured interviews. Semi structured interviews were chosen to allow as much flexibility as possible to aid in the exploration of the participants experiences of working with this presentation.
Results: Interviews were analysed using Interpretive Phenomenological Analysis (IPA), and one superordinate theme is discussed, Exploring Our own Ideation.
Discussions/ Conclusions: These findings call for the importance of self-reflexivity when working with suicidal presentations and recommends self-reflective sessions to explore our own sense making when working with suicidal clients. Clinical considerations, limitations and avenues for future research are also discussed.

Introduction

Suicide is a harmful, frightening and often a misunderstood behaviour, which can seem paradoxical appearing to go against basic human motivations of self-preservation and avoidance of pain (Selby et al 2014). The World Health Organisation (WHO) estimates that the total number of people to have died by suicide in 2004 to be 844000 and accounts for 1.3% of the total global burden of disease (WHO, 2008). In the UK, 6,233 people aged 15 and over died as a result of suicide in 2013, a 4% increase from the previous year. Of the 6233 deaths recorded, 4858 (78%) were male and 1375 (22%) were female with the most common method of suicide being hanging, strangulation, suffocation and self-poisoning (ONS 2015).

Much of the research in the area of exploring clinicians' experiences working with clients with suicidal behaviour tends to focus more explicitly on self-harm in the context of clinical staff, predominantly psychiatric doctors and nurses and nurses and doctors within general medical and A&E departments (McAllister 2002, McCann et al 2006, Timpson et al 2012, Crawford et al 2003, McAllister et al 2002, Saunders et al 2012).

In a systemic review of the literature, Saunders et al (2012) reviewed 74 studies that met their inclusion criteria based on staff attitudes towards and knowledge about people who engage in self-harm in medical settings where staff were involved in the provisions of services to them. The results highlighted the extent to which medical and nursing staff in medical settings viewed those who self-harmed in a negative way. Negative views tended to manifest in feelings of frustration and sensations of failure amongst medical staff with more negative attitudes being expressed toward individuals who presented with repeated instances of self-harm.

The authors highlight that the restraints placed on medical staff within A&E departments are in large, based on limitations of resources, provisions and more

specifically time, which could account for such negative attitudes. The attitudes of psychiatric nurses were used to illustrate this point as it was identified that psychiatric nursing staff held less negative views against self-harm cases. It was perceived that this was based on their ability to form relationships with clients and the authors also make reference to the sympathetic supervisory resources available to them, which are not available to other medical staff (Saunders et al 2012).

This comparison is an interesting one as it highlights a sense of difference amongst general medical staff and psychiatric staff working within mental health contexts. Although the authors do not explicitly focus on this, it could be argued that this offers an interesting comparison between the two, which presents an opportunity to explore further therapeutic practitioners, specifically practitioner psychologists' experiences in working with active suicidal ideation. It is felt that a qualitative method of enquiry would encompass what it is really like for practitioner psychologists working with active suicidal ideation.
This has been mentioned because within the same systematic review, of the 74 studies identified, 8 were of mixed methods and only 13 were of qualitative design. Of the 13 qualitative studies examined, only one made reference specifically to psychologists and therapists and their experiences of working with clients who display suicidal behaviours (Saunders et al 2012).

In this study, Gurrister and Kane (1978) interviewed 27 therapists regarding their different theoretical formulations regarding suicide and their therapeutic preference in working with suicidal clients. The interviews were centred on the therapist's view of suicidal clients, their therapeutic preferences and their agreement or disagreement with various views of suicide (Cited in Palmer 2008).

Gurrister and Kane focused their summary of findings on psychologists' idiosyncratic understandings of suicide based on their recognitions of the severity of suicide in terms of mental distress and reported they felt as though they should prevent attempts of suicide for the needs of the client. to support this, in a similar study on psychologists understanding, Wreth (1996) argued psychologists reported exceptions to the functionality of suicide especially in cases of severe pathological illness such as cancer (Wreth 1996). Highlighting in this case that although psychologists appear to be open to the functions of suicide they do not necessarily allow such exceptions to interfere with therapeutic interventions with clients.

To expand on this notion further, in a study which looked at Australian psychologists' attitudes toward suicide and self-harm, psychologists displayed positive attitudes towards working with clients who presented with self-harm and also expressed beliefs in the right of an individual to decide when to die (Gagnon& Hasking 2011). However, this paper calls for developing future research to explore the impact of psychologist's attitudes on their behaviour towards suicidal and self-harm clients.

Developing from this point, it would appear that psychologists demonstrate an ability to hold ambivalence with suicidal clients and appear to be able to attend to the clients presenting issue. To support this, in their meta-synthesis of 13 qualitative studies of counselling and psychotherapy for the prevention of suicide, Winter et al (2014) make reference to the importance of the therapeutic relationship in working with suicidal presentations. Winter et al identified a consensus amongst therapeutic

professionals that effective therapists are understanding, empathic and non-judgemental.

There is a sense of a humanistic value within our understandings here and that understanding the subjective worlds of self and other needs to be central in our enquiry (Woolfe et al 2010).

Developing on this point further, the question arises regarding exploring and understating the subjective lived experiences of the therapists themselves when working with suicidal presentations. There does however appear to be a lack of research that focuses explicitly on the therapists' experiences. Let alone practitioner psychologists.

In an attempt to explore this, Reeves and Mintz (2001) in their exploratory study that examined the experiences of counsellors working with suicidal clients, highlighted the range of experiences felt by the counsellors from feelings of anxiety, fear, panic and doubting of professional practice and competence. A similar study by Rossouw et al (2011) who explored thirteen therapists (five of which were psychologists) experiences of working with suicidal clients.

Within their study, Rossouw et al (2011) found therapists experience a range of emotional processing similar to that identified by Reeves and Mintz (2001) however the authors also highlight the conflicts that can arise from working with suicidal presentations especially between prevention and intervention strategies in relation to the therapists' responsibilities and what it means to live and die as a human being.

These studies offer a compelling insight into the experiences of 'therapists when working with suicidal presentations as they hold the therapist at the centre of enquiry. The papers avoid offering insight in how to work with suicidal clients' rather, the inner world of the therapists is of central enquiry offering insight and understanding towards understanding the experiences behind working with suicidal presentations.

It is from this inner world perspective, that this research would like to explore the experiences of practitioner psychologists working with active suicidal ideation as a way of expanding on the ideas presented by both Reevs and Mintz 2001, and Rossouw et al, 2011, in an attempt to add to the limited research on experiences of working with suicidal presentations.

Defining Active Ideation

There appears to be no uniform set of terms, definitions and classifications for the range of thoughts, communications and behaviours that are related to self-injury behaviours with or without intent to die. Nor is there an agreed taxonomy that encompasses the full spectrum of what is clinically defined as suicide-related behaviours. As a result, it has been argued that researchers cannot effectively compare study populations or results, therefore creating further difficulty for clinicians in translating such research findings into practical applications when working with clients at risk of suicidal behaviours (Silverman 2006: 9).

It is therefore important to define the term suicidal ideation in the case of this project. Although a generic term, ideation (with or without a plan) is within the commonly used terms that generally describe the range of suicidal thoughts or behaviours (Silverman 2006). Despite there being over 15 definitions within the literature of suicide, ideation in this case, will be defined as a cognitive process and will be viewed as involving the thinking about, contemplating or planning of suicide (Crosby et al 2011).

Suicidal ideation in this instance can be viewed as involving varying levels of severity based on notions of being passive and active. Beck et al (1979) defined passive ideation as a desire rather than a plan to take ones life and active as a desire to make an active suicide attempt. This classification has helped rank categories in order of severity with active ideation considered more severe than passive (Posner et al 2014). To support this, longitudinal studies of suicidal behaviour (behaviour defined as a history of unsuccessful suicidal attempts) have demonstrated that suicidal ideation predicts later suicide attempts in diverse samples of adults and that suicidal ideation can prospectively predict death by suicide in both inpatient and outpatient samples (Koslow et al 2011).

In the case of this project, Active ideation will be defined along the same themes as Beck et all (1979) and views active ideation as a presentation that involves the desire to make an active suicide attempt. The active refers to the energetic pursuit to end one’s life and ideation refers to the ideas, beliefs and feelings (Reeves 2015) that are bound within the energetic pursuit.

Research Aim

From the literature presented above, this paper is concerned with exploring how practitioner psychologists, make sense of their experiences working with active suicidal ideation. It would appear, that this professional group has not been sufficiently researched within the literature presented and it is felt that by focusing on practitioner psychologists working within a range of organisational settings from the NHS, private practice and third sector organisations, would build on the existing literature around exploring practitioner psychologists’ experiences of working with suicidal clients.

The focus on working with active suicidal ideation differs slightly from what has been presented in the literature, as there has been a large focus on suicidal ideation and suicidal presentations. It will be argued that focusing on active ideation will add further depth to the literature as it will attempt to explore the processes and experiences of how practitioner psychologists work with the active processes of suicidal ideation. It will also provide a specific reference point helping to define the presentation, in this case active ideation.

Method

Participants

Seven Practitioner Psychologists with HCPC registration under the heading Practitioner Psychologist were recruited to take part in the study.

Ethical Considerations

Full ethical approval was granted from the researchers University. This included gaining informed consent from all participants prior to their involvement in the study and coherence to data quality and protection protocols regarding confidentiality, data use and data storage.

Data Collection

The Participants took part in in-depth semi-structured interviews in which the participants were encouraged to ‘tell their story’. The researcher aided in facilitating the discussion to promote in-depth exploration and unpacking of idiosyncratic meaning(s). The researcher in this case was guided by the participant’s narrative as the participants were viewed as experiential experts on the topic at hand (Smith, Flowers and Larkin 2009). The interviews lasted for around one hour and took place in my own private consulting room. The interview material was transcribed, and any identifying information removed.

Data Analysis

The theoretical underpinnings of IPA has its roots within phenomenology, originating with Husserl’s attempt to construct a philosophical science of consciousness, with hermeneutics (theory of interpretation) and symbolic-interactionism (meaning ascribed to events are of central concern, but only accessible through interpretive processes) (Biggerstaff & Thompson 2008).

This amalgamation of understanding assumes that the meanings that an individual ascribes to events are of central concern and are only accessible through an interpretive process. Central to this however, is that IPA takes an epistemological stance whereby, through explicit interpretive methodology, it becomes possible to access a person’s cognitive inner world (Biggerstaff & Thompson 2008:5). IPA therefore, will allow me to explore how people (practitioner psychologists) ascribe meaning to their experiences based on their interaction with the environment (most notably the organisations in which they work) (Smith et al 2009) form a critical realist standpoint that appreciates the subjective nature of reality and experience.

Psychosocial literature was utilised to help explore and enrich the analysis and further expand on the meaning of the participants’ narrative. Psychosocial in this case is based on the exploration of meaning that is bound within discursive and subject positioning. Positioning in this case, relates to the importance of the social in explaining human choice, which is bound within the understanding that social discourses can construct an array of subject positions that can be negotiated and occupied, thus providing a non-individualist way of linking individual subjects and the social world (Hollway and Jefferson 2005:149). Psychosocial literature offers an insight that moves beyond individualising and offers a space of interpersonal meaning that can be found in the themes explored throughout the results section.

The analysis of the Data followed the framework proposed by Smith, Flowers and Larkin (2009). The transcribed interviews were read and re-read. Emerging themes were then explored through the following of both the participants narrative and the researchers interpretations and connections between themes were highlighted. This was the case across all interviews which enabled exploration and identification of patterns across the participants' accounts, which facilitated in the identification of superordinate themes within sub themes identified.

The quality of the research was measured against that of Yardley's (2000) four board principles sensitivity to context, commitment to vigour, transparency and coherence and impact and importance. This ensured both quality and validity of research.

Results

The results presented here formed part of a wider study in which a total of three Superordinate Themes were identified. However, in keeping with the philosophy of IPA regarding the richness and depth of experiences, only one superordinate theme, our own ideation, will be presented in this paper.

The theme of exploring our own ideation explores the capacity of the participants to sit with and explore their own sense of human fragility and ideation. It explores the possible universality of suicidal ideation in that the participants acknowledge that working with suicidal clients brings to focus, their own sense of mortality and their limitations to this. I will explore this theme by firstly focusing on the first sub-theme What it means to live and die, which focuses on the participant's limitations in relation to their own thoughts of suicide. Secondly, I will explore the second sub-theme it's not talked about, which focuses on the participants' awareness that as professionals, conversations with other professional colleague's around contemplating their own existence are not discussed.

Sub-theme: What it means to live and die

This sub-theme explores the participants own sense-making around their own thoughts of suicidal ideation and explores their own sense of the limitation in relation to their own sense of mortality. Participant E presents a fascinating insight into the notion of their sense of limitations in relation to their own mortality and poses the importance of recognising and reflecting on this, specifically in relation to their clinical work-

"*Somebody who I was working with, who's eight children died in a fire, and you think how do you even get up the next day and put the kettle on. So, I think it kind of brings a focus on your own ideas, of your own, both the value of your own mortality and in a way, your own line of what would be enough for me.*"

There is a sense here that Participant E is attempting to normalise their personal experience in relation to their clinical work. It also highlights that interactions with clients can evoke feelings of vulnerability and assumptions that can feed into processes relating to a fragile sense of humanness and possible acknowledgement of the limitations to this. This insight also subtilty implies that suicide can present as a universal thought in line with this fragile sense of humanness.

This point is further explored by Participant C when discussing a recent illness- "I had some weird health condition that no one could get to the bottom of, and thankfully it went away, but there was so much pain involved, and I kind of thought I've had enough of this. And you think I may as well call it a day, there's no point in waking up like this every day." Participant D offers an insight that is linked to feelings of vulnerability and distress. Their sense-making is bound within experiencing an event that facilitated contemplating what it means to live or do within this context.

Contemplation linked to specific events was also expressed in Participant D's account when discussing a recent relationship breakdown-

"It's *life-changing, it's heart-breaking, it's like the worse thing ever I've experienced. You can see how, yes I'm a healthy individual, that does not really experience stress, particularly, does not have mental health problems, touch wood. I can see how something as stressful and traumatic as a relationship break-up, or it could be the death of a loved one, or it could be a huge RTA, and I can see how that may lead you to question life."*

This narrative from Participant D highlights explicitly experiencing distressing and traumatic events can provoke questions around the limitations and fragility of human experience. It also highlights that suicidal ideation is perhaps an expression of distress and not necessarily linked to pathology or 'mental illness'. It also implies again, a possible universality of the human condition, the experiencing and contemplation of, suicidal ideation. This is explored further by Participant E- "*These are part of what it means to be alive, you know these thoughts towards death and destruction".*

The notion of a universality was also understood in the context of fleeting thoughts of suicide and not necessarily being linked to specific situations or distress "We can all have fleeting thoughts, because we're fluid beings." (Participant A). These it would appear were unquestioned and assumed "I think it would be naive to assume we wouldn't get these sorts of fleeting thoughts, wouldn't it, I mean I'm not sure how far it goes, but yes probably all the time." (Participant G). Exploring the notion of fleeting thoughts did not necessarily give rise to the contemplation of human existence; rather, they allude to an assumption that it is perhaps part of human experience to experience self-destructive thoughts.

This is further supported in Participant F's account- "*In some ways, people have very different levels of self-destructive thoughts don't they. But yea, I am capable of having those thoughts, we all are I think."* Framing suicidal thoughts in this way facilitates a movement beyond pathologising the phenomenon and promotes understanding within a more humanistic and explorative arena that appears congruent to the possibility of suicidal ideation as a universal human experience.

This insight also implies a willingness by the participants to engage with their own sense of mortality, not only in line with their clinical work but also self-exploration. This is something that was expressed by participant B who also offers a direct link to human fragility-

"*One of the most powerful things I have seen people react to in therapy is when we think about the fact that suicidal ideation can be ok. It is just a thought like any other*

thought, and once it's there in your head as an option its always going to be there as an option… That's what makes us human is that these options will present to you. And why would it not present to us as practitioners in the same way."

There appears to be within the exploration of the participants narrative, a sense of the importance of self-reflection and insight, specifically in relation to their own mortality. There is a theme developing regarding the possible universality of suicidal ideation towards the human condition, and the participants appear quite self-aware regarding their own experiences of suicidal ideation.

Sub-theme: It's not talked about

Although the participants appeared open to the opportunity to reflect on their expressions of their own suicidal ideation within the interview schedule, a significant theme that emerged was that there is often no space for these type of conversations in their day-to-day work. This second sub-theme explores the participants experiencing a lack of opportunity to reflect, report and discuss experiences relating to their own ideation either with fellow colleague's or clients.

The processes of not talking about thoughts and feelings regarding personal feelings of suicidal ideation in the case of Participant F was linked to fellings of fear and possible rejection due to a lack of potential understanding from others-

"Perhaps because of fear, a lot of fear isn't it, and general society and you know people, in general, are not understanding and are afraid of the issue because it's quite, it's such a huge thing isn't it. It's quite difficult to understand if you haven't been through something similar. But, like all of us are prone to having these thoughts sometimes, but then, we don't have those same opportunities to talk about it because it's not reflected or mirroring what is actually happening."

This insight from Participant F also demonstrates the wider 'systemic' issues at play. There is a recognition that on a societal level, possible discourses of understanding in relation to the phenomenon and do not appear to promote such levels of self-insight and reflexivity. This is expressed in Participant F's account detailed above and is also expressed within Participant E's narrative- *"I do think what is it that people do with these thoughts because I guess people by definition, not by definition, but it's not the norm is it to have this kind of awareness of your own internal processes that we are trained to do."*

There is a developing sense here of feeling constrained by and vulnerable to, certain levels of self-insight specifically in relation to suicidal ideation, which it would appear, is not perhaps the case for other professionals. The sense of vulnerability with communicating deepened levels of insight is apparent in Participant B's account- "Is making ourselves to vulnerable by admitting that we are human and these thoughts have perhaps occurred to us as well, yea it's like that separates us from them- suicidal ideation ."

This account from participant B alludes to a conflict with appearing vulnerable in relation to appearing human. There is a sense that professionalism hides processes

of human fragility, and in this instance, professionalism aids in separation, separation not only from personal human fragility but separation from the client. Suicide is perhaps conceptualised as being separate from themselves and suicide is framed within a context of a 'presentation', and a reason for discussing it becomes possible. Suicide in this instance is external to the professional and discussion, or communication is framed as having a reason or purpose.

This insight may go some way as to explore the possible reasons as to why the participants felt unable to communicate or discuss their own ideation. Participant C comments that "I don't know if we do just generally sit down and talk, we do with bake-off but not with suicide. It doesn't really come up in conversation, seems to me needs to be a reason." This very much frames discussions around suicide as being contextual, and there is a sense uncomfortableness and that it would never present itself like other topics of conversation.

This does pose a fascinating insight, especially in light of the contexts in which the participant work in. Participant E provides a compelling insight when discussing communication of suicidal ideas to colleagues-

"I think within the context of my own life, there are edges. I don't think that it's something people talk, well people don't talk about that because you would assume gosh my colleague is a risk to themselves (laugh), and yet we can quite happily say I would cheerfully kill such and such sometimes. I want to do such and such to so-and-so oh yeah, so maybe we're more comfortable with our own homicidal tendencies."

The narrative from Participant E highlights layers of comfortability in relation to exploring and communicating the more fragile aspects of human existence. It also highlights the possible vulnerabilities in having such conversations and poses an interesting comparison between communicating thoughts to harm others vs self. This insight was also reflected in Participant G's account- "*In DBT we have team supervision so the client's suicide is talked about, never our own though, I don't even know if that would be a thing. We do happily talk about hurting other people sometimes though (laugh*)."

There is a developing sense here around the processes of self-disclosure. Participant A acknowledges that possible limitations to communication or disclosure with professionals could be made sense of in relation to feeling contained, similar to the process of therapy with clients-

"If you're talking to colleagues you know, what we do to help people disclose their own suicidal ideation is you create a safe, structured therapeutic space around them. Are we providing the space in which practitioners can do that in an appropriate way, I don't know."

The limits to self-disclosure were also explored in relation to clinical work with client's as highlighted by Participant E- "*It makes me think of self-disclosure, and what would it sound like for a therapist to say to somebody, yea I have thoughts to kill myself (laugh). I don't know how that would do down".* Although there appears to be an acknowledgement towards the possibility of self-disclosure, there is also a sense of

trepidation to this specifically in light of communicating feelings of self-destruction with others.

This point by Participant E does pose further questions relating to congruence with both self and process as well as possible transretinal responses to what is not talked about. What is apparent, however is that the participants recognise the processes of their own human fragility and felt comfortable discussing in the interview schedule what is not normally talked about- their own experiences of suicide.

Discussion/ Conclusion

The theme of our own ideation explores the capacity highlighted by the participants to sit with and explore their own sense of ideation in light of their own humanness and fragility. What is most compelling within this theme is the participants' recognition and contemplation of their own sense of fragility. This highlights a possibility that suicide is something that is within us all. It demonstrates the discursive expression and positioning of suicidality but also links to our own intersubjective positioning of this.

For the participants, what this could highlight is a sense of extended reasoning based on the recognition of the limitations and constraints within discursive positioning. This was highlighted in Participant E's case where negotiation of our own suicidal ideation can be conflicting because there is not the space, as practitioners and professionals, to discuss what is described as a common occurrence. It is important however to make the point that a fleeting or even persistent thought is different from an intentional self-injury or suicide attempt, and it is not the attempt that is of focus here, rather it is the possibility that suicidal thoughts, fleeting or otherwise, could have a universal place within our makeup as human beings.

This is further supported by participant F who not only highlights the potential universality of ideation but also identifies the limitations of effectively communicating this. It would appear here that the underlying communication is that of acceptance and exploration; however, the communication contains a filter regarding the practitioners' own sense of ideation. This filter could be counterproductive because there could be a possible meta-communication that is being communicated to the client in which the client is positioned as different from the practitioner because they are suicidal. Such positioning is absolutely not the case when considering the participants narratives regarding reflection, awareness and acceptance of their own suicidal thoughts.

This further complicates the picture when considering that suicide is brought to the services in which practitioners operate because, within this perspective, the practitioner is not positioning themselves as different from their client. Rather, it is the negotiation on both societal and organisational platforms that promotes difference of positioning. This could aid in the understanding regarding the conflicts and limitations the participants expressed because it would appear that although they are in some parts shaped by this, they appear guided and influenced by their

sense of fragility, which appears in conflict with the dominant discourses available, specifically when considering organisational structures.

The prospect of our own ideation is not a new one: Freud (1920) postulates the notion of Thanatos, the death drive. Within this understanding, the death instinct is a representative of a biological force, more powerful than the life drive. The instinctual correlation that justifies the death instinct, corresponds to the human tendency to repeat unpleasable experiences. This contradicts the notion that people only seek out satisfaction of the erotic drives and instead indicates the existence and activity of a drive towards un-pleasure and death in the unconscious (De Masi 2015: 96).

This can challenge the notion that people only seek to maximise pleasure and can furthermore highlight the sense of compulsions of repetition. However, locating the death instinct as a biological drive within the scope of this project does feel very problematic, in the sense that it individualises the phenomenon and somewhat pathologises the suicidal experience and positions it as something against the status quo. This insight also favours pathological/ biological dispositions over interpersonal socio-cultural negotiation and influence.

However, this is further complicated when considering that the participants are employed in organisations that are specifically indicative of suicidality being pathologised and against the status quo. However, the participants highlight a shift in understanding based on their own sense of fragility and upon and interpersonal and relational investigation representing a depth of understanding and insight, which goes beyond pathology.

A shift of understanding that encompasses the potential universality of suicidal ideation being an integral aspect of humanity appeared useful for the participants as they were able to reflect on their own sense of fragility, enabling them then to enter an interpersonal exchange with their clients. Within this understanding, it could be argued that thoughts of self-destruction and harm are perhaps a fundamental aspect to processing and investment within subject positioning. It is also useful to focus on how ideation interacts with the environment, which would help avoid individualising the experience through discursive positioning that currently denies suicidal ideation as a potentially universal part of experience.

This sort of shift in thinking could aid in our ability to fully engage with the phenomenon of suicide on an interpersonal and relational level, facilitating a shift in current perspective and sense making. This way, we would be able to engage in a dialogue that questions and challenges the over pathologising of a potentially universal experience common across humanity. It offers the possibility to extend our reasoning and sense making in relation to how suicide and its presentations are conceptualised and understood.

Potential shifts in understanding would acknowledge and to an extent respect dominant discourses (medical model) as highlighted by Participant C when explaining that suicide is brought to services and its where its treated. However, as practitioners we would not be constrained and guided by medial discourse, rather we locate our understandings within interpersonal interaction and reflexivity. Value is

placed on biographical history, subject positioning and potential universal experiences of suicidality.

Within this understanding, there is the potential to postulate the possible universality of suicide while accepting that the aetiology of its understanding are also bound within sociocultural positioning (Mishara 2006). This point is raised because Mishara (2006:1) argues that research into suicide and influence from the International Association for Suicide Prevention (IASP) has historically focused on the commonalities in suicide, with adaptations to specific cultures and settings, whilst either ignoring cultural differences entirely or focus upon a specific culture without examining possible commonalities across cultures.

To further expand on this, perhaps the commonalities within suicide are linked to the notion identified here that suicidal ideation is integral to our sense of humanness and therefore common across all humanity? Such a view, however controversial, avoids complete separation and classification of suicidality as a or part of a mental disorder and provides a baseline of commonality across cultures. That said, it is not to say that wanting to kill yourself is and of itself a mental health problem (Participant E) it is in cases linked to diagnostic criteria that applies to those at high risk of suicide, BPD for instance. However, it is about attempting to explore and connect with its possible universality across humanity that may or may not be, linked to a diagnosable condition.

Within this understanding, our own ideation has two functions: firstly, it relates to our ability to confidently and mindfully embody our own sense of fragility and, secondly, it serves as an atmosphere that all possible understandings and insight of suicidality sits in, and in line with the participants' narrative, this referrers to reflexivity. It is about our ability to recognise this as it is essential to the ecology of everything placed within it. The atmosphere is the life force that supplies everything within it with the ingredients necessary to support its existence.

Limitations and future research

Despite the research offering an in-depth analysis of practitioner psychologists' experiences of working with active suicidal ideation, a potentially significant limitation to this research is failing to recruit and include other professionals such as Nurses, Psychiatrists, other professional therapists and support workers. This would have offered a spectrum of professional insight and perspective that would have enriched the analysis further and offer differing professional and personal insight to the analysis. This would be welcomed in future research as it is felt this would offer a broader picture in exploring the experiences of other professional who also come into contact with suicidal ideation.

Clinical Recommendations

The implications for practice from this research are quite wide ranging and specific not only to the field of Psychology but 'Therapies' more widely and also other mental health professionals.

The most important implication for practice, I feel, is the need for self-reflection and reflexivity. Not only on an individual and professional level but also on a team and organisational level. Specifically, in light of exploring the notion of our own ideation as a process of therapeutic exchange and formation of a therapeutic relationship. There is something here around providing an organisational and professional space, whereas clinicians, we can explore and reflect on, the process of our own vulnerabilities.

This has been said, because it is likely that the more Intune we are with our own internal and group processes, the less likely we are to perhaps work with clients and interact with colleagues in less anxious and un-reflexive ways. This in turn, promotes continuity, support and containment on individual, professional and organisation platforms. It also provides us as clinicians, the opportunity to approach different explanations and understandings of suicidality in light of exploring the interpersonal and relational aspects to people's experiences. This, would aid in the further challenging of medical orientated models of understandings for more interpersonal and humanistic ones based on elements of a universal fragility within humanity.

Furthermore, the processes of reflexivity could facilitate a shift in the felt sense away from fear and anxiety to ones of competence and skill. It would seem a good idea to offer protected time, outside the parameters of supervision, reflective practice sessions where practitioners explore the interpersonal, organisational, systemic and personal aspects involved when working with suicidal presentations.

Furthermore, there is scope within the research presented to provide alternative ways of explaining, exploring and even conceptualising active ideation when working directly with clients. This of course would pay homage to the interrelated aspects to the superordinate themes presented in the research and would also impact on potential definitions and ways of therapeutically exploring and working with, clients active ideation.

The research highlights a movement beyond observable acts towards a more interpersonal and relational way of exploring the functions of somebodies' suicidal presentation. In relation to practice, this could mean as well as focusing on the suicidal ideation, also focusing on other factors that may contribute to the presentation, but also other aspects involved in that clients life. Such a stance, would shift the focus from being explicitly on the ideation towards a more interpersonal and reflexive understanding. Such a position, would acknowledge classification systems to understanding suicidality, whilst not allowing it to be the only focus within the therapeutic exchange.

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11. Appendix

PARTICIPANT INFORMATION SHEET

Suicide and Its Discontent: Practitioner Psychologists Experiences of Working with Active Suicidal Ideation

Thank you for wishing to participate in my study. Please take a few moments to read the following information sheet detailing the nature of the study and your participation.

I am Shane Llewellyn I am currently studying Prof Doc. Counselling Psychology at the University of the West of England. I have chosen to research how as qualified Counselling Psychologists you understand, conceptualise and work with active suicidal ideation within your clinical work.

This will be a qualitative project that will use Interpretive Phenomenological Analysis (IPA) to explore how meaning is derived to understanding this phenomenon. You will be encouraged to draw on a variety of different experiences based on professional, personal and academic endeavours as a way of exploring how meaning can be derived from your personal experiences of working with active ideation throughout your professional career.

You will be invited for interview lasting approx. one hour where we will explore your thoughts around how you understand and work with active ideation and what perhaps your perceptions of this may be. We will also explore any of your experiences of this whether personal or professional in light of how this may inform or impact your clinical practice with suicidal clients.

Should you have any queries regarding your proposed or final participation then you will be able to contact either myself or my research supervisor through the e-mail addresses below:

Thank you once more for your participation.

Shane Llewellyn

Shane Llewellyn- Shane2.llewellyn@live.uwe.ac.uk

Niklas Serning- Niklas.serning@uwe.ac.uk

University of the West of England BRISTOL

CONSENT TO PARTICIPATE IN RESEARCH

Suicide and its Discontent: Practitioner Psychologists Experiences of Working with Active Suicidal Ideation.

Researcher: Shane Llewellyn
Supervisor: Niklas Sering

I ………………………… (insert name) am over 18 years of age and agree to participate in this research. I have been given and have understood an explanation of this research project and what my participation entails.

I have had the opportunity to ask questions about this project and have them answered. I understand that my participation is entirely voluntary. I have been informed of my right to withdraw any or all of the information I provide from the research at any time without giving a reason. I understand that I am under no obligation to answer any particular questions. I understand that any information I provide will be kept confidentially.
Please tick the following boxes:

☐ I consent for the interview material to be used to write the thesis report, a journal article, a poster presentation and to be discussed in oral presentations about the research.
☐ I agree to the collection of demographic data that will be complied into a table to be presented in the thesis report and a journal article.
☐ I agree to the interview being audio-recorded and transcribed for the purposes of research conducted by Shane Llewellyn. I understand that anonymised extracts from the interview may be quoted in written reports, oral presentations and a poster presentation.

☐ I agree that Shane Llewellyn will keep the interview material in order to write the reports, the poster and to prepare for oral presentations of the research. I understand that the research material will be destroyed once all forms of assessment relating to the research have been completed.

Signed: ....

Name: ………………………… (please print clearly)

Date: …………………………

Interview Questions

1. Have you experience of working with Active Ideation?
2. How do you work with this?
3. What Informs your practice?
4. What is the felt sense?
5. What are your thoughts of people who attempt suicide?

Example of comments and themes in relation to interview transcript

Super Ordinate Theme	Comments and Themes	Transcript
<u>Exploring Our Own Ideation</u> *Explores the capacity to sit with and explore own sense of human fragility and ideation.*	Sense that participant is attempting to connect with own sense of distress and possible limitations to existence through identifying with the loss, as a parent, of another parent- this leaves them questioning their ability to cope? Is this linked to value?- what does it mean to live and die? In this case there appears to be a limit to life- sadness contemplation	*Somebody who I was working with, who's eight children died in a fire, and you think how do you even get up the next day and put the kettle on. So, I think it kind of brings a focus on your own ideas, of your own, both the value of your own mortality and in a way, your own line of what would be enough for me*
	thankful of the end of suffering? Pain is this the precursor for contemplating existence? Limitations based on suffering? – is what it means to live being linked to not experiencing suffering in such a chronic and unknown way? sadness	I had some weird health condition that no one could get to the bottom of, and thankfully it went away, but there was so much pain involved, and I kind of thought I've had enough of this. And you think I may as well call it a day, there's no point in waking up like this every day

	Distress linked to perhaps underestimating the personal and felt sense of a loss of relationship?- loss and sadness also a sense of contemplation Not about mental health as such- is this about questioning her own assumptions of life? Is what it means to live and die also highlighted here in the sense of loss and sadness? Destruction of the self means destruction of the loss and/ or loved one? Suicide as universal? Normalising the fleeting- sense that it's the making sense that causes the problem? Rationality? Linked into universality? Fleeting is not always suicidal- but the thoughts come! The thoughts come- questions to how deep this goes? How deep does it go? Linked to life? We all do? Universal? Self destruction- is this also	It's *life-changing, it's heart-breaking, it's like the worse thing ever I've experienced. You can see how, yes I'm a healthy individual, that does not really experience stress, particularly, does not have mental health problems, touch wood. I can see how something as stressful and traumatic as a relationship break-up, or it could be the death of a loved one, or it could be a huge RTA, and I can see how that may lead you to question life These are part of what it means to be alive, you know these thoughts towards death and destruction* We can all have fleeting thoughts, because we're fluid beings. I think it would be naive to assume we wouldn't get these sorts of fleeting thoughts, wouldn't it, I mean I'm not sure how far it goes, but yes probably all the time.

	about moving beyond suicide? Symbolising a move from pathology towards more about human existence? Connecting with someone around approaching a possible notion of universality- does this help destigmatise and focus more on the human aspects. Pathology and its place here Also there is a sense of humanistic value, we are all human…. How far does this self awareness go? Links to being universal? Also what are the limits to this- sense that the limits involve the over thinking? How does this relate to talking- containment and safety is offered here- is this reciprocal? Or is this a meta communication Feeling scared of the issue rather than the presentation- what are the limits to this	*In some ways, people have very different levels of self-destructive thoughts don't they. But yea, I am capable of having those thoughts, we all are I think.* *One of the most powerful things I have seen people react to in therapy is when we think about the fact that suicidal ideation can be ok. It is just a thought like any other thought, and once it's there in your head as an option its always going to be there as an option… That's what makes us human is that these options will present to you. And why would it not present to us as practitioners in the same way*

	Also is there something about the wider social, political discourses relating to how its frames and understood? Universal again but also a contemplating how far this could go Sense of disconnect between all aspects (professional, organisational and societal) how does the client sit within this if the processes of mirroring aren't transcended beyond the therapy? Do we need to do anything?> sense of doing implies energy and action? Also is this a limitation of psychology and self-insight- this too is not mirrored where does this go and how does this fit with society etc… disconnect? Vulnerability and scared- also is there something about separation- professional Vs suicide Problems re: universal or is this a meta process ie,	Perhaps because of fear, a lot of fear isn't it, and general society and you know people, in general, are not understanding and are afraid of the issue because it's quite, it's such a huge thing isn't it. It's quite difficult to understand if you haven't been through something similar. But, like all of us are prone to having these thoughts sometimes, but then, we don't have those same opportunities to talk about it because it's not reflected or mirroring what is actually happening *I do think what is it that people do with these thoughts because I guess people by definition, not by definition, but it's not the norm is it to have this kind of awareness of your own internal processes that we are trained to do*

	vulnerable human and we need to be supportive and understanding as psychologists? Does separation make it easier? Or give a context? Does this link to stigma and the heaviness of suicide? Discontent here Comparisons between self and others (interestingly part of MHA assessments) Feeling comfortable? Does MDT play into this? Sense of dark humor as a defense? How does this enter public discourse as being ok? Two people being vulnerable together? Issues highlight detraction from the clients experience however how far could this go	Is making ourselves to vulnerable by admitting that we are human and these thoughts have perhaps occurred to us as well, yea it's like that separates us from them- suicidal ideation I don't know if we do just generally sit down and talk, we do with bake-off but not with suicide. It doesn't really come up in conversation, seems to me needs to be a reason *I think within the context of my own life, there are edges. I don't think that it's something people talk, well people don't talk about that because you would assume gosh my colleague is a risk to themselves (laugh), and yet we can quite happily say I would cheerfully kill such and such sometimes. I want to do such and such to so-and-so oh yeah, so maybe we're more comfortable with our own homicidal tendencies* *In DBT we have team supervision so the client's suicide is talked about, never our own though, I don't even*

	Sense again of vulnerability It’s not talked about in either contexts really- how is it then that clients are expected too? Also links to assessments and MHA- what do we do with this information How does complexity fit to assessing?	*know if that would be a thing. We do happily talk about hurting other people sometimes though* *It makes me think of self-disclosure, and what would it sound like for a therapist to say to somebody, yea I have thoughts to kill myself (laugh). I don't know how that would do down*