Psychotherapist suicidality:

breaking the silence using interactive interviewing

Martyn Oakland

Middlesex University and Metanoia Institute

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Counselling Psychology and Psychotherapy

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Abstract

This interactive autoethnographic research project explores psychotherapist suicidality as a human reality that has been given little attention in psychotherapy and counselling psychology affiliations. It addresses the importance of acknowledging, understanding and supporting psychotherapists who are, or have been, suicidal, and of growing knowledge structures that benefit future support systems. I draw on my own experience of becoming suicidal while training to be a psychotherapist and counselling psychologist at the Metanoia Institute in London - an establishment jointly founded in 1984 by Sue Fish, Brian Dobson and Petruska Clarkson – a Counselling Psychologist who took her own life on 21st May 2006. The study was inspired by my dissatisfaction with what I experienced as an air of silence in the training institution around Dr Clarkson's suicide, a paucity of formal research around psychotherapist suicidality, and a lack of open reflexive dialogue on the subject amongst psychotherapists and counselling psychologists in training and beyond.

To achieve an authentic dialogic exploration of psychotherapist suicidality, I drew on Ellis's (1997) autoethnographic interactive interviewing method to interview three qualified psychotherapists with histories of suicidality. In each interview both parties were able to ask questions of the other's experience of being suicidal when in training or post qualification in psychotherapy. This helped achieve parity in the verbal exchanges, engendering deeper conversations and avoiding othering (e.g., Goodwin 2017).

An examination of the interview exchanges was guided by two research questions. The first, *How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?*' revealed a reluctance amongst psychotherapists to talk about their own suicidality, which included silencing dynamics within traditional qualitative research processes. The second

question, *'What do psychotherapists say when they talk about their own suicidality?'* yielded four main themes: *psychotherapist suicidality as a distinctive phenomenon*; *context, training, and organisational implications; holding and regulating psychotherapist suicidality; under-researched area of psychotherapist suicidality.*

The study found that psychotherapists who have been suicidal experience a clash within the 'space of possibilities' (Heidegger, 1953) offered by the socially constructed identity, *psychotherapist.* Constraining forces emerge in training, often implicitly cultivated by organisational cultural expectations around *anticipated* identities, beliefs and behaviours, that silence rather than amplify, and disempower rather than empower, the capacity for suicidal psychotherapists to speak out without fear, contribute knowledge, and seek support when experiencing suicidality.

CHAPTER 1. INTRODUCTION

1.1 Research study overview

This research study was autoethnographic. It placed me, a psychotherapist with a history of suicidality, in conversation with three other psychotherapists who have been suicidal or attempted suicide. The interviews were two-directional, following the method of interactive autoethnographic interviewing (Ellis, 1997). This allowed both researcher and participant to talk about their personal experience and ask each other questions. The interview transcripts were analysed using an ethnographic method called Verbal Exchange Coding, which is designed to uncover socially constructed meaning from the basic human unit of conversational talk. The analysis was framed by two research questions: (1) '*How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?'* and (2)'*What do therapists say when they talk about their own suicidality?'*

The autoethnographic element of the study empowered me, as researcher-participant, to bring personalised texts into the frame of study, as exemplified by the following excerpt (reproduced) from a diary I kept when I was suicidal during psychotherapy training:

1.2 A sudden ending

'A Sudden Ending' - Journal entry, October 2013

I'm driving back from therapy training, heading out from west London. It's been a good day, lots of honesty in group process about how much I'm struggling at the moment, but with one thing held back; one detail I couldn't say… that I was thinking about killing myself.

I drive up the ramp and hit the motorway…. I'm trying to figure out how, in the third year of psychotherapy training, I could be feeling suicidal while feeling that I can't talk about it at the therapy training centre.

I spot them…

They are yellow with black stripes, jutting out, pointing at me as I speed past them. 'A solid-coned ending,' I think to myself. They are resolute in their concrete and steel immovable purpose, cemented into the kerb along the hard shoulder, poking out from under the motorway bridge supports they protect. I don't think of protection when I see them ahead. Just the means to a way out.

I project a character onto them; they become straight-talking friends with an irrefutable, mournful beckoning smile. What they have to offer me is an end to suffering, the chance for peace, calm, relief from judgment… sleep. But, of course, I cannot be certain of anything beyond finality. So, at one level, that's how I know it will be: a sudden ending.

Against the backdrop of irrepressible loneliness, horrifying isolation, petrifying insomnia, wild, tormented internal rages, screaming into my pillow, planning and plotting my suicide...

I imagine jerking my steering wheel to the left and my honest concrete friends fulfilling their promise.

1.3 Personal motivation for this research study

My interest in psychotherapist suicidality sprang from my own life experience. I am from a military family in which parental absence, emotional neglect and physical punishment were commonplace. By the time I left home, I had severe difficulties with intimacy and experienced pervasive suicidality. The pain was so ferocious at times, I thought I would not survive. But I did survive, physically at least. I struggled to find meaning in my life but found solace in therapy. In my mid-forties, I trained as a counsellor and psychotherapist. Had it not been for my studies, I believe I would have ended my life.

My suicidality had abated by the time I began my psychotherapy training, although I still experienced intense moments of internal struggle. Then my suicidality re-emerged following a relationship breakup in my third year of training. This period of distress lasted several months during which I began to doubt whether I could continue my chosen path into psychotherapy. I felt cheated that after years of personal therapy and three years of training, I found myself wanting to end my life again. I also wondered if it was ethical for me to continue training. With the guidance of my therapist, supervisor, trusted tutors and peers, I emerged from this period of distress and completed my training. My candidness around my suicidality encouraged other trainees to disclose their suicidal experiences. However, these were often private conversations, and there seemed to be little space for exploring what felt like important layers of idiosyncratic meaning when bringing together two social constructs: psychotherapy and suicidality.

1.4 The reality of psychotherapist suicidality

Difficulties in one's personal history often motivate people to train in the helping professions (Adams, 2004; Streeter, 2017) and statistics show that psychotherapists are as likely, if not more so, to experience suicidality or make a suicide attempt than the general population (Kleespies, Van Orden and Bongar 2011). This is supported by a 2018 study that found two-thirds of clinical psychologists at some point in their lives had personally experienced significant mental health problems (Tay et. Al.,). Yet, 'therapists are often expected to be immune from the kinds of problems they help clients through' (Adams, 2004: 10).

An article in The Psychologist magazine entitled 'Psychologist Suicide: practicing what we preach' (Larsson, 2012) documented cases of psychologists who had completed suicide. These included UK-based counselling psychologist Petruska Clarkson and psychotherapist Jon Driver, who completed suicide in 2006 and 2011, and American psychologists Lawrence Kohlberg and Michael J. Mahoney, who died in 1984 and 2006 (DeAngelis, 2011) Larsson (2012) asked *Why the silence?* implicating barriers to research that might include 'fear of consequence, impact on professional standing, or difficulty in reconciling vulnerability' (Kleespies, Van Orden, Bongar, 2011). Reeves (2010) touched on hierarchies of acceptability around suicide, a construct Larsson developed, arguing such pressures are amplified for psychological professionals due to their perceived unique position as exemplars of good mental health.

Reeves (2010) said suicide falls into the 'category of secrets and shame' (Reeves, 2010: 128) My own personal experience of feeling suicidal during psychotherapy training resonated with this, but with added pressure to the secrets and shame. I only disclosed my suicidality in private conversations, away from structured sessions or process groups. I feared the judgement of others and was especially concerned about how it might impact my chances of qualifying. The tension of wanting to end my life while fearing professional implications was something I

described as a *pinch*, an added pressure-point of existential torment. When seeking program approval for this research project in 2018, I experienced this *pinch* after it was suggested to me that I use autoethnography to bring my experience into the foreground:

Excerpt from 'An Innocent Proposal: autoethnography of research program approval journey,' 2018.

One of my presentation slides indicated I'd had my own lived experience of being suicidal whilst in the third year of therapy training; I stated I would carefully acknowledge my experience, but keep my own story to a minimum.

After my presentation I waited for the panel's response. One of the panel members, a newly qualified counselling psychologist, asked, '*Why aren't you in the story? It's a missed opportunity... give us reasons why you've left yourself out? There are ways of doing this, you know. You could use autoethnography to explore your own suicidal experiences alongside your participants*.'

I sat nodding, keeping a smile on my face. The whole point of being here was to get my research approved and signed off (*wishing, wishing*) with limited fuss (*wishing...*)... get the ethics signed off (*easy process, please...*), do my research and get qualified (m*ust get qualified... must get qualified...*).

Behind the facade I was panicking. I didn't want to be *in* the picture and was happy a few paces back, out of the spotlight, illuminating the stories of my participants who would be protected from the sun by an ozone layer of anonymity. How could I put myself and my own story into this and be similarly protected? The answer is I couldn't... *my name will be on the front of this piece of work. People will know.*

Reeves (2010) said, it is essential we fully consider our views on suicide. I would add that for psychotherapists it is also important to reflexively examine the *pinch*: the institutionally contexualised, socially constructed pieces of our own suicidal experience.

1.5 Definition and usage of the term *suicidality*

Being suicidal is a complex, multi-faceted experience, but the language used can reduce and direct it to over-simplified assumptions and/or implicit judgements. A powerful example of this is the use of the phrase, committing suicide. Suicide was decriminalised in the UK in 1961, yet *committing* suicide is still a commonly used phrase, bearing the insinuation of criminality. This has implications for the suicidality sufferer and potentially contributes-to, and perpetuates, stigma. The importance of carefully selecting terminology was therefore essential in this study.

Choosing the right word or words was not straightforward. Words more commonly used when talking about suicidality often referred to specific modes of the suicidal phenomenology, for example, thinking modes, or action modes. Sometimes degrees of seriousness were implied: “strong thoughts of suicide, but no intention to complete”; “cyclical plan escalation”; “not wanting to wake up and pointless existence conclusions". Researchers also highlighted inconsistencies in current definitions of suicide and suicidality (De Leo, 2015; Horowitz, Rosenberg, Baer, Ureno & Villasenor et al., 1988; World Health Organisation, 2014a & b; De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006). Goodfellow and Kolves (2019) reviewed the nomenclatures, definitions, terms and classifications for suicidal behaviour, and found ‘a confusing landscape and poor agreement among authors who publish in English,’ while Marsh

(2015) asked, ‘how amenable are ‘suicide,‘ ’suicidal behaviours, ’and ‘the suicidal process ’ to singular, objective descriptions and categorisations?’

The lack of consistency in research made it unclear that what was being examined across the literature was the same thing. I felt that a term was needed that allowed space for any aspect of the suicidal experience. This was also important because I sought only a small handful of participants and I did not want to exclude therapists who identified with some terminology, or only certain aspects of the experience, and not others. The word I chose was *suicidality.* It was influenced by Marušic (2004), who talked about *suicidalities,* illustrating a range of different suicidal states impacted by differing degrees of intent, plans to act, actions and outcomes. *Suicidality*, was also used by Marsh (2010) and White et al., (2015), and represented an overarching range of experiences, including‘ degree of intent, lethality of method used, likelihood of rescue, degree of planning (impulsivity), and presence and status of psychiatric or medical illness.’

1.6 The need for this research

Camus (1942) said, in 'The Myth of Sisyphus', ‘there is but one truly serious philosophical problem and that is suicide.’ I see this as a calling for psychotherapists and agree with Adams (2004) who conveyed how a psychotherapists personal history is worthy of deeper and more personal consideration. Indeed, Adams (2004), wrote, ‘I cannot write about the personal lives of therapists without in some way revealing aspects of my own’ (2014: 107), a precursor for how I considered going about this study.

I had originally intended to examine psychotherapist suicide rather than suicidality, i.e., to focus on psychotherapists who had ended their lives through suicide. I had imagined calling the research ‘Interviewing Ghosts: why psychotherapists take their own lives, ’ However, the title itself underscored the inherent problem that the central protagonists could not be interviewed –

this was particularly so for the ghost of Petruska Clarkson, who I would dearly wish to have interviewed. Given that I was looking for rich meanings via a qualitative methodology, I felt it would not be possible to continue with this focus.

Through many conversations with people who had been suicidal but not completed suicide, I realised that much more could be gleaned from the experiences of psychotherapists with suicidality, so changed focus to explore those first-person accounts. Alongside my own lived experience, I sought to understand what brought therapists to such 'life weariness' positions (Hjelmeland, H., Akotia, C.S., Owens, V., Knizek, B.L., Nordvik, H., Schroeder, R. and Kinyanda, E. 2008). Shneidman (1996) said, the suicide of a psychotherapist is a tragedy and a searing personal trauma for the surviving patients. In the forty-five years since this impactful statement, there have been no qualitative studies on psychotherapist suicidality. By giving voice to psychotherapists with lived experience of suicidality and drawing attention to 'the many missing stories' (Muncey, 2010: 97) of research in this field, I hoped to redress this; I hoped to help reduce the sense of isolation and alienation of psychotherapists with suicidality by providing a space to be heard.

Quantitative research has dominated the field of suicidology. Between 2005 and 2007, less than 3 percent of research articles published in three international suicidology journals were based on qualitative studies (Hjelmeland and Knizek, 2010). My own review of the abstract findings in quantitative research, from samples of people whose voices were discarded in efforts to provide generalisable patterns by researchers who 'struggle to control the variables that make everyday life so complicated' (Muncey, 2010: 91), and appear 'equally distanced from emotionality' (Grant, 2010: 112), left me feeling equally detached from the very personal experience that I knew was at the core of a person's suicidality. Although important in providing a context for practitioner suicide, quantitative research offered little insight into what it's like to be suicidal.

In contrast, I felt deeply engaged by lived experience research undertaken about different aspects of personal-professional life, offering unique and novel ways of knowing (Rossouw, Smythe and Greener, 2011; Nicholl et. al, 2016. This influenced me to interview psychotherapists with histories of suicidality. I was also strongly drawn to re-design myself as researcher-participant, not just an instrument of data collection and interpretation, but to play an equal role in creating knowledge.

Psychotherapist suicidality is wrapped up in complex social and organisational factors, which I hoped to unearth in this study. Jung (1937) said, 'knowing your own darkness is the best method for dealing with the darkness of other people' (Jung, 1937: 236 – 237). I hoped that by exploring psychotherapist suicidality, other psychotherapists would be encouraged to engage with their own suicidal pieces in a way that improved their clinical work through deepened self understanding. Helping psychotherapists find better ways of supporting themselves was also an important consideration, not least since 'psychotherapist wellbeing is essential to sustaining good practice' (BACP, 2007: 10). I further hoped the project would raise awareness of the reality of suicidality in the helping professions. I wanted the accounts of suicidal psychotherapists to benefit all psychotherapists and related professionals.

1.7 Research rationale

This study investigated what one participant described as 'the last taboo' of the therapy world: the suicidal psychotherapist. It charted the intersectionality between the personal and professional identities of psychotherapists who have been suicidal. It also challenged avoidance and suppression of open dialogue around psychotherapist suicidality, particularly in training establishments.

The rationale for exploring lived experience suicidality of psychotherapists began with noting the paucity of research in this area and the need to further our understanding. It continued with

the premise that the taboo nature of psychotherapist suicidality held within it complex and nuanced factors that were specific to the socially constructed identity of psychotherapists. Uncovering those factors would not only enlighten us to the complexities around the unique combination of being a psychotherapist and being suicidal but, based on the premise that psychotherapists are uniquely placed to understand suicidality per se, would give us deeper insights into the phenomenology of the suicidal state.

Rather than traditional one-way interviews, the study employed interactive interviewing to explore lived experiencelived experiences. It was a contention of this study that the most effective way to explore the phenomenon was for therapists who have been suicidal to have ordinary conversations about it. As such, my participants and I shared our suicidality stories in a series of interactive interviews (Hertz (ed) 1997). This style of interviewing was chosen because of its conversational two-way quality. It facilitated an attempt to achieve mutuality by reducing the likelihood of 'othering' (Goodwin, 2017), in which a participant could potentially experience an 'us-versus-them' power imbalance.

CHAPTER 2. LITERATURE REVIEW

In this chapter, I present a critical review of literature related to psychotherapist suicidality. I evaluate existing literature and identify gaps to locate a space for the current study.

2.1 Introduction and review strategy

My literature review followed the definition offered by Machi and McEvoy (2016), providing a logically argued case for this research study, founded on a comprehensive understanding of the current state of knowledge. It 'presents, analyses and synthesises material from diverse sources … to 'take stock' and evaluate what is of value from the previous body of work' (Grant and Booth, 2009: 93).

I gathered relevant knowledge by searching peer-reviewed journals, initially using the terms 'suicide' and 'suicidality' in combination with 'psychotherapy' and 'training.' I then expanded the search using additional key terms: 'organisational change,' 'organisational power,' 'woundedness,' 'wounded healer,' 'first-person,' 'lived experience,' 'practitioner suicide,' 'autoethnography,' 'interactive interviewing.' I accessed databases through Google Scholar and Middlesex University Library search, retrieving literature from the institutions' catalogue linked to Sage Journals, Emerald Insight, Ebsco Host, Sage Research Methods, Nurse Researcher, PSYCinfo and MEDLINE. The paucity of lived experience research with suicide and suicidality, also justified the inclusion of "grey," or unpublished, literature' (Aromataris and Riitano, 2014). I extended this foray into grey literature in particular when considering medical doctor training experiences: incomplete studies in 2020 due to the impact of Coronavirus.

Due the elongated history of suicide research, I decided not to have a limitation around date of publication. My review only included English-language, peer-reviewed literature and so most of the sources I drew on had a western, developed-world bias. There was very little direct lived experience research or literature on the suicidal experiences of helping professionals - the exception being a paper by Huss (2020a) - and no qualitative research on psychotherapist suicidality. In my quest for sources I encountered an abundance of personal experiences in online blogs, forums, and by word of mouth at suicide prevention symposiums, autoethnography conferences, research conferences, and critical suicidology and autoethnography discussion groups, and it puzzled me why this profusion of experience hadn't translated into formal research. The reality that these peripheral accounts did not yield peer reviewed research became a frustration, however, they did often help direct me to more usable sources.

2.2 A short history of suicidality research

'What you seek is seeking you' Rumi (1207 - 1273)

I begin with a broad overview of suicidality research, to provide a context for this study. There is an abundance of literature on suicide, and as already stated, research into psychotherapist suicidality is sparse. There is no Counselling Psychology writing on the subject of psychotherapist suicidality. Research on general suicide mostly falls into two camps: intrapsychic medicalised; or social-cultural. Both traditions rely on quantitative methodologies and neither prioritise lived experience research.

The gaps and tensions in suicide research provides an important backdrop to the current study, given that a large hole in the literature exists in both psychotherapist suicidality research and first-person methodologies. The aim of this summary is to fill in the backdrop to show what is

missing and identify where this study can contribute to compensate for the limitations and missing pieces.

One million people die by suicide every year and more than twenty-million people 'engage in suicidal behaviour' (Levi-Belz et. al., 2019). Reviewing the history of suicide research left me feeling that there is a tangled and unfathomable comprehension of 'the mechanisms, factors, and facilitators of suicidality' (Levi-Belz et. al., 2019). More than a century of research has focused on 'neurobiology, personal and family history, stressful events, the sociocultural events/environment and contributing psychological factors, both individual and social,' (Levi-Belz et. al., 2019). Yet, there are so many theories and so much disagreement that the field of suicide research comes across as fragmented and perpetually in dispute.

There is an abundance of prediction and prevention models (Gysin-Maillart et al., 2016, Bryan et al., 2014a) that almost exclusively focus on explanation, rather than understanding (Hjelmeland, 2016). Theoretical modes and treatment approaches abound (Joiner 2009; O'Connor and Kirtley, 2018; Rudd, 2000; Shneidman, 1996), with most focussing on the individual, not their context. O'Connor and Kirtley (2018) proclaim '… our ability to predict suicide is no better now than it was 50 years ago', implying that for all the research, progress is minimal, but also reinforcing the message that suicide prediction is a) the principle purpose of research, because c) humans obey general laws and so suicide is predictable.

The Risk Factor approach, as it has become known, is currently dominated by Joiner's Interpersonal Theory of Suicide (Van Orden, Witte, Cukrowicz, Braithwaite, Selby, and Joiner, 2010), which identifies *perceived burdensomeness, thwarted belongingness and capability for suicide* as critical features that lead to suicidal ideation and eventually suicide. The model was critiqued by Hjelmeland and Knizek (2019), who pointed out 'suicide is … widely accepted as a complex, multifactorial, and contextual phenomenon,' (2019: 1) and cannot be reduced to these three internal factors. Further, Knizek and Hjelmeland (2018) speak to the mixed results, small

effect sizes and large variations in quantitative research, and assert that qualitative studies, ' are able to present more nuanced and contextualized pictures of what lies behind suicidal behavior' (Knizek and Hjelmeland, 2018: 7).

Qualitative researchers like Hjelmeland and Knizek appear to have heeded Shneidman's (1996) call for suicide researchers to avoid simplistic notions of suicide, instead to describe what the suicidal state of mind is like. This aligns with the current research endeavour, which seeks insight into the psychotherapists' suicidal state of mind, rather than to produce generalised statistics or attempt to predict suicidality.

Alongside the predict and prevent research endeavours, two distinct traditions in researching suicide emerged in the last two centuries: the 'psychocentric register' (Rimke and Brock, 2012) which framed suicidality as an individual problem of mental illness; and the sociologically rooted approach, which sought social, contextual explanations for suicide. Both could be traced back over one hundred years, in the first case to the 19th century philosopher Esquirol (1772-1840), who medicalised and individualised suicide (a view that dominated 20th century explanations), and Emile Durkheim, who in writing Le Suicide in 1897 (over one hundred years ago) proposed a sociological analysis of suicide. Both traditions could be accused of an element of manifestation, i.e., uncovering what is predicted, rather than what is there. Noticeably, both traditions also leaned heavily on statistics and err away from giving voice to the suicidal.

In response, over the last twenty years, a growing post-structuralist research movement emerged, challenging the dominant discourses of the mental health paradigm and suicidology's statistics-heavy positivism, with writers calling for alternative approaches and a 'more expansive platform for [these] theorists, researchers, practitioners, service users, and advocates to be heard' (White, Marsh, Kral and Morris, 2015: 9). Under the banner Critical Suicidology this movement celebrated multiple discourses, extolling unique individual stories, and valuing

'conversational approaches over expert monologue, seeking solutions from the ground up rather than imposing them from above' ((White, Marsh, Kral and Morris, 2015: 27).

To that end, the post-structuralists honoured and encouraged participation from experts-by-experience, at-risk groups and frontline practitioners to build 'collaborative, relationally-focused … strengths-based models' ((White, Marsh, Kral and Morris, 2015: 27). A growing body of autoethnographic work exemplified this plurality of new discourses. For example, Wheeler (2016) carried out an autoethnographic performance study on life as a suicide survivor and Lee and Gouzouasis (2016) combined music and story to produce an collaborative autoethnography around the death by suicide of a colleague. Both embraced the potential for transformation and healing that reflective self-narrative exploration and writing could bring. It is within this tradition that the current study finds a space.

2.3 Psychoanalytic and phenomenological approaches to suicide

The counselling psychology & integrative psychotherapy training program that I attended had a strong central component of psychodynamic/psychoanalytic theory. Although seeking internal models and theoretical explanations for suicidality isn't a focus of this project, I felt it useful to lay out the history of psychodynamic/psychoanalytic thought around the internal experience of suicidality and then compare and contrast those ideas with phenomenological explications of suicidality.

Psychoanalyst, Peter Fonagy, cited the 'chilling figure of 40% of the UK population having experienced suicidal ideation' and asked, 'what do we know about the causes of suicide?' (Fonagy 2008: xvi). A strong association with psychiatric disorders was postulated, alongside stressful life events, physical illness, age and gender, substance misuse, availability of lethal means, media models of suicidal acts, hopelessness, pessimism, impulsivity and attitudes to suicide (Mann 2002:

xvi). While these factors were explored, offering outside-to-inside generalisations, caution was advised around the temptation to be persuaded by the 'plausibility of associations' (Fonagy, 2008: xviii) and the model told us little about what it is *like* to be suicidal.

Fonagy (2008) noted that psychoanalysis had a 'massive amount to contribute in developing a subtle and nuanced picture of the individual with suicidal ideation' (Fonagy 2008: xviii), by getting into the interior structures of the person's suicidality and developing models that gave us greater insight. Since Freud's Mourning and Melancholia, (1917), psychoanalysis, as a 'sophisticated discipline devoted to the study of subjective experience' (Fonagy, 2008: xvi) has produced over one hundred years of evolving thought around suicidality.

Within psychoanalytic circles, Freud was widely seen as the starting point for understanding the suicidal mind. Freud emphasised the revengeful and destructive states of mind in melancholia turning against the self in hatred (Temple 2008: xxi), while Melanie Klein conceptualised how the 'suicidal patient may split good from bad in the internal world' constructing a fantasy of 'obliterating the bad and leaving the good intact' (Temple 2008: xxi).

The core dilemma was postulated as an intense struggle between 'terror of separateness and fear of engulfment through intimacy' (Hale 2008: 17), conceptualised as an internal fantasy. Suicide was then seen as a 'psychotic moment wrapped up in an unrealistic appraisal' (Briggs, Crouch, Lemma 2008: 4) of a number of driving fantasies: revenge fantasy (impact on others); self-punishment fantasy; assassination (of body) fantasy; and dicing with death (fate) fantasy (Hale 2008: 20). In fantasy - and in the psychoanalytic explanation - the self was seen as 'cracked, or fissured, vulnerable to fracture' (Maltzberger 2008: 43) resulting in emotional flooding giving rise to helplessness and hopelessness. The integrity of the self-representation breaks up and, without effective reality testing, survival may only seem possible 'if the fragmented self can rid itself of the menacing objectified parts' (Maltzberger 2008: 43). This relied on the person fantasising a 'surviving self' (Maltzberger & Buie, 1980).

Bell (2008) described how psychoanalysis offered an explanation of how internal processes get mapped onto external 'objects,' making reality-testing near impossible when the suicidal person externalises their 'inner world to such an extent that external objects become indistinguishable from archaic inner figures' (Bell, 2008: 58). Following, Bell (2008) is describing a 'common central structure in suicidal [patients], a primitive psychotic superego which demands omnipotence, not knowledge' (Bell, 2008: 58).

The connection between the internal agony, or 'psychache' (Shneidman, 1993a) and the life context of the suicidal person was important. The sufferer experienced '..an external world that demands the impossible' (Bell, 2008:58), 'stemming from a deep frustration of one's most important needs in life, resulting in an inner perterbation' (Orbach, 2008: 89), that eventually created a 'new, unique experience,' (Styron, 1992/2008: 89) that resulted in being 'attacked by estranged and hostile forces from within' (Styron, 1992/2008: 89). Descriptions of the ensuing sense of 'brokenness' (Orbach, 2008: 89) remain focussed on the internal state of 'irreversible negative changes in the self' (Orbach, 2008: 89). What was largely left out of the psychoanalytic explanations of suicidality was the impact or consequences contextual factors shifting or changing for better or worse. Of the two sources of pain discerned by Orbach (2008: 89), life stressors - particularly loss - were identified. It may be that loss, and grieving through loss, was seen as irreversible. Yet the suffering inflicted by loss can ease over time. This challenges the notion that the suicidal experience creates internal changes that are irreversible.

Clinical observations of the suicidal persons' pull, or otherwise, to engage with caregivers, brought a relational element to the frame. The psychoanalytic perspective emphasised both a 'relational and emotional understanding' of suicidality' (Briggs, Crouch, Lemma 2008: 1), where suicidality was often seen as an attack on one part of the self by another. Freud described the *constellation* (original italics) of 'suicidal relatedness' (Briggs, Crouch, Lemma 2008: 3).

The use of the term *relational* in psychoanalysis, however, relied on a theoretical premise that 'conflicts are set up between different internalised aspects of others' (Briggs, Crouch and Lemma 2008: 4). *Relational* was dealt with very much at the intrapsychic level in psychoanalytic theory.

It's poignant to note that psychoanalytic models use constructs built around a set of assumptions agreed upon by psychoanalysts. These constructs weren't necessarily agreed upon within the wider world of suicide research, so were often left out in suicidology's modelling of suicidality. The psychoanalytic literature mostly paid lip-service to context, or the person's wider circumstances, and focussed on 'the … primary source of mental pain' (Orbach, 2008: 90) which it saw as 'internally produced' (Orbach, 2008: 90) and 'manufactured and pre-modelled templates formed by early traumatic experiences and early conflicts' (Orbach, 2008:90).

Psychoanalytic theory isn't a unified entity. It 'is made up of a substantial variety of sub-models (e.g. Freudian, Kleinian, Object-Relations, Lacanian etc.)' (Spinelli, 2006: 85). Attachment theory, another developmental theory linked to psychoanalytic thinking, cited early attachment failure, 'particularly with maternally deprived infants' (Campbell & Hale, 2017: 21), that could be replayed in current (adolescent, adult) attachment relationships, to 'repeat the conflicts [in a way that is] intense and overwhelming because the individual is forced to relive infantile traumas' (Campbell & Hale, 2017: 22). These *interpersonal* conflicts become *intrapersonal* structures that are seen as 'likely to persist even when there are positive changes to the environment' (Campbell & Hale, 2017: 22). There is still the strong contention that once embedded in the psyche, these internal processes will endure despite improved circumstances.

Poignantly, prior to 1910 and a landmark symposium *On Suicide: With particular reference to suicide among young students* (Stekel, 1910; Campbell & Hale, 2017: 18 original italics), the study of suicide had previously concentrated on explanations 'relating the incidence of suicide to social and geographical factors' (Campbell & Hale, 2017: 18), notably Durkheim's (1897) Suicide: A Study in Sociology. A theme that emerged through the symposium, however, was the notion that suicide

was 'aggression turned against the self' (Campbell & Hale, 2017: 18). What followed was Freud's 'Mourning and Melancholia' (1917 [1915]), in which Freud suggested that 'hate originally felt towards the [other] person may be redirected towards the self' (Campbell & Hale, 2017: 18), that 'no-one kills himself who has never wanted to kill another' (Stekel, 1910: 87). I found this as a universal factor in suicidality, somewhat rigid.

Freud highlighted 'the reciprocity between the person's ego and his or her body' (Campbell & Hale, 2017: 19). The ego, which 'is first and foremost a bodily ego' (Freud, 1923: 26) was constituted by identifications with important people in the person's life' (Campbell & Hale, 2017: 19), such that a part of the self that was experienced as a 'not self' or 'other' (Campbell & Hale, 2017: 19) became the target of attack. This wish for another's death, often a parent, merged through identification with the bodily-ego. Freud added that, 'in melancholia, the ego gives itself up because it feels itself hated and persecuted by the superego instead of loved' (Campbell & Hale, 2017: 20). The superego, which contained parental injunctions and prohibitions, acted on the body-ego to create 'shame and guilt through ego's transgressions' (Campbell & Hale, 2017: 21). Campbell & Hale (2017) described how, in suicide, 'the unconscious fantasy often revolves around settling old scores from unfinished and unacknowledged battles of childhood' (Campbell & Hale, 2017: 25), a process described by Freud as 'like an unlaid ghost that cannot rest until the mystery has been solved and the spell broken' (Freud, 1909: 122).

Maltsberger & Buie (1980) described how, as people approached the point of wanting to act on their suicidality, they 'experience their body as a separate object' (Maltsberger & Buie, 2017: 27) and fantasise a 'surviving self' (Maltzberger & Buie, 1980) that was dependant on the destruction of the body' (Maltzberger & Buie, 1980). This 'failure to distinguish between self and non-self' (Stern, 1985) blurred reality for the suicidal person, who experienced themselves in a state akin to psychosis during which there was a high risk of acting on the strong urge to kill the body, enshrouded by the fantasy of a surviving self.

Stern conceptualised this sequence of events as the 'core complex' (Stern, 1985) which arised via childhood experiences that construct a mothering object 'perceived as ungiving, poisonous or untrustworthy' (Campbell & Hale, 2017: 31). Those childhood experiences constituted a 'double bind' ((Campbell & Hale, 2017: 31) via the anxiety of being engulfed by the mother, arising from a desire to merge with the mother, or being abandoned to starve should they fail to 'get into the [mother] object' ((Campbell & Hale, 2017: 22). The child may then experience rage towards the mother object that became libidinised into 'ruthless aggression ... converted into sadism' (Campbell & Hale, 2017: 32). In adolescence or adult life, people agonised from *core complex* anxieties replaying through their need to maintain a safe distance in relationships. 'To get too close to a partner raises anxieties about merging or being engulfed; to separate leaves them feeling they have been abandoned to starve' (Campbell & Hale, 2017: 33).

The pathway to suicide, then, was described as beginning with a pre-suicidal state, where the core complex was in equilibrium - albeit unstable - and was then triggered by an event perceived as an act of betrayal, followed by 'constriction,' (Ringel, 1976: 35) defined as 'loss of agency, breadth and flexibility, and a sense of being trapped, overpowered and helpless' (Campbell & Hale, 2017: 35). The constriction phase was subjectively experienced as *time standing still* leading to withdrawal from relationships and a state of frozenness. Although Campbell & Hale (2017) did not see constriction as a necessary component of the suicidal process, it was poignant that, whatever the trigger or triggers, the suicidal person 'cannot assess them objectively, so they are felt to be overwhelming' (Campbell & Hale, 2017: 37). It was the person's internal meaning-making of the trigger(s) that could exacerbate affect flooding, 'likened to drowning, with the patient feeling out of control and desperate' (Campbell & Hale, 2017: 39), leading to 'grandiose schemes for self-preservation through jettisoning the body' (Campbell & Hale, 2017: 39).

There were a number of theoretical problems with the psychoanalytic description of suicidality that drew criticism from other schools of thought, in particular, from the humanistic and existential-phenomonological approaches. Existential psychotherapist, Ernesto Spinelli, argued that the psychoanalytic model is based on a number of assumptions that can be called into question, two of which are: '1) the notion of hidden or 'unconscious' mental processes; 2) the notion of the past as causal agent of current symptomatic behaviour and current personality-based attitudes and dispositions' (Spinelli, 2006: 85). These are theoretical constructs, albeit formed through painstaking attention to the clinical accounts of patients' descriptions of their experience. The uncertainty was around the accuracy of accounts that are actively received and interpreted through the framework of psychodynamic understanding and foreshadows the first-hand account of the person. The attention and intention of the analyst, the lines of inquiry, the questions selected, the patient's story, were filtered to match psychodynamic inferences and support the veracity of the model.

Why is this of interest to the current research? Psychoanalysis has grown out of studying clinical episodes, but it is very much a top-down model, with each new piece added *with the model in mind*, rather than a bottom-up inference-free understanding of suicidality, born out of the uninterpreted narratives of personal experience. An antidote to the psychodynamic model came from the phenomenological approach, which, instead of foreshadowing the sufferer's voice with preconceived theory, highly valued the originality of each unique individual's direct experience. In terms of parallels with the methodology, the current study utilised autoethnography, which aimed to seek out *essence* of experience within the context of *culture*, employing a strong phenomenological epistemology and methodology.

The philosophical discipline of phenomenology, originated by Edmund Husserl (2001/1900-1901), used an inquiry method to produce 'a descriptive account of the essential structures of the directly given' (Pompili, 2018: 20). The first-person viewpoint was sought, 'those that are, in principle, not

directly observable by any external observer' (Pompili, 2018: 20). Phenomenological inquiry was at the core of Suicidology, a discipline that drew on subjective experience to inform suicide prevention. 'Traditional suicidology supports the notion that suicidal individuals are experiencing unbearable psychological pain (*psychache*) or suffering and that suicide may be, at least in part, an attempt to escape from this suffering' (Pompili, 2018: 21). 'Psychache' (Sheidman, 1993a), was considered to be 'the main ingredient of suicide' (Pompili, 2018: 21), and resulted when 'the individual cannot see a way out and believes that ending life is a solution [but that] if tormented individuals could somehow stop consciousness and still live, they would opt for that solution' (Pompili, 2018: 21). The phenomenological approach to understanding suicide could be seen as a remedy to the interpretation-heavy explanations provided by psychodynamic theory. It encompassed 'the need for a broader view of suicide risk...' (Pompili, 2018: vii), looking at the experiences of those who become suicidal, their emotions of 'shame, guilt, abandonment, enniu, dysphoria, hopelessness, and inanition' (Pompili, 2018: vii). The phenomenological stance attended to the *quality* of the experience which, regarding suicidality, was 'more like being in love than having liver disease' (Pompili, 2018: vii).

Rather than universal concepts of suicidality, the phenomenological approach sought out a 'human understanding of suffering in a specific individual' (Pompili, 2018: vii). This was somewhat of a paradigm shift when contrasted with the psychodynamic approach. The focus was on 'what is it like to be suicidal?' (Pompili, 2018: viii) as described by the words of the sufferer. Studying 'the conscious experience as experienced from the subjective or first-person point of view' (Pompili, 2018: 13) while bracketing out theoretical assumptions, allowed for a 'meaningful phenomenology of suicide that involves a true understanding of the suicidal individual's intimate world' (Pompili, 2018: 14). It was interesting that in suicidology, listening to the phenomenological experiences of suicidal people, 'no single factor has been demonstrated to be necessary or sufficient to cause

suicide' (Pompili, 2018: 16). This suggested futility in categorising and formulating experience, when rather, 'the focus should be on what patients feel' (Pompili, 2018: 17).

Phenomenologists did, however, construct models of suicidality but, rather, founded in the direct descriptive narratives of sufferers. Schlimme (2013), for example, observed that 'suicidal mental life had two sides: the experience of desperation AND the knowledge of suicide as one's last option' (Schlimme, 2013: 33). Schlimme said this could be 'narrowed down to two choices, 'staying alive' or 'killing oneself'' (Schlimme, 2018: 33). Schlimme's (2013) phenomenology of suicidal mental life described 'a condition of extreme tension: on the one side, one's life forecasts of ongoing and unbearable despair and, on the other side, one's self-inflicted death promises relief' (Schlimme, 2013: 236).

Phenomenologists also took a critical line when considering the taken-for-granted link between suicide and medical/psychiatric illness. For example, the strong link assumed between depression and suicide came into question when compared with phenomenological accounts, such that 'negative attitudes about the future (pessimism) [becomes] a better predictor of suicidal intent than depression' (Beck and Steer, 1988: 18). Attributing depression as the *causal* factor stopped short of the individual's reality. It may be that the person was, simply, 'understandably sad for what was a mess in his life' (Pompili, 2018: 19). Not everyone who is suicidal is depressed, and not everyone who is depressed is suicidal; the key factor might be 'whether you trust the future to bring changes in your condition' (Pompili, 2018: 18).

These alternative understandings of suicidality were gathered from careful attention to accounts of suicidality as described by the suicidal person. Suicidality, then, could be seen in two ways: as a consequence of a psychiatric disorder (depression); and/or, as an idiosyncratic experience, separate from psychiatric illness. Experiencing both meant there was a 'major risk of suicide as the person is '"attacked" in two ways' (Pompili, 2018: 19; original apostrophes). The sufferer's notion that 'one can put stop to the pain' (Pompili, 2018: 21), was the 'spark that lights the potentially

explosive mixture' (Pompili, 2018: 21). There may be an overlap between psychiatric disorders and phenomenological *suicidality*. However, the phenomenologists would draw attention to depression not being a necessary component, and that 'suicide can occur with no psychiatric disorders when profound distress and psychological pain [suicidality] become unbearable' (Pompili, 2018: 19).

2.4 Vulnerable individuals and vulnerable groups

In the last section, vulnerability to suicide was conceptualised in two different ways: as an intrapsychic vulnerability brought about by developmental conflicts and relationships, and as a context-driven experience, unique to the person. This next section follows the trajectory of the latter, post-structuralist approach, by exploring research that investigated how different aspects of a person's life might impact their degree of susceptibility to suicide.

There is a 'complex interaction between particular social concerns and suicide '(Button and Marsh, 2019: 1). Globally, for example, 79% of suicides occur in low- and middle-income countries (World Health Organisation Suicide Data, 2018) and according to the UK Office for National Statistics (ONS), 'men, divorced people and those living in less well-off areas are at greater risk of suicide '(ONS, 2017). So, it is necessary to think in more nuanced ways about 'the constitutive interactions between individuals and the entrenched and long-term social-structural conditions and processes in relation to which individuals live…' (Button and Marsh, 2019: 1). This frames suicide as an issue of public health and poses questions around the extent to which these 'social facts '(p.2) of suicide are 'complementary or necessarily in opposition ' (p.3) to the view of suicidality being 'a separate, singular, individual subject' (p.2). Their position appears to be backed by a strong body of research around sub-group vulnerability to suicidality, with studies exploring this identifying specific at risk social areas, including *youth suicide* (Ballard et al., 2013; Castellvi et al., 2017; Hengehold et al., 2019; Horowitz et al., 2014);

childhood factors including adversity/trauma leading to cognitive symptoms, sibling bullying and the role of self-criticism (Percher et al., 2017, Bar-Zomer, Brunstein-Klomek, 2018; Falgares et al., 2018); *military/veteran suicide* (Bryan et al., 2014a; Hom et al., 2017; Reist et al., 2017; Ribeiro et al., 2017); *medical doctor suicide* (Gerada, 2018; Guthrie et al., 1998; NHS Staff and Learners 'Mental Wellbeing Commission, 2019); and other factors that can increase the likelihood of lethality including access to the means of suicide (Carter, Milner, McGill, Pirkis, Kapur, Spittal, 2017) and identifying bio-medical responses to, for example, *impulsivity* (Marriott, Hibbeln, Killeen, Magruder, Holes-Lewis, Tolliver and Turner, 2015).

A question held in mind while reviewing these trends (and addressed further in the next section), was whether psychotherapists also constituted a sub-group vulnerable to suicidality. Interestingly, answering that question turned out to be more difficult than if it had been posed around physical health professionals, in terms of the body of evidence and the drive for understanding. Why that might be could be due to 'the suicide rate for doctors [being] variably estimated at between two and five times the rate of the general population' (Gerada, 2018: 165), which has mobilised the medical profession to take the issue seriously. In terms of medical doctor training, concern over junior doctor suicides over the decades has resulted in research looking at factors around medical student/trainee wellbeing and suicidality. Nearly half a century ago, a study of medical doctors and trainees identified personal qualities such as perfectionism, conscientiousness and being driven (which were traditionally seen as strengths), as factors that come to be' exaggerated during times of stress, becoming counter-productive and turning to weaknesses' (Ross, 1973: 136). A more recent investigation identified 'a disconnect between expectation and reality regarding the way postgraduate learners are integrated into the workplace, '(NHS Staff and Learners 'Mental Wellbeing Commission, 2019). These studies centred mostly on individual factors. However, a systematic review and meta-analysis of suicide (and suicidality) among physicians and healthcare workers by Dutheill et al., (2019) stood out

because of its multi-national focus and emphasis on context. The review identified the contradictory nature of data, that 'comparisons were not made between gender, occupation and specialties, epochs of times … physicians are an at-risk profession of suicide, with women particularly at risk' (Dutheil, Aubert, Pereira, Dambrun, Moustafa, Mermillod, Baker, Trousselard, Lesage, Navel, 2019: 1).

2.5 Psychotherapist suicidality: are psychological practitioners a vulnerable group?

The last section reviewed research that investigated different aspects of a person's life and context, and whether that might impact their degree of susceptibility to suicidality. A sizeable amount of research and debate addresses woundedness amongst helping professionals, past trauma and impact on practice (e.g., Benzimin et. al., 2012b, Jackson and Ta, 2001); a useful summary is provided in Huss (2020) but very little includes suicidality. A useful vantage point was provided by research into medical doctor/junior doctor suicidality, investigating whether training and working as a physician could contribute to someone becoming more likely to experience suicidality. An interesting observation from within that body of research came from Dutheil et al., (2019), who reflected how there has been more research into physician suicidality than other healthcare professionals. Dutheil et al., (2019) recommended extending research into other healthcare fields. Ergo, this section maps out what research exists in relation to distress and suicidality amongst practitioners in the psychological helping professions.

There have been several studies into psychologist and psychiatrist distress and suicidality which either relate directly to psychotherapist suicidality or serve as broader yardsticks. Several quantitative research studies and reviews over the last fifty years, all based in the U.S.A., tried to establish rates of suicide amongst psychologists, with a focus on whether psychologists are at greater risk compared with the general population (Fox and Cooper, 1998; Gilroy, Carroll,

and Murra, 2002; Kleespies, Van Orden and Bongar, 2011; Mausner and Steppacher, 1973; Phillips, Liu and Zhang, 1999; Pope and Tabachnick 1994). Sherman (1996) cited Nathan (1986) indicating that psychologists experienced as much or more distress than the general public. This aligned with earlier research findings by Deutch (1985) that suggested psychiatrists, in this case, were more prone to suicide and alcoholism than physicians in other medical specialties (Knutsen, 1977). Depression was also reported to be a primary concern among psychologists surveyed by Pope and Tabachnick (1994). Further, Nachshoni, Abramovitch, Lerner, Assael-Amir, Kotler and Strous, (2008) showed that lifetime prevalence of both suicidal thoughts and suicide attempts were significantly higher among mental health care staff than among the general population.

However, the evidence isn't all one sided and methodological disagreements are at the core of some of the issues. For instance, Guy and Liaboe, (1985) found little experimental justification for higher-than-average rates of suicide amongst psychologists and psychiatrists, while Kleespies, Van Orden and Bongar (2011) questioned the generalisability of earlier findings, citing relatively low sample sizes. Noticeably, there are no studies into psychotherapist/psychologist suicide that show lower rates of suicide, which allows us to postulate that practitioners in the psychological helping professions were *at least as at-risk* of suicidality compared with the general population. To get a better understanding of why this might be required unpacking the detail, for example, ascertaining any differences between those practitioners who worked clinically or not. In this instance, Guy and Liaboe, (1985) noted that little was known about those professionals who also practiced psychotherapy, and Farber (1983) observed deficiency comparing psychologist-psychotherapists with psychologist-educators, -consultants, -administrators, and -supervisors. There were also no research attempts to understand cross-sections of suicidality with other factors, such as age, gender, identity, ethnicity, or history of woundedness (Huss, 2020a). An exception from earlier research

was a study by Mausner and Steppacher, (1973) which found the rate of distress for female psychologists to be more than the rate for the general population. This was interesting because, although standing alone in it's findings, it suggested a potential complexity to practitioner distress not often attended to by other research.

Farber & Heifetz (1981) did find that psychotherapists reported taking work related stresses home, due to constantly giving with no reciprocity from clients, and from [stressful] work conditions external to therapy activities, while more recent studies have found that psychologists who worked clinically with mental health clients experienced burnout, depression, suicide, substance abuse, stress reactions, vicarious/secondary trauma, financial strain and familial and relationship difficulties (Smith and Moss, 2009). Such occupational hazards 'were found to increase the likelihood of job-related stress or burnout in psychologist-psychotherapists, including professional and emotional isolation, lack of therapeutic success, or demanding paperwork and administration duties' (Norcross and Guy, 2007: 37). Adams' (2004) doctoral research relating the stories of forty therapists who had experienced life struggles, concurrently invited the reader into her own personal and professional torment - of facing 'five months of stratospheric anxiety … and profound shame' (Adams 2004) following a professional complaint from one of her clients. In seeking to explore how therapists' personal lives affect their practice, Adams wrote: 'working as a therapist is difficult but facing myself is harder still' (2004).

Surprisingly, Adams didn't report suicidality of any sort amongst her population. This is particularly puzzling since 22 out of her 40 participants reported depression, with 7 describing their condition as 'chronic, having struggled with depression for much of their lives' (2004) and people with depression can be 'at greater risk (of suicide)' (Reeves, 2010: 21). Indeed, the most widely used measure for depression in UK NHS Primary Mental Health services, the Patient Health Questionairre-9 (PHQ-9; developed by Drs. Robert L. Spitzer et. al), uses nine key

indicators for depression, one of which is: *Thoughts you would be better off dead or hurting yourself in some way*. So, one would imagine there to be a narrative of suicidality amongst Adams' research population.

Maybe, since suicidality wasn't the focus of Adams' research, this wasn't directly disclosed or named. Nevertheless, this seems to suggest an element of hesitancy to be fully open amongst Adams' participants, an observation backed up in discussion with Adams at a talk she gave on her research, where Adams acknowledged that there almost certainly would have been some 'holding back'.

Possibly the most distressing event for a practitioner is the suicide of a client (Brown, 1987). Norcross and Guy, (2007) established client suicidality and aggressiveness, in what they classified as negative client behaviours, as potential contributors to practitioner stress. A rare qualitative study involved a discussion between a clinical psychologist and a psychiatrist, both practicing psychotherapists finding that when a client in therapy completed suicide, it was 'etched into the memory as one of the most traumatic and painful experiences of a professional career,' (Grad and Andriessen, 2016: 2). The event provoked 'not only professional questions, doubts and explanations, but also personal, basic human feelings, not entirely different from those experiences of the relatives and friends of the deceased,' (Grad and Andriessen, 2016: 3).

The fear of a client's suicide can also trigger practitioner distress (Nichol, Loewenthal and Gaitanidis, 2016; Pope & Tabachnick, 1987; Sherman and Thelen, 1998), resulting in 'individual disequilibrium in which one's personal wellbeing is compromised' (Smith and Moss, 2009: 1). Nichol et al. (2015) identified that working with suicidal clients was demanding and anxiety provoking for psychotherapists, while Ramberg and Wasserman (2000) showed that when psychologists continuously came into contact with patients' suicidal preoccupation, it resulted in them being less able to forget their own problems, including suicidal thoughts.

That psychological practitioners can experience distress and suicidality also prompts interest in a related area of research, looking at help-seeking behaviour amongst psychologists. Studies showed that numerous personal and occupational factors decreased the likelihood that [psychologists] would seek assistance when in trouble (O'Connor, 2001). Oteiza (2010) identified themes impacting whether a psychologist would engage in personal therapy, including perceived effectiveness of previous experiences of personal therapy; while Norcross (2000) reflected on how psychological principles, methods, and research are rarely brought to bear on therapists themselves, noting that 'the paucity of systematic study on psychotherapists self-care was unsettling' (Norcross, 2000: 37).

In summary, there is no existing evidence to show that psychotherapists are more vulnerable to suicide, but equally, psychotherapists are not shown to be invulnerable or less susceptible than the general population. There is an absence of qualitative, lived experience research on psychotherapist suicidality, which could increase granularity and elucidate more in-depth understanding. Dutheil et al's., (2019) call for further research seemed to be stunted by a long-standing bias privileging empirical research over qualitative studies - which might also provide part of an explanation as to why there is such a paucity in qualitative research. More granular, qualitative investigations could uncover multiple complexities and embrace lack of generalisability as a new reality in this area of research. There is an additional reason for uncovering the multiple complexities of psychotherapist suicidality. Dunne (1987) noted that even a comparable rate of suicidality amongst psychotherapists might be something psychotherapy clients might struggle to understand or find meaning around. He suggested that the struggle to understand could be aided by research that uncovered the nuances of psychotherapist suicidality, including lived experience research.

2.6 Psychotherapy trainees: stress, distress and suicidality

This section looks at research that explored trainee psychotherapist distress and suicidality, paying particular attention to the organisational dynamics of training institutions.

Guy and Liaboe, (1985) commented that psychotherapy students must cope with the rigours of academic work but are also required to focus on themselves as 'the person of the therapist' (Guy and Laboe, 1985: 470). Cushway (1997) identified similar difficulties and contradictions for the psychotherapy trainee, that on the one hand, trainees are expected to become more self-aware and to expose their frailties as a step towards greater client sensitivity, and on the other hand, being selected because of their personal, as well as academic, qualities, have to live up to this in training and display no weakness. Cushwell (1997) reflected how this may present seemingly unresolvable dilemmas. The consequences of these unresolvable dilemmas may explain patterns noted by Forrest, Elman, Gizara and Vacha-Haase, (1999), who observed, 'many [trainee] psychologists self-report continuing to work even when they are too distressed to function effectively,' (Forrest, Elman, Gizara and Vacha-Haase, 1999: 627). Then, as well as grappling with their own psychological difficulties, trainee therapists are also exposed to the suffering, pain and distress of others (Farber, 1985).

Forrest saw this as a serious challenge for psychotherapy and psychology training, reflecting 'we are struggling to understand and implement our responsibilities as gatekeepers for professional quality control,' (1999: 683). Cushwell (1997) wrote how as a trainee, she was surprised by the number of demands and, when later becoming a trainer herself, experienced pressure in her supporting role for stressed trainees. Cushwell (1997) also observed that psychotherapy trainees can be older than generic students and be a group at risk of psychological distress. Drawing on other research (Whitman, Spendlove and Clark 1984), Cushwell (1997) noted that in addition to the usual student stressors of fear of academic failure, loneliness and perceived powerlessness, older students may have developmental needs which can be frustrated within the standard university environment.

So, what of the gatekeepers in the training programmes: the tutors and supervisors? Lamb (1999) found that the relationships between psychotherapy trainees and trainers, including maintaining professional boundaries in training programmes, was key to anticipating and/or minimising impairment amongst trainees. Additionally, Vasquez (1999) observed that supervisors and tutors found it stressful when faced with trainee impairment, reporting the desire for positive experiences in supporting roles as a contributing factor to the stress response when there are problems. Poignantly, Vasquez (1999) also perceived students to be, at least temporarily, in a position of subordination, and that there was a need to carefully assess and minimise the realities of the power imbalance and to prevent exploitation of students. He added that supervisors must maintain responsibilities to '…the future clients of students, who, by virtue of the therapeutic relationship, are also in a temporary position of subordination' (p. ?).

In summary, research has suggested that a distressed student in a subjugated position of power, seeking support from a stressed supervisor, who wants a positive student relationship, and so is feeling reluctant to engage in the student's challenges, might impact the professional supporting relationship in a way unique to psychotherapy training. This pressure point may result in trainees experiencing suicidality, but it may just as easily result in the student holding back from disclosing their distress. However, there is no research into the potential suicidalities of trainee psychotherapists.

2.7 Organisational contexts: power and shame in training programmes

Tracking research into psychotherapy trainee stress and distress took a direction from the individual, upwards through the interpersonal, to the organisational. Following Forrest et al. (1999), this section looks, then, at literature that focussed on the organisational dynamics within training institutions. It begins by reflecting, again, on work within the medical training world, as

a helpful backdrop to research in organisational power dynamics (Grant, 2001) and emotions within organisations (Fineman, 2003).

Similar to psychotherapy training, junior (trainee) doctors are required to work in multiple health settings where they are supervised and evaluated by senior consultants in order to qualify. Studies have shown that this sub-group of students 'repeatedly experience psychological distress during their medical training' (Guthrie, Black, Bagalkote, Shaw, Campbell, & Creed, 1998: 237) and that junior doctors report 'higher levels of work-related stress, burnout and lower engagement than more experienced staff' (NHS Staff Survey, 2019: 13). Focus group results (Oakland, 2020; *grey literature* published internally in Health Education England) strongly implicated the training experience itself as a tone-setter for career expectations. Themes of *needing to feel valued*, *desiring open inter-professional communication and feedback* and *being aware of, and subject to, placement hierarchy and power dynamics* were aspects of the working environment that were highly important to trainees, yet experienced in markedly different ways by individual trainees in different healthcare and hospital settings. Negative experiences around these themes could result in inflexible beliefs about what *being a doctor* might be like, and be potentially carried forward well beyond qualification. The importance of being able to admit mistakes without fear of punitive repercussion featured strongly in trainee accounts. Interpersonal relationships with supervisors, particularly in terms of feeling safe and valid, were seen as paramount in the training experience. The quality of those relationships shaped the likelihood, or not, of interpersonal openness, honesty and support seeking.

Grant (2001), identified similar issues in mental health nurse training, particularly around power dynamics, that created 'familiar and repeated procedures (Grant, 2001: 174). Grant (2001) used the construct of *structural power* as the 'best analytical fit' (Grant, 2001: 173) to explore how organisational factors shaped the experience and practice of clinical supervision. Trainees constructed 'familiar ways of conceptualising power' (Fineman, 2001) that resulted in the

development and sanctioning of 'feeling rules,' (Fineman, 2001). These unspoken rules governed whether it was perceived safe or unsafe to express emotion, often resulting in 'authentic displays of emotion [being] discouraged in clinical supervision sessions'.

In psychotherapy training, clinical supervision is mandatory, though mostly limited to organisational supervisors (often training institution tutors or ex-tutors), something that Grant (2001) noticed in psychiatric nurse training as a reality that could set up distorted dynamics by influencing 'face-saving and impression-management strategies' (Grant, 2001: 173-177).' Yourman and Farber (1996) found that 85.9% of psychotherapy supervisees '…found themselves telling their supervisor what they believed he or she has wanted to hear on at least one occasion' (Yourman, 1996). Yourman theorised 'shame is one possible reason' (Yourman, 2003: 601), which fitted with Grant (2001) postulating 'an implicit contract within which (nursing) trainees needed to be seen to be coping with their job' (Grant, 2001: 173-177). Both shame (Yourman, 2003) and perceived coping (Grant, 2001) could potentially amplify the feeling rule that it is 'not in the interest of supervisees to display emotional vulnerability within supervision sessions' (Grant, 2001: 173-177). Grant added that forms of 'face-saving and impression-management strategies' (2001: 173-177) could underpin organisational relationships, which in psychotherapy training might be translated as *demonstrate resilience* even when one is struggling.

The work by Yourman (1996), Fineman (2001) and Grant (2001) indicated that in the training phase of a therapists' career, the potential for institutionalised 'repeated patterns of expectation and influence' (Grant, 2001: 173-177) might create a form of self-censorship based around feeling rules. Organisational patterns of expectation (Grant, 2001) within psychotherapy training could, then, result in a pecking order in emotional presentation and labour (Hochschild, 1983): who can say/display what to whom (Fineman, 2003). Given this, if a trainee was suicidal, they may weigh up the risk of telling a tutor or supervisor in light of organisational beliefs around

what is expected of me, and conclude their suicidality fell outside that expectation. The resulting *deep acting emotional labour* (Hochschild, 1979) through not disclosing could manifest outwardly as an *I'm OK* scripted response, involving 'suppressing what you privately feel, to come into line with what the [supervisor] wants you to feel' (Hochschild, 1979: 551).

Rogers (1995) wrote a first-person, retrospective account, describing these kinds of experiences while enduring severe distress during psychological training. Rogers (1995) reported attempting survival-oriented strategies to protect their mental and emotional healthiness, while experiencing immense stress in meeting their clients' needs, and balancing pressure over their educational and professional training responsibilities. It's noticeable that these concepts and accounts are twenty plus years old, so how have training institutions responded-to them? A recent Australia-New Zealand Counselling Psychology study by Nicholson Perry et al. (2017) noted a shift from a culture that appeared to be about 'weeding out incompetent trainees' to 'preventative and remedial strategies')p. ?). While some processes involved in the identification and management of those students experiencing impairment, the structures had been refined and systematised to include opportunities to facilitate early identification and remediation.

These pieces of research need to be built on, backed up with additional lived experience accounts, that might encourage organisations to evaluate themselves and improve trainer-trainee power dynamics. An interesting perspective comes from the field of organisational change and the concept of *wicked problems*: seeing anything highly complex, contradictory, and cross-cutting, as a wicked problem. Sobelson (2019) found that suicide is a wicked problem characterized by a high level of uncertainty surrounding the problem and solutions, a high level of interconnectedness with other problems, and high potential for social iii and political conflict. The next section explores the paucity of the kind of qualitative, lived experience research, that

might provide a meaning-based body of evidence to support organisational change, including in training institutions.

2.8 The paucity in lived experience research

Rogers (1995) talked autobiographically about working as a psychotherapist while experiencing mental health challenges. She described working with a five-year-old boy at a centre for emotionally disturbed children, a week after experiencing psychosis. Roger's story was moving and insightful, but in the twenty-five years since, has been followed by few other such accounts. Hjelmeland and Knizek, (2010) proposed a need for more studies focusing on understanding suicidal behaviour, rather than seeking explanations. Yet the call has barely been headed, particularly in practitioner research. This may be, as explicated in the last two sections, because lived experience suicidality research poses unique difficulties for therapists. A recent exception has been Huss's (2020a) study on first-person experience with suicidality among helping professionals, which includes her own disclosures of suicidality. Huss said, 'an open conversation that embraces professionals who know what it feels like to be suicidal must occur' (Huss, 2020: 111), but to date, there has been no lived experience research on psychotherapist suicidality.

Practitioner accounts of suicidality are more prevalent in popular and grey literature. In the late 1990's, psychiatrist Redfield-Jamison (1997) hinted at the prevalence of suicidality within her own profession, writing poignantly about the potential consequences of her own disclosures: 'I have no idea what the long-term effects of discussing such issues so openly will be on my personal and professional life, but, whatever the consequences, they are bound to be better than continuing to be silent' (Redfield-Jamison, 1997: 10) More recently, in a short yet impactful book chapter, peer support coordinator Rowe (2016) described the suffering and weight of stigma within her recurrent suicidality as 'a mix of the surreal and brutal reality' (Rowe, 2016:

154). Rowe talked about 'the social and medical stigma surrounding recurrent suicidality' (Rowe, 2016: 154) and the powerful effect to be gained in 'finally speaking out against damaging stigmas' (Rowe, 2016: 154).

Redfield-Jamison and Rowe speak to the challenging intersectionality of personal life, professional reputation, and suicidality in the helping professions. But stigma and it's ensuing symptom of silence are, of course, active even outside this personal-professional intersectionality. In the foreword to Webb's (2010) book *'Thinking about suicide: Contemplating and comprehending the urge to die'* in which Webb described his own suicidal journey, Valerie Walkerdine commented that it is 'so rare in the literature on suicidology to hear the point of view of those with suicidal feelings, that indeed a whole field of research can be constructed which never seems to talk to those it claims to pronounce on' (Webb, 2010: i). Webb's work was based on his completing the world's first PhD on suicide by someone who had attempted it, making better our attempts 'to grasp the basic suffering' (Webb, 2010: 1).

Webb said, 'there is a fundamental flaw at the core of contemporary thinking about suicide, which is the failure to understand suicidality as it is lived by those who experience it.' (2010: 2). However, Bager-Charleson & Kasap, (2017) talk about how there may be idiosyncratic challenges of emotional entanglement in research, that dissuade engaging in research on self. Elton (2018), writing about medical doctors, described the 'stigma doctors can face if it is known that they have suffered from a mental illness,' (Elton, 2018: 1). Practitioner-researchers like Elton might override the apparent silence script because they do not want to collude with 'the fantasy that depression, or any other mental illness, only happens to other people,' (Elton, 2019: 1). The potential fear amongst psychotherapists, or practitioners in the helping professions, to embark on lived experience suicidality research, might be reinforced by a fear that survivor therapists [could] feel devalued because of their past/present patient status (Adame, 2014). This urge to avoid disclosure through lived experience research is addressed in a journal article

by counselling psychologist Larsson (2012), who suggested it might be that the therapeutic community is reluctant to make public an issue that might not be fully understood by consumers of psychological therapies, or fear may put psychological practitioners in a bad light. Similar to Dunne (1987), Larsson intuited, 'practitioner suicide may be a delicate area to examine when considering the image the profession wishes to project' (Larsson, 2012: 550).

2.9 Literature review conclusion and research aims

This literature review has shown how the last two centuries of research into suicidality has been dominated by two overlapping research stories: research aligning with dominant medical model *explanations* (Hjelmeland, 2010) of suicidality, introduced by Esquirol (1772-1840) and postulated by Marsh (2016) as the compulsory ontology of pathology; and sociological research that contextualises suicidality by a range of societal factors that intersect with individual differences, as first advanced by Durkheim (1897) and continued into socio-cultural and socio-political studies frames of reference (White, 2016; Reynolds, 2017). Cross-cutting both stories is a fervent suicide prevention movement that mostly takes the lead from quantitative data (e.g., ONS, 2017) is supported by the NHS in the UK but is often headed by charities (e.g. in the UK: Samaritans, Mind, Rethink, Sane) some of which focus on specific at-risk demographic groups, but almost all align with the medical model premise that suicidality is singularly a mental health concern. Most suicidality research has favoured positivist approaches to studying its subject matter (Huss, 2020), neglecting additional perspectives, paying little attention to the need to supplement research with qualitative studies (Hjelmeland & Knizek, 2010). There is a particular paucity of lived experience qualitative research and first-person accounts from within the psychological healthcare professions. The voices of psychotherapists with histories of suicidality are not heard at all.

Having identified a gap in the research, this qualitative first-person research study on psychotherapist suicidality aims to punctuate the absence of psychotherapist suicidality voices. I drew on my own lived experience lived experience of suicidality in dialogue with three other psychotherapists who have histories of suicidality, to produce verbal exchanges that explore and co-create our stories. From this, I hope to generate a dialogue within the psychotherapy community around psychotherapist suicidality as a neglected and potentially avoided aspect of psychotherapist phenomenology. I aim to do this by charting an effective and ethical path into this complex and sensitive subject.

2.10 Research Questions

Both threads involve addressing why there is an absence of lived experience research in psychotherapist suicidality. I have constructed two research questions to uncover why therapists find it particularly difficult to talk about their suicidality, and why researchers avoid asking about it. The first question asks what emerges in conversations between psychotherapists experiencing suicidality. I framed this exploration by the question:

'What do therapists say when they talk about their own suicidality?'

The second area of interest involved what happens when therapists talk about their own suicidality. This question addresses the gap in the literature where the lived experience accounts of psychotherapist suicidality could offer rich, meaningful, reflective responses to the question:

'How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?'

CHAPTER 3. METHODOLOGY

3.1 Chapter overview

This chapter describes the research methodology and procedure for this qualitative project, including a discussion on ensuring quality and ethics. Embarking on this research journey first required a decision about the ontological stance between realism and relativism: is there an objective truth to the experience of suicidality or, are suicidality realities complicated and diverse, with no absolute facts, instead, multiple individual truths? This study erred on the side of the latter view, assuming a broadly relativist stance with a social constructionist paradigm. The epistemology and research design followed this broad view, as will be described next in the opening section.

3.2 Ontology, epistemology and methodology

'Ethnographers have always placed a high value on a literary style that evokes as well as represents "what happened" while they were in the company of others' (Goodall, 2013: 204). I find this quote very helpful in arguing the case for relational autoethnography in my qualitative study. My research sought to understand psychotherapist suicidality by using an interactive autoethnography methodology, and in doing so offered an opportunity to discuss both what was said and what happened. To achieve this, the study used Ellis's (1997) interactive interviewing method as its data collection method, to produce a series of verbal exchanges between psychotherapists who had experienced suicidality. The methods chosen

corresponded with the study's attempt to obtain and value transactional knowledge (Denzin and Lincoln, 2011) in the form of co-constructed subjective meaningful experiences. The co-created verbal exchanges (Goodall, 2000) were analysed for levels of unique meaning and understanding.

Goodall places Verbal Exchange Coding within a social constructionist paradigm, and spotlights verbal exchanges (conversations) as the generating force for the social construction of cultural realities. Social constructionist traditions emphasise the socially constructed nature of meanings in which people are regarded as 'meaningful actors' (Porta and Keating, 2008). As such, the interactive methodology helped facilitate an in-depth inquiry into how psychotherapists act meaningfully when they sit together and talk about their suicidality, and what meanings are constructed. This approach utilised the rhythmic alternation of I-thou and I-it relatedness (Hycner, 1993) to produce an analysis that attempts to uncover meanings and the socially constructed nature of those meanings.

19th Century Humanist, Wilhelm Dilthey, emphasised the importance of understanding people's lived experiences which occur within a particular historical and social context (Dilthey Emery and Emery, 1954). The study of lived experience is vital to Social Constructionism, then, since 'there is no way of experiencing the 'real relations of a particular society outside of its cultural and ideological categories '(Peck, 2001: 200), and there is no permanently fixed reality that is mind dependent (Schwandt, 2000). Unlike the methods used in the natural sciences, which concern themselves with law-like regularities (Ritchie, 2014), studying the social world of meanings and human agency therefore requires a methodology for capturing and portraying competing perceptions and meanings. Consequently, the study of social reality transcends empirical enquiry - an argument put forward nearly 250 years earlier by Immanuel Kant (1781). Social constructionist approaches seek knowledge that is provisional and

affected, rather than an accurate portrayal of reality that is immune to researcher/participant subjectivity and bias.

Dilthey et. al., (1954) spoke from a more social constructivist position, adding self-determination and human creativity into meaning formation. So, as well as understanding participants meaningful acts and how they are socially constructed, there is a contingent argument that knowing isn't passive. What is being investigated in this study, then, is how personal agency interacts with institutional-cultural ideals, and how those meanings are built, or socially constructed, by two social actors operating from within a unique sub-cultural: psychotherapy.

3.3 Arts-based research methodologies

Autoethnography sits at the fringes of qualitative methodologies, often being considered unscientific and self-indulgent. Autoethnographers commonly embrace this critique, considering themselves to be more akin to art than science. Qualitative researchers are 'interested in the individual's lived experiences in the world and how one interprets those experiences' (Higgs, 2008: 549). So, when looking for a home for autoethnography, it is noteworthy that arts-based research centres strongly around reflective practice and enables researchers to 'transcend difficulties [and] solve problems' (Higgs, 2008: 545). Further, arts-informed work allows the researcher to step in *less discretely*, since 'in all qualitative research, the researcher is inseparable from the process' (Hertz, 1997; Higgs, 2008: 548). This makes it 'particularly suited to post-positivist and constructivist paradigms' (Denzin & Lincoln, 2011; Higgs, 2008: 546).

Arts-informed research helps 'expand the base of qualitative research methods [to] broaden our understanding of human behaviour and mental processes' (Higgs, 2008: 546). Social perspectives and intersubjective processes are particularly applicable, since an arts-based approach can open up dialogue around hidden phenomena that might otherwise remain unspoken. This *opening-up*

takes place via 'the blending of alternative epistemologies, [creating] cognitive dissonance' (Higgs, 2008: 548). It is the cognitive dissonance that bumps the mind away from the expected. Inherent ambiguity in artistic processes primes cognitive dissonance, which often sparks growth and learning' (Higgs, 2008: 554). Importantly, this 'allows us ... to situate our research practices relative to their purposes and not necessarily according to the authority of tradition' (Higgs, 2008: 549) (inspired by the Listening project https://www.bbc.co.uk/programmes/b01cqx3b). The boundaries of traditional qualitative research 'have been expanded by these unique methods of creating and reporting human experience' (Higgs, 2008: 547), that include fictional narratives, poetry, prose and performance. Creative qualitative research, couched in postmodern progressive territory, shifts the paradigm 'toward a more relativistic mode of knowing ... and new creative ways of knowing and representing understanding in studies of human psychology' (Higgs, 2008: 547). This provides 'opportunity to broaden the scope of qualitative design' (Higgs, 2008: 547).

An arts-based approach can be entered into orally, by recording experiences and reflections, collecting artefacts, allowing metaphors to emerge, and 'attempting new forms of communication' (Higgs, 2008: 550); techniques that ring similar to those employed by autoethnographers. Indeed, reading around literature on arts-informed research, I was struck by how many of the processes employed by artists can be likened to those employed in autoethnography. Just like all art, an arts-informed approach can be entered into orally, by recording experiences and reflections, collecting artefacts, allowing metaphors to emerge, and 'attempting new forms of communication' (Higgs, 2008: 550). Following the oral tradition, the arts have 'been applied to inform culture of psychological truth for at least as long as humans have had literature' (Higgs, 2008: 548). Performance and theatre, e.g. the works of Shakespeare, leave audiences 'more informed about the human condition and about themselves' (Higgs, 2008: 548). So, different narrative forms, in the oral and written tradition, have 'provided a means of constructing and reconstructing meanings and relative truths in the complex drama of human cultural evolution' ((Higgs, 2008: 548).

In a post-structuralist analysis of psychotherapy, Spinelli (2006) used a metaphor of 'magic feathers' that therapists deploy in their belief that therapy will only work if things are set up the correct way. Much like Dumbo believing that he couldn't fly without grasping magic feathers, therapists hold onto time, location, conditions, set-up, boundaries around behaviour and disclosure, process, etc., as their essentials for therapy to work. Spinelli invites therapists to loosen their grip and step out into novel ways. Much like psychotherapy, I am drawn to research approaches that strip away the magic feathers and open space for novel ways of researching, in order to reveal the hidden and open up dialogue where silence prevails.

The inspiration for adopting an approach and method that leans-into arts-based values for the current study is strongly driven by these observations; that 'artistic expression is frequently at the leading edge of change, defining a reality unseen by the language of objectivity' (Higgs, 2008: 551). This allows us to 'move and be moved in a reflexive [and transformative] act, that creates a way of knowing' (Higgs, 2008: 551). Researchers are drawn into their chosen area via reflective events. The transformative energy produced around being reflexive creates change in the researcher, which then becomes part of the object of interest. There is a 'reflexive nature of the relationship between researcher and participant, a process in which researcher becomes participant and the method fo producing knowledge is transformed' (Higgs, 2008: 551). The blurring, or levelling, of researcher and participant, is something that is actively sought in this interactive-autoethnographic study. In the same way as 'arts encourage a transcendental capacity' (Higgs, 2008: 552), autoethnography, as an arts-informed process, has a transcendental function. Levelling the playing field between researcher and participant can be viewed as a transcendental act, some would say, transgressive.

The use of metaphor in research - and psychotherapy - is commonplace because of its own capacity to transcend experience and create meaning. Metaphors are used by therapists to 'characterise and communicate often difficult-to-describe felt experience' (Higgs, 2008: 552).

Indeed, 'one of the greatest challenges of research in psychology is effectively describing inner states or experiences' (Higgs, 2008: 552), and metaphor can a key enabling ingredient for inner experience to be effectively expressed. The craft of poetry, as a metaphor, '...unwrap(s) the profound effects of culture...' (Higgs, 2008: 552). Poetry 'is used to read the "unsaid" that is a backdrop for the said' (Higgs, 2008: 552). Higgs (2008) speaks of how the use of metaphor can render the "not-said," speakable, 'for the purpose of listening to the sometimes unspeakable' (Higgs, 2008: 553). This helps researchers 'listen to those who are oppressed by their languaged position in the narrative of being' (Higgs, 2008: 553), 'allowing us to see new ways to live and grow and new ways to know' (Higgs, 2008: 553).

Imagination plays a generative role at the beginning of any research. Like the process of making art, alternative/transcending research methods 'can nurture the intellectual flame that pushes the inquiring mind into a quest for new knowledge' (Higgs, 2008: 553), kindling imaginative processes to further inquiry, since, 'even basic science involves improvisation…,' (Higgs, 2008: 553). Arts-informed research, like arts-based research, 'creates a discursive space in which possible new ways of knowing are fostered and imaginative, creative processes are fuelled' (Higgs, 2008: 554). The antithesis of this process lies in a more typical process of defining 'the norms for acceptability and adaptation in social and cultural contexts [whereby] the search for the meaning of being and the individual self is crowded into a known space,' (Higgs, 2008: 553).

3.4 Why autoethnography was chosen over other approaches

In the design stage of this project, Thematic Analysis was chosen as the initial methodology, using a standard one-way qualitative interview method. As part of this, a self-reflective account would be added to bring the researcher's voice into the narrative. However, this would be a reflexive description beyond the interviews and this approach seemed to be treating the researcher's experience as a bolt-on, an afterthought to the inquiry. Given that it was the researcher's original episode of suicidality while in psychotherapy training that provided the primary phenomenology - the spark that inspired the project - it seemed somewhat lacking to bring the researcher's phenomenology into the story later, beyond the interview narratives. It was considered essential to bring that experience to front and centre of the investigation. Leaving the original phenomenology to afterthought, could also have been considered a collusion with the silence around psychotherapist suicidality. It is more comfortable and more objective to investigate *other* than *self;* a more genuine, generative and progressive way to break the silence would be to reveal and explore *self-with-other* in the interviews.

The draw towards autoethnography was considered a facilitator to break the silence. Autoethnography presented itself as a solution, particularly given that, 'all social praxis researchers are embedded in the social milieu they are studying.' (Poulos, 2021: 10). An embedded researcher embroiled in the the research milieu, but holding back on the contribution of their story, seemed both antithetical and, again, colluding with silence. Given that a goal of the research was to shine light on and reveal new knowledge, it didn't make sense to assign the researcher's phenomenology to the margins. Instead, it became viewed as essential to 'engage the researcher's voice in qualitative writing' (Poulos, 2021: 10). By 'digging deeper into the researcher's experience' (Poulos, 2021: 10), confronting '...human emotions as raw, transcendent, messy, irrational, and sometimes ugly...' (Poulos, 2021: 14), it would open up the potential to 'write from an engaged subjective position to get at the richer nuances of participation-observation' (Poulos, 2021: 10).

Another advantage of writing autoethnographically, was that it allowed the researcher to write first person accounts which 'provided them with a transition from being an outsider to an insider in the research' (Hitchcock & Hughes, 1995). Personal reflection adds context and layers to the story being told about participants, (Bochner, 1984). However, I was also interested in the participant's cognitive and emotional responses to the researcher's story. It was the meanings produced by the mutual interactions of two suicidal phenomenologies in reflection with one another, that interested me. In that, I wanted to bring in an arts-based element to the frame, utilising poetry, prose, autobiography, songwriting, and self-reflection, to aid 'subjective and intersubjective knowing [to] emerge in the act of making art' (Higgs, 2008: 549).

There was also a personal drive to explore and write culture through a creative exploration of self that preceded and guided academic considerations around methodology. Hamilton (2021) wrote in her 2021 paper, *Autoethnography Research – advantages, disadvantages and limitations*, 'I always felt that my research project would be carried out in a creative format – I never really considered working in any other way' (Hamilton, 2021). It wasn't this straight forward for me as the researcher to bring my phenomenology to the centre of the project; I had a lot of apprehension around doing so. But the conviction that creatively and mutually exploring self-in-relation-with-other was the best way to uncover the richest accounts and dialogic interactions from the study, won out in the end. Hamilton (2021) continued, '...with openness and vulnerability also comes several advantages to using this method [autoethnography]. Firstly, I am the focus of the project and have complete access to all my own thoughts and experiences needed to draw from for my research' (Hamilton, 2021). I could carry a ninety minute interview with me, beyond that ninety minutes, reflexively, using writing as a research practice that drives inquiry rather than as a “mopping up” activity after research is conducted (Richardson, 2005).

3.5 Tensions in using Autoethnography combined with Thematic Analysis

Although this isn't a mixed-methodology study, I felt that it would be interesting to bring a technique used to elicit themes as a generator for reflective discussion, so included Verbal Exchange Coding and a Thematic Analysis of the original interview transcripts. Carrying out a thematic analysis, as part of an autoethnographic study, brought with it methodological tensions, which I will address here.

Poulos (2021) described autoethnography as an inherently hybrid approach to research, with a multitude of endeavours, including '... focus groups & interviews,' (Poulos, 2021: 11), that are channelled and filtered through the autoethnographic self-reflexive gaze. Autoethnography may not be suited to tracking trends, however, it does engage in 'studying inductively, searching for themes, patterns, insights, meanings, interpretations, and explanations of human action and interaction' (Poulos, 2021: 11). Although autoethnography isn't looking to quantify or measure, 'all social praxis researchers are embedded in the social milieu they are studying,' (Poulos, 2021: 12).

Autoethnography involves a commitment to reflexive self-exploration from the beginning of the research process as a central active process throughout the research journey. Anderson (2006a) has proposed that this reflexive self-exploration can include generalisations - where autoethnography, particularly evocative autoethnography, would not typically include generalisations. Anderson spoke of autoethnographers 'not only truthfully rendering the social world under investigation but also transcending that world through broader generalization' (2006a: 388). Analytic autoethnography, as opposed to evocative autoethnography, attempts to bring a realist perspective to autoethnographic writing. It has been described as a way of authorising 'the artist-researchers who identify themselves as autoethnographers, but who want to use analytic reflexivity to improve theoretical understandings of their creative practice' (Pace, 2012: 4).

There is a tension between those who want to protect the writer's voice i.e. in evocative/emotional autoethnography, and those who seek to write autoethnography but also to provide analysis and generalisations. My position is that it is possible to hold these tensions as dialectics that cross-pollinate one-another. However, Ellis and Bochner (2006) warn that by introducing analysis, there is a risk of 'transform[ing] the story into another language, the language of generalization and analysis, and thus you lose the very qualities that make a story a story' (Ellis & Bocher, 2006: 440). The fear is that analysis within autoethnography could 'contain, limit or silence the researcher's self' (Pace, 2012: 3).

One of the key features of analytic autoethnography, as explicated by Anderson (2006a), is that 'the researcher demonstrates a commitment to theoretical analysis, not just capturing what is going on in an individual life or socio-cultural environment,' (Anderson, 2006a:). The goal is, 'to uncover, record, interpret and position, from an insider's perspective and experience, the processes they use' (Stewart, 2003: 2). This view positions the current research more comfortably with an autoethnographic process that is cyclical: themes identified in the analysis, cycle round through the researcher's active, self-reflexive pursuit. The themes identified in the analysis technique employed within the research, much like themes identified in any of the plethora of research studies encountered in a literature review, are reflexively processed, digested, and expressed via the self of the researcher, and rendered into a final autoethnography. While thematic analysis was employed as a contributory ingredient to the exploration, the ultimate endeavour was not to produce finalised insights, but to instead assemble open-ended texts that '...draw out implications, spark insights, raise questions, tell compelling stories, open conversations, inspire readers, move human beings emotionally, and create openings to further study and future research' (Poulos, 2021: 12).

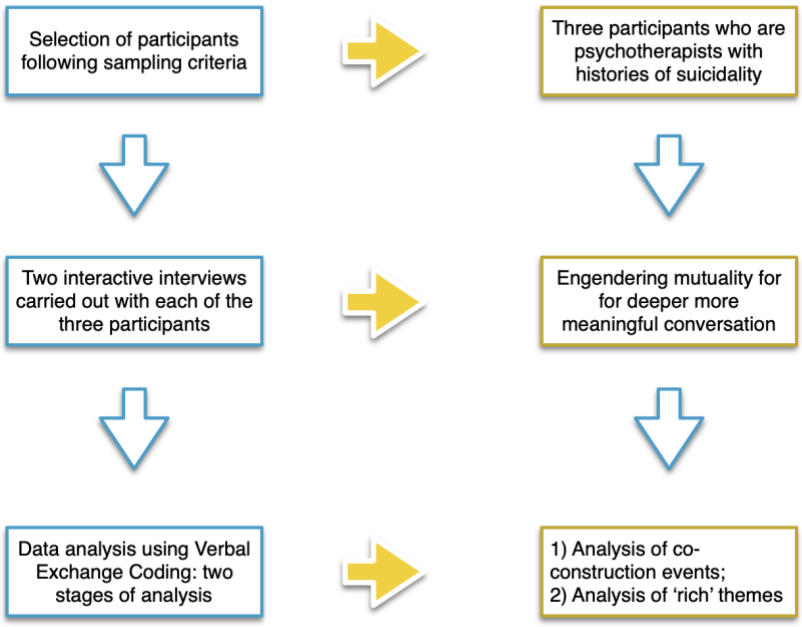
Does this make the current research a hybrid approach? Does it matter what this particular autoethnography is called? That this is a study in which the researcher takes a mutual, centrally engaged

role in the milieu, while employing self reflexivity in writing that takes insights gleaned, in part, from a thematic analysis of conversational interactions, might invite the hybrid title. However, Vryan (2006) '...cautions against framing an understanding of analytic autoethnography in terms of it not being evocative or emotional autoethnography ... [because] both kinds of text are capable of being analytic works' (Vryan, 2006). Vryan notes that some autoethnographies are oriented toward explicit analysis (Vryan, 2006) while others are more oriented towards evocative/emotional writing. That the current study lay somewhere between the two, while adhering to the principal of being '...a story with a purpose - the practice of cultural analysis and critique' (Poulos, 2021: 12), rendered the need to give a label to the particular style of autoethnography non-essential.

3.6 Research procedure overview

Following the literature review, a framework was needed to produce meaning-related understandings of lived experience psychotherapist suicidality, understood as socially created. This research aimed to redress the preference for quantitative methodologies in suicide research (White, 2016), the quest for explanations (Hjelmeland and Knizek, 2017) and linear cause-effect predictive models (Joiner 2009; O'Connor and Kirtley, 2018; Rudd, 2000; Shneidman, 1996). Rather than commenting on reality or truth (Berger and Luckman, 1966a), but consistent with Hjelmeland and Knizek (2017), the current study instead sought a way of achieving *understanding* over *explanation*.

Following on from the research ontological, epistemological and methodological discussion, the design of this study comprised the following components and steps (Fig 1):



3.7 Participants and sampling criteria

Three qualified psychotherapists, two female and one male, working in private practise in different locations across the south of England, took part in this study. The participants had different professional affiliations and training: integrative, psychoanalytic/psychodynamic and psychodynamic/person-centred/existentialist. The method of interactive interviewing and having two interviews per participant, required a low participant sample (n = 3). There was a case for also giving participant status to the researcher due to the interactive interview method (n = 4). However, it was decided that for sake of clarity the researcher would be labelled 'researcher-participant' (n = 1). The low sample rate was necessary to focus on rich and detailed accounts of in-depth stories. The methodology included a goal of resisting any attempt to produce generalisable data.

3.8 Inclusion criteria

My sampling strategy consisted of: (a) advertisement (n = 1) and (b) snowball strategy (n = 2).

(a) Advertisement: (n = 1) The advertisement consisted of a paper and electronic visual recruitment flyer (Appendix A). The flyers were posted on the information boards of counselling and psychotherapy services and gave the basic premise of the research and invited potential participants to make contact and arrange a phone call to check in with them over some initial research requirements. The participant recruited by advertisement saw the flyer on the notice board of the counselling service in which they worked;

(b) Snowballing strategy: (n = 2) this involved word of mouth and emailing potential participants or organisations (e.g., the Critical Suicidology organisation) who could disseminate the flyers. Potential participants were similarly contacted by phone for a preliminary discussion. Of the two participants recruited through snowballing, one was a peer recruited at a conference, the second answered after seeing my flyer on a counselling service notice board. The participants

Each participant was informed that they would be taking part in a two-way interactive conversation that would involve both of us talking about our experiences of being suicidal. Their right to being supported during the research process and their relational ethics right (see 3. below) to have access to their final transcripts, with the option to withdraw included, were made explicit.

The three participants all met these requirements. I had no personal or collegial connection with any of them.

The inclusion criteria were:

- Be a qualified and accredited psychotherapist

- Be a psychotherapist in training
- Have an experience of suicidality during training or on/beyond qualification

3.9 Exclusion criteria

- The sole exclusion criterion was that the participant couldn't be currently suicidal.

3.10 Revised title and data collection revision

It's important to note that due to a shift in approach in data analysis method, the title of this research project was revised post-interviews/data collection. The original information pack (Appendix B) has a different title to the final thesis draft. The core research endeavour and methods selected for interviewing/data collection remained the same.

3.11 Data collection

The methodology of interactive interviewing is described in this section. The research strove to achieve a sense of mutuality by inviting the researcher's lived experiencelived experience of psychotherapist suicidality into the account. This was achieved by employing the autoethnographic methodology and procedure of interactive interviewing.

Autoethnography is an approach to research and writing that seeks to describe and systematically analyse (*graphy*) personal experience (*auto*) in order to understand cultural context (*ethno*) (Ellis, 2004; Holman Jones, 2005). It is a contemporary qualitative research methodology, demanding unusually rigorous, multi-layered levels of researcher reflexivity

(Ellis and Bochner, 2000) (Short et al, 2013: 1). Using interactive interviewing, in which the interviewer brings their own complementary lived experience of a phenomena together with an interviewee, allows the researcher to explore the less-explored areas, or 'borderlands' (Rosaldo, 1989; 208 in Grant, 2010: 208) in relation to psychotherapist suicidality. The researcher is repositioned as researcher-participant in a dyad which permits both to ask and answer questions of the other, offering an aspect of reciprocal subjectivity that engenders co-created verbal exchanges. Ellis and Bochner (2000) suggest that using autoethnography is a powerful way of gaining access to areas of experience 'shrouded in silence' (Ellis and Bochner, 2000) (Ellis, 2011: 3).

The data itself included external and internal sources both from participants and researcher-participant. *External data* might include journal entries, documents and artefacts, demographic info etc; while *internal* data encompassed memories, critical auto-interviewing and creative products (poems, songs, artwork). Bringing them together in collaboration with participants avoided exclusive reliance on personal memory (Chang, 2008: 55).

The interactive interview method and procedure involved each participant (n = 3) being interviewed twice, with a space of two to three weeks between each interview for each participant.

The goal in data collection was to create rich co-created verbal exchanges of multiple accounts that could be analysed individually using the first phase of Verbal Exchange Coding and in conversation with each other using the second phase of coding. Data emerged through paying attention to impressions, noticeable themes, salient patterns, identifying personal values, preferences and aspects of cultural identity and cultural membership (Chang, 2008: 131).

A central activity was to seek gaps in self-awareness. What caught one's attention, stirred emotion, in joint endeavour with the participants, made stories 'twice told' (Denshire and Lee, 2013, pp. 225-227) through a process of assemblage. Re-iterating across multiple temporalities

involved writing from the past, in the present, for the future (Hughes and Pennington, 2017: 63). Collaboratively investigating a small number of cases in depth and detail (Etherington, 2004: 140), enhanced interpretation of the meanings of the data, and critical reflections on purposes and motivations of social actions (Atkinson and Hammersley, 1998).

Face-to-face dyadic interviews were carried out irrespective of the distance between participant-researcher as it was deemed important to be in physical proximity given the unconventional interviewing method. After the participants contacted the researcher, the research purpose and procedure were outlined in a phone call and with a written information pack sent by email.

Arrangements were made for first interviews by email, and arrangements for second interviews were made at the end of each first interview. Written consent was sought prior to interviews, and participant consent was checked and confirmed in every interview. The semi-structured interview schedule was used as a guide to be leaned on if the interviews required, not as a fixed framework for the interview. Consistent with the ontology, epistemology and methodology of the project, the interview process had flexibility that could be engendered by both researcher-participant and participant.

A contention of this research study was that interacting interviewing sat more congruently with both myself as a researcher and as a method for getting the most out of the interview, through verbal exchanges (Goodwin, 2000). When reflecting on this, I broke the word interview down into its component parts (inter-view) and googled their meanings, finding: **Inter**: a prefix meaning between, among, in the midst of, mutually; **view:** the ability to see something or be seen from a particular place. This altered position on the meaning of interview followed an ontological thread that ran through the core of this study: that human meaning, being socially constructed, is generated at the interpersonal, co-constructed level by verbal and written exchanges, that have a continuous two-way flow, to-and-from the historical, societal and

cultural level, connected by living, fluid human relationships. Constructivism's focus on how the individual cognitively engages in the construction of knowledge, differs from social constructionism's claim that 'knowledge and meaning are historically and culturally constructed through social processes and action' (Young and Collin, 2004: p. ?). This research takes a slightly different view that rather than being different and incompatible, constructivist processes can iterate, communicating and exchanging, with social constructionist processes.

3.12 Critiquing and defending interactive autoethnography

A general criticism of autoethnography is the (positivist) idea of self as a contaminant in research (Muncey, 2010: p. 97). Using personal experience is considered biased data (Anderson and Glass-Coffin, 2013; Gans 1999) and autoethnographers are seen as navel-gazers (Madison, 2006), self-absorbed narcissists who don't fulfil scholarly obligations of hypothesising, analysing and theorising (Ellis, 2011: 17); self-indulgent and solipsistic (Etherington, 2004: 141), doing too little fieldwork, observing too few cultural members and not spending enough time with (different) others (Buzard 2003; Fine 2003; Delamont 2009).

Working through these challenges while making research design choices, it was necessary to reflect: '*why do I need to tell you about me, about my experiences?*... and... *what makes writing about my life social science and not a novel?*' (Hertz, 1997: p. xvi-xvii). A methodological response was that interactive-interviewing autoethnography would open up for discussion psychotherapist suicidality as a subject that has been shrouded in secrecy and eclipsed by distanced writing and grasp the basic suffering (Webb, 2010). A contention of the research that drove the design was that to achieve as in-depth an exploration as was feasible, two-way exchanges of verbal personal knowledge and experience was essential to elucidate suicidal

beingness as it is lived by those who experience it (Webb, 2010). This made two-way verbal exchanges not just 'more credible, ethical, imbued with integrity, empathic and potentially effective' (Short, Turner & Grant, 2013: 11), but *essential*.

Autoethnography is often dismissed for being 'insufficiently rigorous, theoretical and analytical, and too aesthetic, emotional and therapeutic' (Ellis, Adams & Bochner, 2011: 17). However, this study wasn't trying to emulate the standardised procedures of social science, but instead to understand the meaning of what people thought, felt and did; indeed, how *I, myself*, 'feel and express emotionality, [while being] able to stand back and examine it from the outside in' (Ellis, 2004: 120). It is not about making excessive knowledge claims. Etherington (2004) suggested that, since autoethnographic research troubled familiar rules for judging the quality of research, in a similar way we needed to find 'deliberately transgressive ways to judge quality' (Etherington, 2004: 147). Rather than being preoccupied with scientific accuracy, the goal was to produce 'accessible, analytical texts that changed the world we live in for the better' (Holman Jones, 2005: 964).

Alongside concerns about confidentiality, validity, replication and generalisation (Hertz, 1997: xvii) were debates around reliability, verisimilitude and generalisability. The 'context, meaning and utility of these terms were altered' (Ellis, Adams & Bochner, 2011: 15) such that questions of *reliability* referred to the narrator's *credibility*, and issues of *verisimilitude* and *generalisability* required a role change from respondents to readers. This way, the writing was always being tested by readers for degrees of *probability* and *authenticity*: in other words, how likely is it that this account reflects subjectively genuine experience. Autoethnography could be evaluated around 'how readily it helps readers communicate with different others or offer a way to improve lives' (Ellis, 2004: 124), while holding questions such as, '*how useful was the story?*'; '*to what issues might the story be brought?*' (Ellis, Adams & Bochner, 2011: 15).

This study sought to create meaningful descriptions of psychotherapist suicidality, but as one (researcher) interacted with other (participant) (Ellis, 2004), accessing a deeper level of information (the emotional intimate realm). Embracing and working *with* scrutiny as ethical stance throughout the research, became a critical aspect of conveying thoughtful, careful, and thorough work - the hallmark of credible autoethnography in critical social research (Hughes & Pennington, 2017: 68). A major ethical requirement was to make *struggle* transparent (Chang, 2008: 142). In fact, this was also at the core of my research aim. Problematising *as an attitude* anticipated the messiness and pain of uncovering psychotherapist suicidality.

3.13 The semi-structured interview schedule

An interview schedule was provided in the participant information pack and comprised a guiding framework for initial prompts and questions to be drawn on as needed. Each interview had this schedule to hand for both participant and researcher-participant, should it be needed, and in all the interviews the first guiding prompt (see below) was drawn on. Additional questions arose organically through the verbal exchanges; no further guiding prompts from the schedule were used. Below is the first prompt from the interview schedule, the full schedule can be seen in Appendix C. ???.

Guiding framework for initial prompts and questions:

1. I'd like us to talk about our experience(s) of being psychotherapists, or trainee psychotherapists, who have been suicidal. I can start the discussion by telling you a bit about my own experience, then you could tell me your story. If there is any journaling/writing, poetry, songs, creative/artistic material that emerged from the suicidal experience, we could start by reading or listening to that.

3.14 Data analysis

'Meditating on the lived experience' (Klossowski, 1969: xv) was an essential activity in the data analysis. There was a risk of producing frozen meanings and abstractions instead of creating unique and fluid representations of intersubjective conversations, in temporality.

In response to this risk, I engaged with deliberate generative thinking and evaluation in the interviews themselves, and beyond in the writing, continually reflecting and synthesising ideas.

The study employed the data analysis method of Verbal Exchange Coding (VEC) as described by Goodall (2000) to analyse the conversational interview data. VEC is a communication-based ethnographic and autoethnographic means of discovering 'what matters in the social construction of cultural realities' (Goodall, 2000: 98). Combined with Interactive interviewing (data collection), VEC sits within the social constructionist paradigm.

The rationale for choosing VEC as a means of analysing the interviews came from its applicability for communication-based research. VEC was chosen over 'other evocative methods for analysing talk and text' (Saldana, 2016: 165) because it had a strong methodological fit with the aims, questions and methods employed in this study. It also had a clear, structured and systematic procedure for extracting co-constructed meanings.

'Verbal exchanges are the organising focus of everyday experience' (Goodall, 2000: 98) and verbal exchange coding is designed to make sense of 'what matters in the social construction of cultural realities' (Goodall, 2000: 98). VEC is 'the verbatim transcript analysis and interpretation of the types of conversation and personal meaning of key moments in the exchanges' (Saldana, 2016: 206). It lent itself nicely to the two-way conversational style of interactive interviewing, providing an organising structure to uncover emergent meanings from the interviews. It provided a structure that could answer both research questions in a systematic way:

- ***What do therapists say when they talk about their own suicidality? (***covered in section 4.2)
- ***How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?*** (covered in section 4.3)

The verbal exchange analysis process involved:

- (Section 4.1) Each interactive interview was re-written as a verbal exchange account, in a novelistic style that included 'nonverbal cues and pauses' (Goodall, 2000: p. ?);
- (Section 4.2) In order to uncover *Rich Points* (Agar, 1994) for evaluation and discussion, the original transcripts were re-coded, drawing on Braun and Clarke's (2006) six stage framework of qualitative data analysis, typically used for thematic analysis theme extraction. This structure for analysis followed an organic, iterative approach that initially yielded 24 sub-themes, further coalesced into four superordinate themes, each with two subordinate themes. These super- and sub-ordinate themes were conceptualised as rich points and discussed further:

- Familiarisation with the data
- Initial coding, including open coding, line-by-line coding and constant code comparison
- Searching for (rich point) themes, applying successive categorisation and comparison
- Reviewing themes
- Defining and naming themes
- Reporting the findings

- (Section 4.3) All the interviews were coded for generic types of communication (phatic, ordinary, skilled, narrative and dialogic), then reflected on, looking for meanings from coding and interpersonal events, or 'what happened' in the exchanges. These were the process aspects of the interview, which offered insights into the complexities of context-bound human discussions.

Issues considered during the three steps of data analysis:

Throughout the data analysis, evaluation and interpretation process, it was important to hold in mind that my contribution as researcher-participant, bringing my own account of psychotherapist suicidality, would not just influence, but conjoin with the fluid and co-created cultural meanings constructed by participants. This was a living process, as we engaged in 'storying and re-storying [our] experiences' (Grant 2010: 114). My contribution to the joint construction involved an inevitable mobilisation of the *culture in my self* in parle with the *culture in the participant's self*. Maintaining a continual reflexive stance to that conjoined cultural construction helped avoid frozen meanings. Periodically posing questions like: '*why was my story told that way and not another?*' (Grant 2010: 114); *what idealised 'truth' might we be grouping around?; would this stand if we re-ran the interview? What are we avoiding talking about? What was the purpose of that change in narrative flow?* assisted the aliveness of reflexivity.

Data interpretation involved seeking cultural meaning beyond the data (Creswell & Creswell, 2018: 144), so the exchanges were consistently brought back to the cultural environment of psychotherapy. Bringing the researcher experience into the frame meant considering *self* also as 'a carrier of culture' (Chang, 2008: 125), so it was important to shift attention back and forth between the personal and the social context while periodically objectifying the self - or looking at one's *self* from the outside-in, hovering at a distanced position.

The cultural aspect of data analysis and interpretation (Chang, 2008: 126) was a key part of my rationale for using interactive autoethnography and for applying Moustakas' heuristic analysis approach. In traditional qualitative studies, the researcher and researched are delineated by placing the researcher outside the culture being studied. However, by straddling researcher-researched (insider-outsider), I was able to take an endless number of 'border-crossings' (Chang, 2008: 127-8) to experience and decipher the cultural meaning of the data from both positions; because in autoethnography the insider and the outsider converge (Chang, 2008: 127-8). I found that holding in mind Moustakas' (1994) immersion and incubation strategies helped facilitate those border crossings - immersing into the subjective cultural world of the suicidal psychotherapist part-self, then stepping out into researcher-self for periods, followed by reflection.

3.15 The centrality of relational ethics in this research

Interactive Interviewing implicated my participants and potentially their colleagues, intimate others and actors in their lives, such that vigilance around the care of the participants required a heightened sense of ethical responsibility (Ellis, 2007). In response, the study employed a relational ethics stance to ensure client care.

Literature around the relational ethics of narrative inquiry was found to be helpful. When applied to the current study, five interrelated **relational ethics considerations** were operationalised (Clandinin, Caine & Lessard, 2018):

- Engaging with imagination, improvisation, playfulness, world-traveling
- The necessity in moving slowly in ways that allow for listening and living
- The necessity of ethical understandings as always in process, engaged with *wide-awakeness* (see section 3.13 for broader discussion).

- The necessity of always engaging with a sense of uncertainty and not-knowing that acknowledges living ethically as living within liminal spaces that position us in places of dis-ease
- The necessity of understanding that ethical relations are lived embodiments, that ask us to be still and attend carefully to, and with, silence and with contemplation.

Bringing the researcher's lived experience into the verbal exchanges and then writing auto-ethnographically about the exchanges, the analysis and discussion, required additional ethical attendance to issues of implicating others in the researcher's life. It also required an ethical approach that honoured and respected how those disclosures might change things for the participants, how they were written about and what might need to be additionally considered in terms of ensuring care, while staying true to the meaning of the story. Ellis (2004) suggests relational ethics recognises and values mutual respect, dignity, and connectedness between the researcher and researched and between researchers and communities in which they live and work. Clandinin, Caine & Lessard, (2018) emphasised the importance of remaining mindful during the entire research endeavour of the additional considerations involving 'wakefulness' (Clandinin, Caine & Lessard, 2018: 62) to the joined worlds of participant and researcher-participant, and how those worlds might merge or collide. The same piece of writing might upset one person, anger another and comfort a third. Embarking on this interactive research endeavour therefore required considering the many eventualities of writing auto-ethnographically about self-with-other, knowing that both participant and researcher-participant 'live in the world of relationships' (Ellis & Bochner, 2011: 14).

The challenge was not a minor one. Atkinson & Delamont (2006), for example, suggest that autoethnography *cannot* be published ethically, since telling author narratives inevitably leaks-in third parties and co-cultures. The claim is that this is impossible to avoid and guarantees

'impact and implication on people and their wider associations who might not have given explicit permission' (Turner, 2013: 216). Further, what the autoethnographic writer considered their ethical rights 'might conflict with someone else's ethical rights' (Turner, 2013: 216).

As an interesting counterpoint, Ellis (2001) notes that this 'ethical muddle' is closer to the truth of [lived] experience than a contrived clarity based on prescribed rules (Ellis & Bochner, 2001: 615).

In practice, the joint endeavour of participants and researcher-participant making informed choices in an open dialogue around anonymity and implication, with the knowledge that taking part in research exposed oneself to such risks, could only be *good enough*. Even with a transparent and well briefed framework that grounded itself in relational ethics, consent could only be a matter of enlightened choice. As part of the relational ethics in this study, then, it was valuable to hear the participants, to remain 'wide-awake together' ((Clandinin, Caine & Lessard, 2018: 59), to be continually and mutually conscious, open and reflective.

A broad concern was how the research might 'impact and implicate psychotherapy itself' (Hughes and Pennington, 2017: 85) and to what extent that may not be ethically justifiable, versus justifiable to invoke necessary institutional change. Given that a research goal for this project was to speak to the organisational level in psychotherapy (see section 2.6 in 'Literature Review'): Heideggerian 'world view' (Gorner, 2007), the broader organisational dynamics and organisational feelings (conscious and unconscious) and psychotherapist group identity, a key responsibility was to ensure any implication came from an ethically informed and balanced place.

A specific issue was to do how to manage the potential of contact with participants beyond the study, either accidental or inevitable. In 2021 there were approximately 200,000 psychotherapists in the UK, who moved within a small world of mutual affiliations and circles. There was a real possibility of inadvertently being on a training course as a participant, or using

rooms in the same counselling service, for example. I provided each participant information about such issues and the opportunity to discuss them.

Finally, but not least in terms of ethical considerations, drawing on personal experience in research leaves the researcher inevitably exposed and implicated in writing (Adams, 2004; Etherington, 2007; Trahar, 2009). This became a returning truth throughout the interviews and beyond; it came as a reminder that the researcher's future self - and so personal and professional identity - would be inevitably associated with the subject matter of this research. Indeed, Tolich (2010) warns of writing about vulnerable parts of the self through autoethnography: 'like an inked tattoo, posting an autoethnography to a Web site or making it part of curriculum vitae, the marking is permanent' (Tolich, 2010: 1605).

There are no simple solutions, but the following actions were written into the research design and procedure, covering all aspects of ethical vigilance:

- *Member-checking* was an important part of the relational ethics approach. The participants and their broad community of persons written about (Hughes and Pennington, 2017: p. 85), as potential implicated others by supposition, were offered access to scripts throughout the research timeline, allowing them to respond (Ellis, 2011: p. 14) with alterations and deletions. In other words, if they felt for example that a person in their life had been implicated, whether identifiable or not, they had the right to have that detail altered or removed.
- *Anonymising:* Given the sensitive area of the topic every effort was made to ensure anonymity, to the extent of each participant's requests. Pseudonyms were used where needed. All personal information was kept confidential. The participants were offered choices as to how their stories were represented in the text.

- *Care of research data and material*: Recordings were transcribed and will be deleted after completion of the viva process. Specific biographical details and any information which located the identity of the participants were altered or omitted, as per the participants instructions.
- *Recruitment considerations:* As already discussed (3.5 Sampling and inclusion criteria), following the advertising and snowballing recruitment strategies, a first-come-first-served basis of applicants meeting the recruitment criteria allowed for protection of those applicants who weren't successful, since there were no personal judgments made.
- *Initial consent*: This was required from each participant. Participants were verbally briefed, and the continual member-checking consent process was explained. *Consent* in the use and naming of real identities was discussed explicitly with the participants, while at other times creativity and metaphor was employed to keep the characters in, by layering and disguising without losing meaning (Muncey, 2010: 55).
- *Interviews:* Each participant was asked to take part in two semi-structured interactive interviews, 2 to 3 weeks apart. The interviews took place in a confidential location, agreed on between researcher and participant. Each interview was approximately 60 to 90 minutes in length, and each interview was recorded, with consent being sought at recruitment stage.
- *Breaching confidentiality*: Researcher obligations regarding participant disclosure of (a) criminal or (b) gross or serious unprofessional/unethical conduct re - BACP/BPS/HCPC guidelines, were explained and discussed with each participant.
- *Wellbeing and safety of participants*: A 'safety net' approach was taken, making transparent the possibility of re-experiencing distressing emotions through discussing vulnerable and painful experiences, and that the interviews and post-interview environment would provide a framework for continual support through this process,

particularly if the participant became distressed or suicidal. Next-of-kin and GP contact details were requested and obligations around safeguarding and risk management made explicit. The framework for support included an information sheet outlining crisis support resources.

- *Termination and withdrawal*: Part of the continual consent, member-checking ethic and framework of support (outlined in the information pack, Appendix B) gave participants the right to terminate their involvement in the research process at any point in the timeline of the research journey. Attentional vigilance around each participant regarding the onset of distress or discomfort included that the researcher was prepared to halt proceedings, postpone or terminate. Participants engaged in a process that asked them to be frank in discussing personal and/or professional details, so it was important to provide emotional support where required.
- *Researcher self care*: A vigorous ethical approach was applied to researcher self care. A *self care plan*, was drawn up, attending to five areas: Physiological, lifestyle, mental/emotional, social support, spiritual. Researcher physiological wellbeing included paying attention to exercise, sleep quality and nutrition. With the research being emotionally evocative, it was important to adopt a wellbeing approach with adaptive physiological needs. Researcher structure and routine were attended to. Building in rests and relaxation time, particularly outdoors, was important. The researcher re-entered therapy at the start of the recruitment process. Attending to researcher mental and emotional wellbeing also involved keeping a mood journal, attending regular tai chi classes, and practicing self-compassion-based meditations. Practicing tai chi also crossed over into the researcher's spiritual self, something strongly advocated by Webb (2010). Not least, the importance of maintaining a community of social support through family and friends was vital.

This research study received ethical approval from the Metanoia Institute in affiliation with Middlesex University, London, UK. The study adhered to ethical principles of conduct for professional and researcher behaviour, as set out by the British Psychological Society (BPS) 2009, 2014 and Health Care Professions Council (HCPC, 2012).

3.16 Reflexivity

An overarching research stance that knitted with relational ethics was engendering *reflexivity-as-rigour* as a process for 'monitoring and reflecting on all aspects of the research project' (Hughes and Pennington, 2017: 94). This seemed particularly important in managing beliefs and feelings around what the researcher was doing.

I reflected on the meaning '*wide-awakeness'* (Clandinin, Caine & Lessard, 2018: 62) as a way of conscious 'reflexivity through perpetual readjustment of past and present' (Etherington, 2004: 146). The concept of wide-awakeness made sense to me as a non-judgemental, mindful stance, that became particularly useful when, for example, responding to problems that arose in the interview setting around role allocation and allowable material. Engaging with, rather than minimising, any 'value-laden human reality and cultural predispositions of self' (Chang, 2008: p. 130) opened possibilities for a 'critical and reflexive *new*-self' (Crotty, 1998: 156) to respond non-reactively to any issues that arose.

3.17 Research or therapy?

Carrying out [interactive] autoethnographic research can open us up to 'half-known aspects of our identity' (Penn 2001: 45) that can easily throw us into uncertainty and even, in this case, unexpected dynamics. Ellis (1995) notes that autoethnographic research can be rigorous,

theoretical and analytical, but also emotional and therapeutic, resulting in conversations at a greater depth. This can be viewed as an advantage of autoethnography, but also a criticism due to the blurring of research interview and therapy. Indeed, an issue that arose in this study was the impression one participant (Theo) formed of our interview becoming more like a therapy session for the researcher, attempting *therapy by the back door* (this event is discussed further in Chapter 4 'Findings').

So, what helped distinguish this inquiry as a research task over a therapeutic one? A transparent, open-ended conversation about the potential therapeutic aspect of interactive interviewing with each participant, meant that the 'explicit and central activity of reflecting on interconnectivity of self and others' (Chang, 2008: 54) could take place; the mutual stance then becoming more reflexive and any sense of the interview being therapeutic acknowledged in the moment and discussed for what it was. Therefore, talking about aspects of suicidality could become both an effective way to achieve depth *and* a 'healing endeavour' (Etherington, 2004: 145).

3.18 Introduction to Chapters 4 and 5: Findings and analysis

In the next two sections I present my findings and analysis for this study, presented in two chapters one for each of the steps of analysis:

I invited three psychotherapists to take part in an exploration of psychotherapist suicidality. Each therapist had been suicidal at different times in their lives and in their careers as psychotherapists. I sat with each therapist individually on two occasions each, and we talked interactively about our experiences of personal suicidality. The format of interactive interviewing (Ellis, 1997) included the researcher as a researcher-participant, disclosing and narrating their own lived experience.

The current chapter described a two-fold framework for analysis. These will be expanded upon in the following chapters:

Chapter 4: **Verbal Exchange Coding (VEC)** :- answering the question: 'How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?' This section focussed on the interactional dynamics of each verbal exchange encounter.

Chapter 5: **Verbal Exchange Rich Point analysis**, drawing on Braun and Clarke's (2006) data extraction methods :- answering the question: 'What do therapists talk about when they talk about their own suicidality?' This section focussed on the issues and themes that emerged as points of interest across the interviews.

CHAPTER 4: FINDINGS

4 Introduction: Novelising, coding, reflecting and rich points

This section outlines the findings from the verbal exchanges. Taking part in these remarkable encounters - six interactive interviews with three participants: Theo, Eve, and Molly - was deeply impactful. The findings, detailed below, were produced by analysing and reflecting on the encounters using a system - Verbal Exchange Coding - that I believed would do justice to the unique qualities of each encounter, while drawing out important points of reflection on *what happened* (research question 1) and *what was talked about* (research question 2). In this way, I was confident that the analysis would honour the singularity of each participant and each encounter, while lifting out important reflections, themes, and discussion points from the encounters in conversation with each other. In that way, the substance of 'what matters in the social construction of cultural realities' (Goodall, 2000: 98) could be uncovered. Verbal exchange coding, which is situated within a social constructionist paradigm, was used to interpret the conversations between the three participants and the researcher. The suicidality of each participant remained the abiding focus throughout the study.

This chapter outlines and examines the main findings from the exchanges between the researcher and each participant. The Findings section is organised in the following way:

4.1 Each of the three interactions (six interviews) are written out as verbal exchanges

4.2 The verbal exchanges are coded for 'rich points' (Goodall, 2000) and discussed further.

4.3 The exchanges are talked about, and reflected on, framed by the verbal exchange codes

Section 4.1 and 4.2 are structured to answer the first research question:

'How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?'

Building on section 4.1 and 4.2, section 4.3 answers the second research question:

'What do therapists say when they talk about their own suicidality?

4.1 The Verbal Exchanges: Theo, Eve, and Molly

N.B. All the names of the participants have been changed and are pseudonyms to protect confidentialty.

4.11 Theo

Interactive interview 1: Theo - *I'm hoping that's sufficient suicidality for your study?*

Theo was my first recruit. I'd met him at a training event in Sussex where we'd got chatting about my research, and he'd said he'd be interested to take part. Experience had taught me that not all practitioners were comfortable with my research subject, but Theo appeared immediately interested and not at all wary.

My interviews took place at Theo's house in southern England. Theo led me into the small therapy room comprising an armchair and a small sofa. 'You've come a long way… what do you need?' he asked, with a soft voice. 'Come into the room... you're allowed.'

I guessed he'd noticed my nervousness. 'I'll be honest with you,' I said, 'this is my first interview.'

'I'll be gentle with you,' he smiled, offering me a choice of seats. I chose the sofa, noting this was probably where his clients sit.

I talked nervously and apologetically, 'I wish I'd chosen an easier subject to research!'

'Presumably this speaks to you... trust that... honour that,' Theo placated.

I wanted to get started promptly, in part to settle my nerves.

'As you know, the interview is interactive and semi-structured. Would you like to begin?' I asked Theo.

'I'll need some guidance, somewhere to start…' he asked.

I read him the first question from the interview prompts sheet: ’What are your experiences of being a psychotherapist or trainee psychotherapist, who has been suicidal…?’

Theo had trained as a psychotherapist after turning thirty, switching from his first career in IT. He described being suicidal intermittently from his teenage years but didn't understand it as *suicidal…* just that he wanted a way out.

'It makes it far more concrete to use that phrase, *suicidality*,' he explained, '...not the language I would have used… I didn't want to kill myself... just didn't want to live *this* life.'

Shortly after turning thirty, a friend gave Theo a copy of Carl Rogers' book, *On Becoming a Person*. He instantly connected with this seminal humanistic text.

'Finally, here is a language in which I'm understood, where there is room for me,' Theo explained.

'What a gift! … it opened up this whole community where I could be heard, respected, listened to and valued.’

Fast-forward to now, in his early fifties, after 'twenty-odd years in therapy,' Theo contextualised his suicidality around a 'neglectful childhood.'

'My dad is incapable of seeing me as an individual,' Theo explained. 'Therapy has been about growing self-awareness from ground zero. *Self* is more of a recent project.'

Theo described his first placement as a volunteer counsellor, which had an immediate impact on his sense of *self*.

'It was a terrible first session,' he laughed, 'there was a lot of awkwardness. But on the train home, late at night ... a huge smile came over my face. I felt like I’d bought my ticket to the planet... I had *worth* and it was OK for me to take up that space.'

I could identify with feeling disconnected and alienated from my parents as a child. But as he talked, I realised I was inadvertently measuring his appropriateness for this research. I found myself wondering... *was his suicidality enough?*

'I desired to be able to press a button and that's the last ... thought ... no pain,' Theo continued.

I realised he might not be able to say, 'I was suicidal.' His complex life story was wrought with fear and abandonment. But where was the suicidality?

As if reading my thoughts, Theo said, '…I'm hoping that's sufficient suicidality for your study?'

It immediately seemed absurd to consider *insufficient* suicidality. Theo had expressed a deep and enduring sense of inconsequentiality. Becoming a therapist didn't simply render us 'superior in our ways of managing [ourselves in] the world' Adams (2014: p. 60).

Theo was speaking about 'being whole' and I was reminded of a song I'd written along that theme and decided to share it with Theo. I felt nervous and wasn't sure if what I was doing would have the intended effect of deepening our dialogue. But, with a sense of apprehension, I began singing:

If you asked me to change
I wouldn't be the same,
some part of me would be gone
and all parts of me belong
Like the morning needs the night-time,
and tragedy's child throws a lifeline,
and sunshine longs for a frost at dawn, to…
shine winter away…

Theo gazed into a corner of the room in contemplation, then thanked me for playing. I filled the silence with a short explanation; 'it's about… integrating… parts of yourself that you wish ... you could cut away…'

'The sense I got out of it was sadness... and... hope.' Theo finally said.

I felt relieved at his comment; mostly that he'd said anything at all. 'Spot on ….that sense of… the shadow-side being… an important part of the whole.'

'When I was in it,' Theo reflected, 'I had no observing self… mentalising capacity. I've been developing that… for years in therapy I'd thought, come on then, fix me …and, actually, that isn't quite how therapy works...'

Listening back to this section of the recording, I'm painfully aware of how naive I sounded. Singing Theo a song in an attempt to deepen the dialogue suddenly seemed disingenuous.

Theo was talking about connection and attachment and I picked up on the theme.

'I think I'm caught up with that idea of … suicidality is a form of disconnection.'

Theo considered this for a moment. 'Connection is like a network, a mesh that holds you together. A safety net for... social beings. If you're not feeling those connections, you're slipping through the net.'

In a slightly forced way, I saw another opportunity to get more of 'me' into the narrative. I gave Theo some context to my third year of psychotherapy training.

'I'd ended a short relationship,' I said, but then I found myself isolated, living in a flat in a secluded commuter-village. I started thinking about suicide.

'There's the link,' Theo interjected, 'social disconnectedness'. His words seemed to confirm the relevance of my story, so I read something from my journal.

October 2012 - third year psychotherapy training:

I'm driving back from university, heading out from west London. It's been a good day, lots of honesty in group about how much I'm struggling at the moment, but with one thing held back; one detail I couldn't say…

I drive up the ramp and hit the motorway….

They are yellow with black stripes, jutting out, pointing at me as I speed past them. A solid coned ending. They are resolute in their concrete and steel immovable purpose, cemented into the kerb along the hard shoulder, poking out from under the motorway bridge supports they protect. I don't think of protection when I see them ahead of me. Just as the means to a way out.

I project a character onto them; they become honest friends with an irrefutable, mournful message. What they have to offer me is an end to suffering, the chance for peace, calm... sleep. But, of course, I cannot be certain of anything beyond finality. So, at one level, that's how I know it will be: A sudden ending.

Against the backdrop of irrepressible loneliness, horrifying isolation, petrifying insomnia, wild, tormented internal rages, screaming into my pillow, planning and plotting of my suicide... I imagine jerking my steering wheel down to the left and my honest concrete friends fulfilling their promise.

'What do you see as the purpose of reading that now?' Theo seemed perturbed.

'Reconnecting,' I said, nervously, '...with a state of *being* I experienced at the time…'

Theo looked like he was trying to be convinced, but not quite getting there. I felt anxious. This had been a particularly difficult journal entry for me to read. I felt protective over it and wanted it to be received compassionately.

'But I think... the warmth I was getting from connection with the… barriers ... the means to suicide, that almost soothed me, you know…'.

When Theo spoke again, it was as though it required enormous effort to choose each word.

'The reason I asked the question is… I became increasingly uncomfortable…… that this had become your therapy session... and I felt, hang on a second….'

I wasn't prepared for Theo's comments. Instinctively, I apologised. ‘I’m sorry that made you uncomfortable…’

’I'm not saying it from that point of view… if you were my client, I would have no problem in going there. It might not be comfortable, but I'd see that as my job. But in this context I'm questioning... at what point does it slide across from mutual exploration into therapy and how much of the autoethnography element is to get some part of you healed? I'm uncomfortable with the back-door-ness of that.'

I felt bewildered. The 'back-door-ness' comment landed hard.

Theo continued, 'Part of me thinks, if it's autoethnography you can do your own exploration, so why do I need to hear the depths of your pain? There was certainly a part of me going, no don't take me there… I don’t wanna go there…'

I understood Theo's yearning *not to go there*. But I also felt confused about what all this meant for my research. Theo and I sat back in our chairs. I could tell we were both worn out.

'I'm not at the top of my game at the moment, in terms of my own resourcing,’ Theo said.

I suddenly felt guilty, but I didn't know what to do next.

Theo sighed. 'In terms of my expectations, I thought we would be exploring my experience, with you drawing on your experience to enrich the dialogue. It feels like we've crossed a line from that. I’m here to offer some insight, not to be your therapist.'

'I guess any qualitative research interview could slide into feeling like therapy,' I reflected. 'The interactiveness of this is probably where there’s been a misunderstanding maybe?'

Theo acknowledged what I was saying, but didn't seem satisfied. 'I don't know. I sense the more I see your reaction the more I'm right. There was something you were drawn to unconsciously, to bring your own needs.'

'Well, there had been no intention on my behalf to get therapy out of our encounter... the choice of my prose had been contextual,' I said, realising I now *did* sound defensive.

It felt like we'd reached an impasse. As our interview came to an end, I struggled to hide my disappointment. My hope to go deeper through interactive interviewing and uncover something not yet discovered (Muncey, 2010) had met it's first hurdle: the sensitivity around the subject, combined with the unfamiliarity of a two-way research interview method.

On leaving Theo's house, I found myself irritated with him for not having read the information sheet thoroughly. But I realised… it felt more comfortable to project the problem onto Theo. I needed to own my responsibility for what had happened.

After the first interview with Theo, I arranged a session with my research supervisor. I explained that the interview had been challenging and that some unexpected problems had arisen.

In the supervision session we talked about the importance of the interactional dynamics that had transpired in the interview. My supervisor, Max (pseudonym) stated how those dynamics were an indication of how difficult it is for two psychotherapists to talk about their mutual suicidality.

Max and I discussed a plan of action before the second interview, that included contacting Theo and offering him a revised research information pack.

Interactive interview 2: Theo - *There can be therapists, I hope there's plenty of them, who haven't had suicidal thoughts and are perfectly capable of offering empathy to somebody who has…*

When Theo agreed to the second meeting, I didn't realise at the time how close he had been to pulling out. However, the second interview became a much-needed opportunity to discuss and make sense of what happened, which was both essential for the research and helped both of us process and lay to rest our previous rupture.

This time, at my request, we used Theo's reception instead of his therapy room. We considered where each of us would like to sit and how we would proceed, discussing explicitly the dynamics now known to us. It felt good to be there and I had learned from the first interview. It felt more congruent.

Once we settled, Theo talked about the malaise he had experienced after the first interview. 'I know you gave a rationale for the stuff you brought in, but I didn't feel it,' Theo said. 'I felt *done-to,* (Benjamin, 2017: p. ?)'

Given the sensitive nature of the research focus, anything that came across as planned or contrived was risky. Understanding this highlighted how difficult it was for psychotherapists to talk about their own suicidality - even those therapists who had agreed to do so.

'You're not responsible for my assumptions,' Theo said. 'But I didn't think reading from your journal was in the service of progressing the discussion.'

'In hindsight,' I ruminated, 'I could have expressed my thoughts about *connection* without picking up my journal. I just felt it was interesting that I'd disconnected from my support networks then attached to another connection: motorway bridge barriers.'

Theo looked thoughtful. 'I'm much more connected to you in the way you are saying it now rather than reading out something that… was a bit of show and tell kind of thing… not comfortable. This feels more grounded and appropriate.'

I took a risk and disclosed how I wanted to get away from this conversation at the end of the first interview, and Theo admitted to wanting *out* as a participant. 'I thought, I only have to see

him for another hour and a half in my life! Theo said. Then Theo switched tack. ‘I’m wondering what it was about the meeting that you wanted to get away from?' He asked. ‘Do you think it’s difficult in ways you had anticipated, or in different ways?’ Theo asked.

‘Definitely in different ways. I walked out of here thinking I hadn’t prepared enough. I should have thought more about what could happen.'

'Go gently,’ Theo said, trying, again, to reassure me. ‘Human interaction can go anywhere and we’re both psychotherapists… the potential for sharp tangents is that much greater!’

We changed subject onto feeling nervous, or like an imposter, as a newly qualified psychotherapist.

'There was this sense of, *who am I to be sitting in this therapist chair when I’ve got so far to go in my own client chair?*

'Our struggles reverberate through time,' I reflected, ‘… it changes form and plays out in different ways, but it still has an effect.'

'There's a compulsion to say *it's the client's mess*. But I think there's something very grounding for both therapist and client to be over-your-knees in shit. You're in the shit together. Instead of thinking, ‘the shit is behind the glass screen, and that's nothing to do with me - the us and them kind of thing... but, we want to *get into the fertiliser!*'

'My sense is, whilst it can be really useful to have been where our clients are,' Theo said, 'you can never truly walk in somebody else's shoes. It can help with empathy, but it can also hinder, because saying my experience gives me access to *your* experience, can get in the way of you genuinely witnessing their suffering.'

'And what of therapists who don't have similar experiences to clients... can they not empathise?' I asked.

'There can be therapists, I hope there's plenty of them, who haven't had suicidal thoughts and are perfectly capable of offering empathy to somebody who has,' Theo replied. 'But… I've had clients who by the end of therapy have said, *right, I'm better…* and I'm thinking, *how do you do that?* So there's more than one thing at play. When we're talking about, *do I feel a charlatan because I've had suicidal thoughts?...* I've more often found myself thinking, *am I a charlatan because I'm incurable!* There's more dimensions to it.'

I was pleased Theo and I had managed to steady what felt like our sinking ship and have the second interview. I felt a deep congruence that, as two therapists, we had repaired our rupture. The richness of our dialogue had made that even more satisfying.

4.12 Eve

Eve was a psychotherapist who worked predominantly with survivors of sexual abuse in a specialist centre. She had been practicing for ten years and also had a thriving private practice. She lived in a small market town in Sussex and was married with two young children.

Interactive interview 1: Eve - *Let's pull this rug up*

I immediately liked Eve. There was a gentle openness about her. She asked some questions and disclosed that parts of her story of being in a physically abusive relationship might trigger trauma-associated symptoms, including feeling suicidal:

'If I'm feeling uncomfortable in the moment, I'd like to be able to say... could we slow it down?' Eve also acknowledged that I could also be triggered. It felt liberating that we were already talking our suicidality.

'This is a heavy topic,' Eve said.

I agreed, 'Yes, it's normally dealt with by making it objective. It's why people don't talk about it.'

'It's the last taboo.'

Eve began her story with an air of regret. 'I threw away my old diaries,' she said. 'I got sober eleven years ago and needed to throw away my old identity, my old drinking self. I was frightened of *her...* myself in that self-destructive state.

'My very last drink… I wrote, *I just can't take it anymore*. And obviously I was thinking about suicide because I always thought about suicide. I turned over the page in my journal and there were my gratitude lists, from when I started sobriety. But life isn't that simple. I didn't just turn over into a person who had no problems, although I think that was the fantasy when I got sober. I continued to have suicidal feelings, thoughts, and attempts. I got sober when I was twenty-five, then had a massive breakdown over the abusive relationship. There were other things in there, but... I think the relationship triggered attachment trauma.'

I couldn't help pondering the significance of attachment being mentioned so early on in our conversation.

'I started therapy,' Eve said, 'then I entered psychotherapy training and thought… I can see this being a sustainable life for me. I was very suicidal, with severe post-traumatic stress, only making half of the classes. I was hallucinating and slept with a carving knife, sat with my back against the wall for hours because I was too frightened to move. I had this fantasy, I don't know if you had this… that all my sins would be wiped out. I had a lot of interpersonal shame around what I'd done and how weird I was... *am*, I mean!' Eve laughed. 'I figured, when you're dead,

people don't remember that, you're sort of whitewashed... so that was also part of the fantasy. Like, people never speak ill of the dead,' Eve laughed again. 'What's your story?'

I prepared to talk about myself, while grappling with a sense of Eve's story eclipsing mine. I couldn't help comparing our suffering, but what Eve said about the abuse was deeply impactful. I began tentatively, remembering how things had gone when I first disclosed my story to Theo. 'My upbringing had been loveless… physically and emotionally abusive. I was very lost and directionless in my teens and twenties, didn't know who I was, everything felt wrong. I had a double life, turning up at work in very responsible job, then drink and drugs all night. It was an interesting part of my life but also very harmful… I didn't see a reason to live.

'I've had multiple breakdowns,' I raised my fingers and mimed quotes, then explained: 'My parental was, *snap out of it*... When you're vulnerable, you could start believing that stuff and think... maybe I just need a good kick up the bum. The more distressed I became… the more uncertain I was about what was happening. In the confusion came a voice of calm and relief. "*You can end this all…*" it was soothing.

'When I started my therapy training, I believed it was the end of my troubles. But a relationship ending sent me into the biggest breakdown so far. What made it even worse, was… I didn't think this could happen anymore. That's where the two things came together for me, because this research is about being suicidal as a therapist or trainee... and that makes it different.'

It felt hard talking about this again. I hesitated before I told the next part of my story, fearing judgement.

'So there I was thinking, *I can't tell anyone what I'm going through* and I was still seeing clients. Stuff was happening in the room with my clients, that when I look back on it, should have rung alarm bells, that I needed to stop. But I wasn't really being honest with people, I wasn't being honest with my supervisors. So I carried on.'

'I wasn't being honest with my tutors at university, because I… feared… this might mean I don't qualify... and I have to qualify, I told myself. So, I kept it to myself. I hid it.'

Disclosing this to Eve felt exposing.

'Yeah, definitely,' Eve said. 'It's frightening. Kind of plays into the isolation.'

I had always known that isolation was a key factor in my suicidality. In the midst of it I had developed fantasies about being sectioned and incarcerated in a psychiatric unit: the ultimate isolation.

'I wanted to be psychotic and sectioned,' I told Eve. 'Because my parents had given me money to train, I imagined my dad going, '*well that was a waste of money, then …* having to make choices about what I say and who to... I didn't want that responsibility, it seemed easier to lose my mind.'

'But,' I added, 'in a twisted way, stuff like that kept me alive. It was incredibly painful but also quite soothing.'

Eve thought about this. 'It's kind of like there's a weird comfort, isn't there...'

'It always seemed to come back to what people would think of me,' I added, 'how I'd be written in history. A lot of my crises were wrapped up in existential stuff about... what is actually the fucking point?… that the whole human existence seemed so insignificant. And what is all this suffering about?... The way I manage those kinds of questions now helps me, rather than destabilising me.'

'I took a break from working,' Eve said. 'While working with a client I missed something really obvious. My own experience of prolonged domestic violence had desensitised me to the signatures of abuse, so I didn't spot that this client was being abused by her son. I just spiralled… I felt ethically conflicted about continuing working.

I remembered the tension I felt about continuing to work. I could empathise with the ethical struggle. ’This might sound awful, but when I'm in pain and hurting, I can connect more easily to clients, sit with the shit much better.'

I thought about what she said. 'I've experienced that,' I disclosed, ‘though I know I shouldn’t have kept working, I felt a much deeper connection with my trauma clients. But you said *this may sound awful*...?' I inquired.

'Because it's part of *my* growth,' Eve explained, '...being a therapist supports the adult part of me, so my expectation is that I'd be judged. Ethically, if it was based on just that, it would be a bit dubious. Particularly if I was causing harm to my clients. And obviously I wouldn’t go forward if that was the case. I wouldn’t be doing therapy just to make me feel great… So I was protecting myself from any potential misunderstanding. What I found most difficult was other therapists and their expectations. Not being able to talk to other therapists…. because the responses you get are quite often judgemental.'

Judgement added to my emotional *pinch,* with fears of not qualifying holding me back from opening up. For Eve, there was social apprehension, but it was more about the prejudices of other therapists than fears of not qualifying.

'I feel more able to be open about my suicidality as a qualified therapist, than I was as a trainee,' I reflected. 'Every year I saw people being shown the door.’

Eve described a contrasting narrative. ‘On one occasion my supervisor said, *I’ve been suicidal, has anyone else?*'

I tried to imagine if any of my course tutors would do that. At that troubled time, I needed someone in a leadership role to take the initiative and show their woundedness. I remember having strong beliefs about my tutors and supervisors' invulnerability. I needed role models who affirmed the importance of therapists being in touch with their fragility, the strength in that, rather than as something to be hidden.

'Because us therapists are a *fixy* bunch,' Eve reflected, 'in training people would respond to me as a patient, put me in that one-down position, which was really uncomfortable. So, the natural response was to not say anything.'

Our commonality seemed to involve anxiety around the reactions of others. Eve noted something else:

'You're like me,' she said, 'you can't cope with hiding things under the carpet… you're there, going, '*hey, let's pull this rug up,*' and everyone's going, '*nooo don't do that, that's really painful*'…'

'But I didn't have the guts to say, *Hey*, *I'm suicidal*,' I told Eve, 'I was too scared, while just wanting to be heard.'

'So you left it to adult Martyn, to go back... you know, heal it backwards,' Eve said.

I loved that phrase the moment she said it, *heal it backwards*.

'But there's still fear there,' Eve noted. 'And you're hitting key things about being a therapist, that we are expected to keep our stuff private. There's a real taboo about self-disclosure. I think it's right that our stuff doesn't dominate therapy, because that doesn't help our clients. But breaking down the idea of the expert therapist being a person who has it all together, is all sorted, never has any kind of tricky relationships, is completely boundaried with everyone, and who never has any feelings they can't handle... that's problematic.'

Interactive interview 2: Eve - *I think there's a part of you trying to convince me that you're OK... and there's a part of me doing that, too…!*

Two weeks after the first meeting we arranged to meet again. I was looking forward to seeing Eve again; after one interview, she'd become a symbol for embracing vulnerability. As with Theo, particularly in our last meeting, it was liberating talking with someone who had a shared experience of woundedness.

'It was really interesting,' Eve agreed, when I told her my thoughts. 'Like you, it was nice to talk about suicidality in a different way, because when you talk about suicide with people who don't have an experience of it, you're often met by fear. So it's really nice, because I'm alright. I'm not dead,' Eve laughed. 'And you're not dead!'

Eve's comment was humorous, but there was also a reality to it. We'd made it back. No-one pulled out or died.

'To be able to share and laugh,' Eve continued. 'It made it more human. Rather than something odd that happens *over there*. Imagine a world where we all talk about it ... all able to have a comfortable conversation about living and dying!'

Eve's words were double-edged. Alongside the warmth I felt seeing her again, there was sadness, heightened by a sense of disappointment in myself for having been suicidal again. I asked for some water; Eve had set things up to 'play mum' as she put it, with the water, snacks and tea facilities on a table beside her. She obliged and I took the brief respite to prepare myself to disclose what had happened between the interviews. Eve beat me to it.

'A couple of weekends ago ... I… got very suicidal,' Eve said.

Her words took me by surprise and she looked at me with a sense of knowing, as though she could see I was holding back on my own disclosure.

'I have emotional flashbacks when anything about sexual trauma comes up. I get this sense of intense isolation, and I used to deal with that through self harming and suicidal thoughts. This time, I wanted to stand in the middle of the road. But… now I have a therapist who I can talk to about this...'

Eve took a sip of water.

She had braved talking about something that risked her being precluded from the research. It didn't escape me that if that was the case, then I should also preclude myself. It helped hearing

her mention her therapist as someone whom she trusted. For my part, I'd also found a good therapist who had helped me through my latest episode.

'So, did you hold it differently this time?' I asked Eve.

'At two in the morning probably not…' she smiled. 'But I knew it would pass. It felt like an imaginary way out, rather than an actual way out, which helped.'

'I go into that space too, you know, release energy into it; sink into the anxiety.'

I was aware I still hadn't told Eve about my own recent suicidality. I felt I was being unfair to let her disclosure stand alone but, paradoxically, I also knew that telling Eve would mean I'd need to write about it... and then *everyone* would know. The layers of fear, the barriers to openness, were right there, alive in this interview.

'It's like my brain's on train tracks that go via the suicide station,' Eve said. 'They're well-worn grooves … it's gone there a lot. It's really habitual. Even though I've changed direction and have lots of other options, when I feel under pressure, those grooves are so well worn and it's such a familiar path, my brain will just go there.'

'Yeah,' I retorted, 'but you've got a different set of points that you can switch onto, right?'

We both laughed at my clumsy attempt to develop Eve's metaphor.

'I think I've used suicide as a coping mechanism and a comfort.' Eve said. 'It's comforting knowing I can end it all, that I can stop the world and get off.' Eve sighed. 'And there's that stomach clenching feeling of... I could actually do it. Which feels deeper.'

Eve paused for a moment. Then she said, tentatively, 'So I also remember that one of the ways I protected myself during sexual assaults and rapes, was imagining I would just cut my own throat.'

I momentarily felt sick at the thought of Eve suffering such horrific attacks and needing that fantasised suicide to cope.

'I realised in therapy a couple of weeks ago, that the knife I imagined was turned the wrong way,' Eve continued. 'And I don't have to hurt myself anymore. I can get angry at him, rather than at me. And...' Eve sighed, '…that's a relief, because the suicidal thoughts were tied into not wanting to be with this, because my body's been hurt. Because it's actually harder to tell you about my sexual trauma than it is to tell you about my suicidal episode.

'The sexual trauma is very present at the moment. I'm happy for you to know, that's why I came, yeah… I need to feel honest and authentic. Those are the bits that I don't talk about. I hold those… very private.'

'Sometimes, in therapy, I've been referred to as a *suicide survivor,'* I remarked. *'*And that's OK, but what does that really mean? Most of the time I think it was just luck that kept me alive, particularly with the substance use binges that, looking back now, played out like Russian Roulette.'

'What kept me alive...?' Eve pondered '... Actually, people depending on me... the times I've been more likely to kill myself have been when I don't have anyone depending on me.

'I became suicidal a year into my sobriety,' Eve explained. 'I had a sponsee in AA, and I remember deciding to put off suicide until she got to step five of the twelve-step program. When I slipped into those days of being suicidal recently, it was the thought that I couldn't leave my son without a mum that kept me tethered. Just like when I was struggling with postnatal depression, my baby was depending on me. So I couldn't kill myself. That was the bit of me that was clinging to life.'

I agonised over telling Eve about my recent episode of suicidality. It seemed precarious. My recent episode was mild and controllable - a long way from escalating into suicidal actions. Or…

was I just trying to kid myself? I knew that staying silent was in no way mutual. So, there was no avoiding…

'After our first meeting I had a stress reaction to some things at work,' I began. 'I felt overwhelmed, and… suicidal thoughts came in… but … I was able to step away from it…'

I still wasn't being fully honest. I hadn't dealt with it that easily and, actually, I was still affected.

Eve chuckled, 'I think there's a part of you trying to convince me that you're OK... and there's a part of me doing that, too!'

We both laughed. Eve's keen observations melted my anxiety. It felt like we were co-constructing a safety container together... looking after each other.

'You're very observant,' I said, 'Cos I did feel an urge to say, *oh, but I'm alright now…'*

Eve smiled. 'Yeah, well I often feel I have to convince people... *oh, but I'm alright, I didn't go ahead with it, I had this part of me that was connected to reality...* like we need to contain people's fear.'

'I did that with my therapist last week,' I said. 'I left out the detail that I'd had suicidal thoughts. Because being a therapist I know what that sets off… I kinda thought, well, I'm alright… we don't need to do all that.'

'Whereas' Eve countered, 'I always disclosed with my therapist, in fact I was more upfront. After my recent episode I told her and then said, *now I'm worried you're going to question my fitness to practice*. Cos that's what I always come back to. And she said, "*I'm not thinking that at all*." She said, '*let's just process*.'

In that moment I wanted all practitioners to have the courage to respond that way to suicidal disclosures. It was contextual, of course, and risk protocols are often very necessary. But I ached for the *let's just process* piece to be the default instead.

'I don't want people to take responsibility away from me,' Eve said. 'In a paradoxical way, if I was to take the decision to end my life, that is my choice. I would have weighed up the consequences.

'And ... I'm not suggesting I'm going to...!!' Eve laughed. 'There we go again… I can't quite *not* do reassurance!'

'No, we can't *not,* can we!' I retorted.

'... *Just so you know I'm fine...'* Eve parodied herself.

*'*But I do think there's a tension, isn't there, between what responsibility I hold for myself, what responsibility you hold as a therapist for other people, the duty of care. It's the rub between those two, counterpoised by the ethical part about respecting someone else's decision ... and then there's the empowered position of making that decision for yourself,' Eve reflected. 'Cos even if someone had experienced massive trauma, for example, and wanted to end their life, who are we to say *no*?'

'Kinda leaves us with a dilemma about our clients, though?' I thought for a moment. 'And... how they might be impacted if… if you were to go, if you were to take your own life?'

'But that's probably why I became a therapist!' Eve answered. 'I couldn't... not while I have clients who depend on me. I've set life up in a way that keeps me in it.'

'I suppose that for me, if I'm giving something, that gives me a purpose… to live,' I reflected. 'That's keeping me *in it* too! Getting meaning from being a therapist keeps me alive...'

'So, would we say this to other therapists?' I asked.

'I think you open up to people rarely… it's about your fitness to practice and the judgement that can come. Like in training, you didn't tend to tell unless it was a real problem.'

'Yeah, I didn't because otherwise I was always gonna be '*the one that was suicidal in year three'*.'

'We're always thinking about what other people will be thinking and feeling, aren't we!'

'Definitely in training sessions; there's a tutor sat there. We're always hyper-vigilant about what they might think.'

'I wonder what they might think of this research? I'm imagining waves of disapproval...!'

'That's interesting,' Eve said. 'So even the process you've been going through, is a real process of coming out...'

'There's this idea that we sit outside humanity, that we've got it all sorted, the idea of the perfect therapist,' Eve pondered. 'But... you walk into vulnerability, don't you. As a therapist.'

'Fall into it,' I suggested.

But there's something in walking the walk, isn't there.'

'Like this research. We're walking into revealing our vulnerability.'

'Do you think the knock-on will be in the service of our clients?'

'That is what I'm hoping for…'

'But it's dispelled something,' Eve said, thoughtfully. 'it's like when you disclose something to your client, decide to risk a boundary. It brings you closer to each other, demonstrates that you share a common humanity.'

I loved this idea, of sharing a common humanity.

'I wonder if we could extend this to ourselves?' I said.

'Yeah, that could be an outcome for your research: a helpline for suicidal therapists... or whatever else you come up with!'

4.13 Molly

Molly was a psychoanalytic psychotherapist who worked in private practice in London. She had been a therapist for twenty years and had a long-term partner and two adult children.

Interactive interview 1: Molly - *I've never told anyone this before.*

''See, I've never told anyone this before … I was thinking about this on the way here,' Molly said, gazing out of the basement window. 'I wrote a couple of notes, to remind me. I want to tell a story, because it feels like a narrative. It goes back to when I was eighteen.' Molly sat back and turned towards me.

'I was reading Anna Karenina, about a woman who jumps in front of a train. She wants to find love; she wants a better life. She ends up killing herself. I remember being really affected by that and thinking: *can't you do anything in life that you really want, without being punished or punishing yourself?*

'And then… coincidentally, I went off to Uni, and there was a girl in the room next door. She'd had a boyfriend since she was thirteen and went to Uni age eighteen. She met somebody else in the first week. The ex-boyfriend visited, and… I never forget it… after she told him, he crashed his motorbike on the way home and was killed. He was only eighteen.'

Molly spoke like it was a continuation from a previous conversation. I hadn't elicited anything from her, but I was happy that she'd taken the lead. I sensed she'd waited a long time to tell this story.

'About a week later,' Molly paused, '... a friend and I were out in a bar, drinking...' Molly coughed and cleared her throat, '...and there was blood in the toilet and, this girl, she'd cut her wrists.' Molly paused again and adjusted herself in her chair. 'We got her to hospital... she was OK. You know, it's like, she was haunted, this girl…' Molly continued, 'by this whole thing that

happened. It was just a young person pursuing happiness and then feeling that she'd been punished. You know, like Anna Karenina. About six months later, my younger sister tried to kill herself. She'd taken an overdose, but fortunately not enough. She was very unhappy about lots of things. She's quite a deep person but didn't tell anybody. We'd always been brought up not to speak... *just get on with stuff*, you know.

'After I had these experiences,' Molly explained, 'I feared thinking like that. Yeah… *I mustn't think like that.* Then I got married young, twenty-two, and had a very difficult experience. I got pregnant and gave birth to a little girl and she died, a week old. It was very hard. Then my father, who I was very close to, dropped dead. A month later. Heart attack. And I remember having these feelings of not wanting to wake up. But I didn't know what they were. I sort of thought, *oh it's just because I've lost my dad*... but the feelings were quite powerful. I did have children, but the feelings always came back when I heard horrible stories and things… they always come back.'

'Anyway, during my training,' Molly continued, 'my analyst died.' She took a deep breath and sighed. '....and these feelings... came back...'.

Molly had to force those last words out, running short of air as she finished her sentence. She clasped her hands tightly together, her voice trembling.

'I suppose I'd never really been in touch with them... suicidal feelings... because you didn't. I mean, when I was eighteen, this happened *to* people. It's like a fear, isn't it, like seeing somebody getting burnt… *I'm never going to be thinking like that… Block it out*.'

I reflected on my own capacity to *block it out*, which wasn't that effective. Molly's story was heartrending.

'I was seeing my analyst for four years ... and he was an old man. Over several months he got very ill. Then… I was on the verge of finishing my training... when he died. I just wanted to get through it…'. Molly sighed again and turned her gaze back out of the window.

'I looked up stuff on the death of a therapist, and there was hardly anything. It was like a taboo. *A therapist doesn't die*. Then I had a new therapist for a while, and it didn't really work. It wasn't the therapist's fault... I didn't want to be there. And I had suicidal feelings again, but I didn't dare say anything.'

I had been mostly quiet as Molly talked. She paused longer this time and I was struck by her last comment.

'You didn't dare say anything...?' I asked.

'I told my supervisor I didn't want to wake up. He said we'll keep an eye on you … he was very good. But these feelings came back stronger again. I didn't tell my supervisor because he wasn't my therapist, and therapy wasn't going well. Just before I finished my training, days before, my mother died. I mean, *thank you mother,* you know,' Molly scoffed, ironically. 'Bless her, she picked her moment. It wasn't unexpected, she was very poorly with dementia. It was a release for her, really. But it was like this feeling again of… just being… burdened ... you know, it would be easier to escape.

'Even if you're in therapy you're still burdened. You can't get rid of this awful thing that's going on,' Molly said. 'And I'm not sure it helps seeing clients, but I was seeing people throughout this. In some ways it did help, it was the only time I could forget about myself. But that's really not healthy. Anyway, as soon as I'd finish I'd feel… bad again.'

'So it was a sticking plaster?' I asked, immediately regretting the crassness of my question.

'…it was a way of just blocking something out, again,' Molly answered, '…like I was very good at doing. I just blocked anything out that was very painful. And carried on making the best of things.

'That's my story, I suppose.'

I shuddered at the savage life events Molly had endured and wondered how any person could bear all that. Molly sighed and gazed out of the window again.

'I carried on training and just before I was about to do the viva, I was at the station one night looking at the rail tracks, and I felt quite frightened. I thought it would be so easy just to, you know… and then I thought well that would be really selfish because everybody would be missing their train.

'I told my new therapist and he said, *where are you getting your train from*? As though, if the station was busy, *you'll be alright, then*. The legitimacy of my anguish was immediately disenfranchised. It was hard enough finding the courage to tell him, then for him to weigh up whether there's enough people at that particular station to stop me jumping. I thought, I won't bother again.'

'You were disavowed, not taken seriously,' I interjected. 'Do you think he might have been treating you differently because you were a trainee therapist?'

'Yes I think so,' Molly answered. 'And trying to keep me upright... which… I needed to be, I suppose. Not down on the tracks.'

So, despite the rashness of his words, Molly saw her therapist's intervention in a positive as well as a negative light. Like Theo, Molly seemed to struggle with saying *suicide*. I explored this with her, and she said it was because it was a painful word to say. Molly described how that had extended to client work, that she'd always feared naming suicide might increase the likelihood of a client making an attempt.

'I do name it now,' Molly reflected. '...and don't feel it would be my fault - which I would have felt before. So that was a huge breakthrough for me. I felt responsible for my dad dying and all the things happening in the past, then I thought, I'm no longer responsible… and that made it easier to talk about it with clients. You know, what is going on for you at the moment? We can talk about this; you don't have to hide and pretend.'

'I got an email about my research: "*it's good to hear about your study, suicidal feelings of therapists*." I thought, oh, that's interesting, I didn't write suicidal *feelings* of therapists. The word *feeling* engaged me differently and made me question the impact of language.'

'An emotion is fleeting, isn't it,' Molly contemplated. 'It's transient, not stuck down.'

'So, what difference would it make if we engaged with suicidality as an emotion?' I posed the question with some interest, because saying *emotion* seemed to reframe it as something more accessible.

'We don't use the word emotion, but say *ideation*,' Molly pointed out. 'Which is different, because *ideation* is something that's more processed. If we had the concept of suicidal emotion, would it change the taboo?'

'You mean, would we engage with it differently?'

'We could. Rather than panicking because you've had a suicidal *thought* that will be safeguarded.'

'It would elicit less judgement, or reactionary risk-management responses?'

'You know, I think I would probably say that to somebody,' Molly said, 'rather than are you thinking of suicide? I would say, are you *feeling* suicidal?'

'And you? Would it be easier for you to say, *my suicidal feelings*?'

'I think it would.'

'The unmitigated rawness of my distress felt worse because I *was* a therapist,' I told Molly. 'I'd had lots of therapy before training, so it was the shock of not being *mended*, a fixed person who could float above the world. With that additional pressure the suicidal thoughts came in.'

'It's like despair, isn't it…'

'... it was despair… it was lost hope.'

Molly seemed quite animated now. ‘Being fed a myth, that if you’ve had therapy you’ll be more resilient… that awful word, *resilience*. As though all you’ve got to do is be tougher. But, actually as a therapist you need to be more vulnerable and open.’

‘I remember, naively, going back into therapy just to get the hours required to qualify,*’* I told Molly.

'Yes, it's like a tick box, a hundred and sixty hours of personal therapy… tick, right, I’m done. And it doesn’t work like that, does it.'

‘So, when I hit crisis, therapy helped contain my suicidality. I *really* needed it, turns out! In my moments of suicidality since qualifying, I’ve benefited enormously from that learning, of the importance of having a therapist. I've had periods when I've not been in therapy, but when I felt I needed additional support I went back.’

'Yeah, I’ve returned to therapy again,' Molly said. 'After the summer break, I came back to my clients and felt envious of them.' Molly laughed at her own humility.

'It was like, *they’ve got me, I’ve got no-one*. So, I thought, *I’ll go and get a therapist*. Maybe that’s just what the training taught me. I gave myself permission, rather than just coping - which is what I’ve always done… *coped*. You need to have somebody to share it with.’

'You’re right… you have to learn to give yourself permission…'

'Yeah... like, you wouldn’t recommend your clients to *just cope,* would you!’ Molly laughed.

I agreed. ‘But a lot of therapists think what applies to our clients doesn't apply to us; that we are somehow different.’

'My therapist…’ Molly mused, ‘…the one who died… he used to say training was dirty, that you have to change in a way you might not always like. I like that... you get more in touch with your rough edges, and… it’s not all glory and somehow, you’ve become a better person. You’re more in touch with the crappiness of life. You can’t help but get dirty. Maybe that's more truthful.

Although, to say it's going to be dirty might not be great advertising for training schools!' Molly laughed.'

'Isn't that interesting,' I said. 'Because that's your therapist saying that, but the training institutions don't tell you that…'

'I think they cleaned up the language,' Molly reflected. 'Made it less direct; used words like, *experiential*. But… thinking about it, that's euphemistic. Kind of circumvents the rawness of what *experiential* might mean. It could mean, *fucking torture!*'

'I was told by somebody I had to *knock my mourning on the head*,' Molly said.

'What does that mean?!'

'It means I should no longer mourn,' Molly chortled. 'Because somehow, if I'm *trained*, then mourning is something you're better at, or don't even do.'

'What do you think about that?'

'Well, I thought of Donald Winnicott. I actually said that to him... *Winnicott said that mourning shows a depth of soul*.'

Mourning shows a depth of soul… it heartened me to imagine Molly giving that response.

'I think it was a figure of frustration, like, you've got to get over these things. But my mother had died. And you have to carry on. And you've got this terrible thing you're carrying around with you, that you've got to come to terms with. Because you don't lose your mother every day.'

I thought about this. *You don't lose your mother every day*. And then being instructed to *knock mourning on the head*. Mourning is a process that follows its own timeline. You can't just end it consciously.

'There's the pressure to get on with life,' Molly reflected. 'As well as the idea of, *right, I'll just do coping no*w, *I'll try to be resilient.* And you're kind of pushed into it, because you have to function.

'And also there's a limit to what you can tell your partner,' Molly added. 'Because you don't want to give them a burden. I've always been a bit of a coper, you know, wouldn't tell him so much.'

Molly's words tripped me into thinking about my own life. I remembered, when I decided to train, having this glowing sense of what a gift my *new life* as a therapist would be to my loved ones. I could be better for them; they would benefit from my new-found stability as though training would be a ticket to my guaranteed mental and emotional functioning. And if I did ever struggle, which I imagined would be infrequently, I could easily muster up a veneer of professionalism around my suffering. It would not affect anyone, including myself.

'The sense that we're *beyond human* feeds into the taboo of therapist suicidality,' Molly said, 'which is terrible, because even therapists are human!'

Even therapists are human. I wondered how we might be viewed from the outside. 'Do you think clients think we're human?' I asked. Both Molly and I laughed.

'When my mother-in-law died,' Molly said, 'I got into trouble with my placement for telling clients I was going to a funeral. Because it happened really quickly, I had to cancel clients at short notice, so I thought I'll just tell them. My placement managers worried that my clients would be thinking of the funeral. But actually, my clients were just concerned for me. Most of them said, *we're really sorry is there anything we can do?* So, I think I was human to then. They said, you've looked after me so now I want to look after you. It was very moving. And it was also *my* human response, actually, I'm going to tell them someone close has died.'

I liked Molly's defiance. I felt that she needed to be.

'Cos I can imagine a whole load of supervisors going… woahh,' I said. 'And unpacking the perils around disclosure. But the way you describe it is refreshingly rebellious!'

Molly smiled. 'I think it was actually very useful… not that it was intended to be useful, therapeutically, but there was quite a lot of tenderness there.'

'Tenderness, yes. And it sounds like it enriched the therapeutic relationship.'

'Yes, and actually, their experience was that people aren't always letting you down deliberately, but also that therapists can suffer.'

'So, on suffering... what do you think clients would make of knowing their therapist had been suicidal?' I asked Molly. 'I mean, it's hypothetical, because you're not going to disclose that, right?' I said, laughing spontaneously.

Molly laughed with me. 'No, I wouldn't disclose my suffering directly, I don't think it would be helpful. I've always found it really difficult, especially when female clients say things like, *what would it be like to lose a child?* My child died at only a week old. I find that really difficult, like… *if only they knew*. I feel like saying, *well I'm someone who's lost a child and I'm sitting in front of you. And it's OK.* But you can't say that. Because if you did, it becomes about you.'

'So, you wouldn't say to someone who was disclosing feeling suicidal, i*t's OK I've been there as well. And you'll survive it...*'

'Absolutely not,' Molly retorted.

'I suppose, for me, it's not hypothetical, because my lived experience will be public through my thesis. It'll be the research that I'm associated with. You'll be anonymous, of course, but I can't be anonymous. And... I've been digging my heels in a little, going, *do I really want to go there?* So it's not so hypothetical for me to ask, how do I imagine clients might respond, if they knew?'

Interactive interview 2: Molly - *'I lost two friends recently, to breast cancer… I felt guilty having suicidal thoughts, because of them. It's always to do with guilt, for me…*

As we entered the room, Molly said, with an air of mischief, 'I'm not going to sit anywhere till you tell me!'

Then she said, 'But, seriously, I will sit in my therapist chair, if that's OK... it's the only protection against lack of structure I have,' Molly reflected. '*This is my chair!* I'm hanging on to it!'

I liked that Molly was being playful. It was a good way to begin the final interview.

'I felt really good after seeing you last time…' Molly said.

'Me too, I didn't want it to end,' I agreed.

'Even with the time we had, I felt being able to share made it less toxic. It made my mind up to ask for another therapist, instead of capitulating.' Molly disclosed. 'I'm quite good at being slippery, as my supervisor told me. Instead, I decided not to hedge around.'

'Did it help being asked directly to talk about [your suicidality] here?'

'Yes, I knew I wanted a therapist who could actually say, *are you thinking of doing anything to yourself…?* Because there was a lot of avoidance in my previous therapy. It was like blind sight. I wanted to tell him something but felt I couldn't. And he rushed past it instead of staying with it. Maybe it was his own fear, I don't know. We're all human. But speaking to you last time really helped.'

'I was reading this book by Brett Kahr, *How to flourish as a psychotherapist*,' Molly said. 'It's all about how you've got to have superb mental health and come from a really happy family to be a successful therapist. I thought, *I can't read this anymore*. Because it's a bloody lie. A lot of therapists don't come from happy families, and they have to work out their own stuff as part of the training. Well you never sort it out. Because that's part of being a human.'

'And that's been an important realisation for me,' I reflected back. That I'm *not* going to become suddenly fixed; a superhuman… I could be congruent with that.'

'Because there are some people who are blessed with happier backgrounds,' Molly continued, 'but just to say we all have to be fixed…. that's discomforting. I work well with disturbed people *because* I come from a disturbed family - which makes *me* disturbed as well! You can't say… *oh you're very good at working with disturbed people, Molly, but you're not allowed to be disturbed yourself, because otherwise you're not fit to be a therapist.*'

'Or, maybe worse,' I added, 'you pretend you're not disturbed, you shut that part off in order to act-out an elevated position.'

'Like a clown,' Molly pondered. 'But since you say *shut off* ... I've spent most of my life shutting off. Having a depressed mother and a violent father, a lot of my life was spent shutting off and

shutting up. And that was repeated in my own therapy... and because I was training, it felt like, *put up and shut up*.'

Put up and shut up. I definitely knew that one from my own family history and, ruefully, from my training.

'And the pressure when you're training,' I added, 'is to be in good mental health. *Because I'm being measured, here*…'

'Yeah… I'm being judged. And I think that's quite dangerous, actually.

'But, you know,' I pondered, 'part of what I'm looking for with this research is to contribute to our world, not just with a set of abstract findings but how can we help ourselves. How can we make things better? Some of the things we've identified that are problematic for us wounded healers can actually be put to good use.'

'Yeah...' Molly looked thoughtful. 'Without just a tick box thing... *oh, you should do more exercise ... take up a hobby*... that doesn't really help you when you're completely lost.'

'I was told take up running!' I said. 'But... then, I've also encouraged clients to do so. I don't think it's necessarily a bad thing; I manage anxiety by going out for a run or for a walk. But you can't just leave it there...'

'...because that's running away from it,' Molly interjected. 'You might need to stay with it.

'But therapists who ascribe perfection,' Molly shifted the focus back. 'Isn't it just their own risk assessment against trauma?... R.D. Laing said: *the greatest despair is not acknowledging you're in despair*. He trained at the Tavistock and said they were all *super-duper therapists* who couldn't acknowledge their own despair. They had to be flourishing and *super-duper!*

'My dear late therapist died on my birthday.' Molly said.

I emitted an audible moan... *could it get worse...?*

'His wife sent me a text, just as I had to go out and see a client. I almost felt his ghost pushing me out the door... *it's only fifty minutes. You'll survive that.* Afterwards, I was in a clinical discussion group, and this therapist said, *I always have two phones at work, one for personal things and one for work things*. And I thought, *you can't risk assess against everything...* I'd rather have known he was dead than not know. You can't protect yourself by just having two phones. I was quite angry actually. I only have one phone and that's for everybody.'

'But, what's behind the need, to block stuff off, have these protections?' I conjectured.

'It's hanging on to the chair, isn't it…' Molly smiled.

'*Hanging onto the chair*, *yes!*' I laughed.

'...if I can limit the information coming in, I can't be affected by it. But I don't know if that's being truly alive. Because we do get affected. It's like a need to prove we're in control.'

'I think you're onto something there, the need to maintain the self-illusion that you're in control. Because it is an illusion. We're not *the super-duper!'*

'It *is* an illusion,' Molly agreed. 'Because it's part of the wonder of being human, that we get things wrong, that we suffer, get messed up and mixed up. Even therapists. My tutor said I had to be in good mental health, that I wasn't to be upset about my therapist dying. *Sort yourself out*, he said. I was told off, really. Then I had to go back into therapy. Because I was not in good mental health, apparently. But actually, I was only sad.'

'Ahhh, that sadness is pathologised...' I sighed.

'Then, when I started therapy, I became really depressed.' Molly said. 'But I never acknowledged my depression. I remember going into work one night and I was feeling absolutely terrible. One of my clients who was severely brain damaged, knew I was depressed. She put her hand on my me and said, *poor old Molly*. She picked up on it. What I'm saying is, we're supposed to keep *shtum,* but the client might know anyway.'

'Because "our clients" are us*,'* I said. 'We just need to stop pretending we're different.

'I agree,' Molly beamed.

'So, how could we change things, move to a more healthy position?'

'I think to be more honest about things. So, it's about... is there a space where we can open up? Therapists might not find the answers in therapy. They might get the wrong person. But... maybe there could be some kind of group. Like AA for therapists!'

'One of the other participants suggested that,' I chuckled. 'To set up a *suicidal therapists* group.'

'It's very powerful to be in a group,' Molly said. 'Where I used to work, two of my colleagues killed themselves because of despair. And we didn't even have time to talk things through, about where we were, what we were witnessing, and what it was bringing up for us. Maybe we can be more honest in an anonymised group?

'Particularly around this particular difficult, painful area of extreme distress and suicidality,' I elaborated.

'But in an arena that hasn't got this all-singing-all-dancing therapist myth.'

'Yes, and that also doesn't have…'

'...two phones!' Molly's voice broke into a wild cackle!

'Something happened on the day of our first interview,' I told Molly. 'I'd messed up rearranging a long-term client and ended up cancelling their appointment at short notice. The following week, my client, who is a trainee therapist, was curious about what happened. He knew I was doing PhD research but didn't know what on. So when I told him it was to do with that, he was interested to know more.

'So, there it was!' I smiled wryly at Molly. 'Just as we'd talked about. I was facing my client, knowing if I described my research, fully, to him, he would unavoidably learn about my suicidal history. And if I conveniently left out the detail that it was autoethnographic, I'd feel incongruent. It was a double-bind.'

'So what did you do?' Molly asked.

'I told him. All of it. The following couple of sessions he wanted to know more, particularly how that impacted his therapy with me. I wasn't sure if I was doing the right thing. At one point he asked, *should I be worried about you?* This troubled me.'

'Difficult...' Molly conjectured.

'Of course, my reflections were all within the context of knowing my published research would reveal this away, anyway. I don't think I'd have disclosed otherwise... although... it wouldn't be my doing if he'd found out on his own. But interestingly, the most poignant aspect emerged over the following weeks. I experienced a sense of us becoming somehow closer, more trusting, more therapeutically bonded. My overall feeling was that it had been a good thing.'

'It felt right?' Molly reflected.

'Yeah... it felt right. It was like we'd pulled our chairs closer together. That's not a generalisation; I wouldn't say, *so my findings are, go out and tell your clients*. But it's interesting what happened. You're the first person I've told ...probably fear of being judged again!'

'I'm going to tell my supervisor, which is OK because we've been working together a long time... though, interesting that I feel the need to say feel reassured.'

'I suppose, when we talk about it,' Molly pondered, 'we talk about it theoretically. But this brings it home, doesn't it.'?

'Yes it does.'

'I lost two friends recently, to breast cancer,' Molly said. 'I felt guilty having suicidal thoughts, because of them. It's always to do with guilt, for me.'

'Guilt is never far away, is it,' I reflected. 'It intensifies the compulsion to bury our distress.'

'Yes, it's like a cut-off,' Molly added. 'I was having suicidal thoughts this summer. And it was wrong. And I'm saying it's wrong and judging myself, because I should have been thinking of other people. I felt absolutely desperate this summer. With all the things that had happened in the past year, I didn't really want to be here.'

'You know, on the way up here today, I was thinking... what we engage with, us therapists, is ultimately hopeless, because we're all going to die.' My comment wasn't intended to be humorous, but Molly and I broke into laughter.

'Think of all the studies that try to predict increased likelihood of death by *this*, by *that*, by *the other*, and I always think, taken to the logical conclusion there's a one hundred percent likelihood of dying through being born.'

'But that's what Ronnie Laing said,' Molly pointed out. 'Sex is a terminal STD.' We both guffawed again. 'Because actually, when you have sex you make things that die. There's only one outcome.'

'That's right! So come on, let's just get real about this.' I threw my hands up in the air.

'Yes!' Molly also became animated. 'It's like the person with the phone... *how much can we prevent?* We *can't* prevent death. But we can engage with it honestly, in a way that alleviates suffering, and live better lives by being more accepting.'

Camus (1955) argued that suicide is the only relevant philosophical question: whether we can find meaning on encountering the absurdness of existence. I wondered if we had a unique opportunity, us psychotherapists, to engage in conversations around the decision to live or die, in a unique and profound way that is further enriched by turning the lens on ourselves, reflecting first-person. I wondered if the greatest forfeiture was, through absent-mindedly positioning ourselves apart from the people we work with, that we missed a rich opportunity for self-exploration in the service of humanity. Our *self* provides the only data to which we have direct access and

Theo, Eve, Molly and I achieved this. I can recall perplexed responses from some colleagues when I told them my research plans; as though suicide was the last thing anyone would want to self-explore. I felt the opposite. These conversations had produced life-enriching dialogues, each yielding its own black holes and revelations.

'It’s interesting,' Molly said, 'you had a funny do and I had a funny do. Both of us had a funny do, didn’t we!'

I laughed at Molly's choice of words.

'It was like… this was always going to happen... our funny do's.'

'It's where it was all leading,' I added. 'I hadn’t thought about it before all this stuff happened, our funny do's! Now, I find myself thinking, *this is astonishing...* our conversations feel so valuable.' I deliberated. 'And I don't think it should end here.'

'Maybe you can get that group going. That would be a good outcome!' Molly said, enthusiastically.

'Sure, but... I think all this starts with our training.' I said. 'A founding member of my institution killed themselves, you know. We didn't engage directly with it in training, we didn't explore what that meant to us. *How does that affect us? How do we think and feel about that?'*

'We never had *that session* and I felt let down. Because why would you not, as therapists? If you couldn't, who could?'

'It's dealt with in bitty, fragmented ways, isn't it.' Molly suggested. 'Split-off bits. Because nobody can make sense of it.'

'That was the rub of it for me,' I conjectured. 'We work with uncertainty, with... *not making sense.* Our clients might have an ambition to sort everything out and make sense of it all, but as therapists we know that we’re engaging with not-knowing.'

'It reminds me of the Martin Buber quote,' Molly said, '*every journey has a secret destination*, that you may never know. Cos actually once you know it…' Molly continued, 'it takes away the juiciness of life, doesn’t it!'

We were both laughing again. There was something really nice about the way we allowed humour into the most difficult of conversations.

'That’s a good way to end, isn’t it,' I concluded. 'Let's embrace the juiciness of life!'

Autoethnographic Interlude

On completion of the research interviews, I found myself immersed in a creative melee. The feeling was one of intimate connection with my participants and with our inspirational conversations. Given my propensity to create poetry, prose, and song at such times, I sat and wrote, over a few days, an ode to vulnerability - to the beauty of it, the fragility, the openness, the courage in it. In this research endeavour, I had attempted to convey the sensations of myself and others, combining my voice with the voices of those who joined me; attempting to represent an *essence* of suicidal psychotherapist selves, while remaining unconvinced that this was ultimately achievable. The burst of creativity I experienced in writing *'The Vulnerable'* felt like a huge release; a giant wave surging over these sticky realities, washing away the claustrophobic feeling of fear and consequence that built through the troubled two years in attempting to achieve project approval.

I used the intuitive style that came to me at the time of completing the interviews (non-conventional for a doctoral thesis, ring the echoes of repeated warning and discouragement) expressing instinctively each aspect of vulnerability that emerged, via Theo, Eve, Molly, and I, in this study, as it came to me in the aftermath of our conversations.

I wanted to offer this poetry before embarking on the analysis, to set the scene in how the core of me tends to experience itself, to offset the formality of academic processing.

The vulnerable trainee

I am at your mercy,
I am following your lead.
You show me the way,
You show me what you do with your vulnerability.

Hide it and so will I;
Denounce it and I'll bury mine, deeper.
Express it and you offer me courage,
Celebrate it and it becomes a strength.
I can shout it out-loud, then.
Don't mention it and I will assume it is not to be mentioned.
Pour judgement over it, and I will deny my vulnerable self, for the rest of my professional life...
...until I can contain it no longer.
But I have to make my own choices;
I choose, in the pressure of the moment, to continue
working with the vulnerable.
So I carry on... so I carry on.
I'm not honest with you, my tutors, my leaders.
Pour judgement over me, and I will not qualify...

My fears hold sway. In isolation I stay.

The vulnerable practitioner

What you gave me, stuck,
How you showed me the way, became my way.
Those hushed conversations in the training corridors, provided
the backdrop to my fears: don't be seen, don't tell, don't expose yourself. I am the practitioner who should have been told, no.
I don't show, I don't spill, I am solid, unshakeable, resilient as hell.
I lock the doors and, secretly, I take my pills.
Proud in the title that shores-away my
vulnerability.

The vulnerable research participant

If I asked you to come here,
and I knew something of your possible fears,
then, I knew, you were waiting for me to show the way.
If, in my attempt to do so, I fucked up,
and your fears broke loose from their straining chains, Then, it was my doing, my responsibility.
I am sorry.
But please let's continue.
Because, if you saw me failing, falling, cracking, sweating, moaning, bumbling, forgetting, needing, yearning... and you were still here when I finished my shit-storm... then we were both in the right place; we were both finding each other.

The vulnerable researcher

In-concluding a place for vulnerability,
is the 'last frontier' I shall never leave,
of inner exploration, the 'next frontier' I shall never leave,
of dialogic exploration - a discomfort I shall never leave,
as something that I now am, that I inhabit, and shall never leave. I am the vulnerable researcher, I

joined hands with
all those encourages and dissenters - did they know?
and I took the blue pill. I can never go back.
Question: what does a researcher do when not researching? Answer: rage out-loud to hedgehogs.

(Inspired by Bager-Charleson, et. al., 2018: 121)

The vulnerable supporter

The containing power of someone supportive, a supervisor maybe, or therapist,
holding my vulnerability as you did rendered you as vulnerable as I, while imbuing you with powers you probably know about,
as I imagine those powers were offered to you, as support when you were fragile,

And that's how you know.
And that's how I know;
your strength, like mine, came from your suffering, from
your relationship with love;
from your vulnerability.
But you were the teacher,
you stayed close to your values, when you practiced and taught, when you boldly asked:
'why are we so afraid?

4.2 Theming for *Rich Points*

This section examines pivotal findings, or *rich points* (Agar, 1994), from the verbal exchanges. Rich points (Agar, 1994) are 'episodes or speech acts within conversations that contain cultural knowledge; these are sources of critical deconstruction of how cultures are understood from the inside' (Goodall, 2000: 108).

A data extraction process following Braun and Clarke's (2006) six stage thematic analysis framework (see 3.12) produced themes and sub-themes, that were then synthesised into four superordinate rich points, each with two subordinate rich points (Table D1 below), then evaluated and discussed, with the aim of answering the second research question:

'*What do therapists say when they talk about their own suicidality?*'

Following Braun and Clarke (2006) working with the original transcripts, the first strategy was to carry out a thematic analysis. On initial read-through, analytic memos (Saldaña, 2014) were made. Analytic memos are small notes made to the side of the transcript text, a 'place to "dump your brain" about the participants, phenomenon, or process under investigation by thinking and thus writing and thus thinking even more about them' (Saldaña, 2014: 58). Reflecting and developing the analytic memos helped produce two hundred first level coding topics across the interviews, which were then clustered under twenty-four umbrella themes and further integrated to produce six final themes in each interview. The codes produced from each interview were then integrated into umbrella concepts to produce a final set of themes and sub-themes. The final themes and sub-themes were tested out against the transcripts once more and galvanised into a set of four superordinate rich points each with two subordinate rich points (Table D1 below).

Each rich point built on the previous. So, for example, the issue around interviews feeling like therapy sessions, with both negative and positive connotations, developed through a number of concepts: holding onto power via the therapists chair; the importance of feeling 'on the chair' with peers, tutors, supervisors; how important it was in the interpersonal realm for psychotherapists with suicidality to have open, non-judgemental channels to be heard and find support.

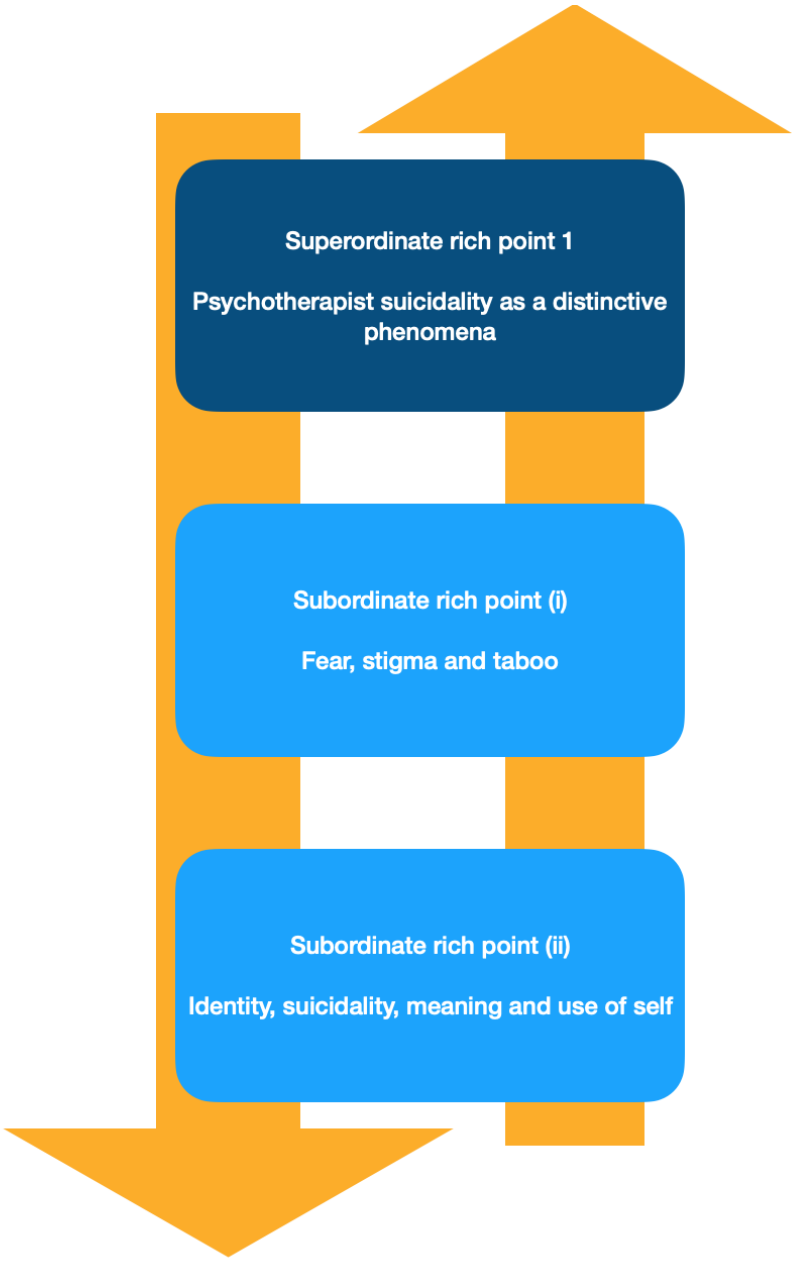
Four central and two linked subsidiary *rich points* for each superordinate theme were identified from the thematic analysis, illustrated in table D1:

Table D1

	Superordinate rich point 1	Superordinate rich point 2	Superordinate rich point 3	Superordinate rich point 4
	Psychotherapist suicidality as a distinctive phenomenon	**Context, training, & organisational implications**	**Holding & regulating psychotherapist suicidality**	**Under-researched area of psychotherapist suicidality**
Subordinate rich point (i)	Fear, stigma, & taboo	Invoking structural & organisational factors	The struggle to be believed	Barriers to lived experience research
Subordinate rich point (ii)	Identity, suicidality, meaning & use of self	Training contexts	Interpersonal factors dominate self-regulation	The importance of attending to language & terminology

The superordinate and subordinate rich points were allowed to flow through one another as the analysis took place, as shown, as an example, with the first super- and sub-ordinate rich points in Diagram D1:

Diagram D1



4.21 Superordinate rich point 1: Psychotherapist suicidality as a distinctive phenomenon

From the interviews, it seemed clear that one single unified version of psychotherapist suicidality was neither attainable, nor desirable. The uniqueness of each of my participants and their life stories became something precious. However, there were aspects of being a psychotherapist with suicidality that made it distinctive.

Anxiety and fear were present in the interviews. Fear of talking about one's own suicidality and of implication and consequence, seemed ever-present. This may be because understanding psychotherapist suicidality is about understanding a person's context: their life story, motivation to become a helping professional and adaptive responses to protect old wounds. It was noticeable that trauma was present for all four of us. With that in mind, the interviews had a potentially hazardous quality for all of us, as our conversations were likely to increase contact with our own trauma and adaptive responses to that. Combine that with fear of consequence that emerged from the interviews, and the avoidance our participants show in their professional contexts, and we can say that psychotherapists find it difficult to talk about their own suicidality. Organisational contexts can change this as Eve found working in different settings that either disavowed or celebrated woundedness.

Feeding into this superordinate theme of 'Understanding psychotherapist suicidality as a distinctive phenomenon' were the two subordinate themes: (a) Fear, stigma, and taboo; and (b) Identity, suicidality, meaning and use of self.

Subordinate rich point 1 (i): Fear, stigma, and taboo

That '...*mental health workers struggle with stigma about their own issues,'* (Reynolds, 2017: p. ?) seemed unambiguously clear in the interviews. But what did that mean? Eve's inner turmoil was an imported agony, wrought by a brutally abusive social history. In adulthood, she battled

her way out of addiction, only to be felled by serious mental illness. She tripped into suicidality on so many occasions, always with a sense of this being the very last response to her woundedness. Eve described psychotherapist suicidality as:

> *Eve: …[it's] the last taboo, ….no matter how you try to frame it or wrap it up in cotton wool, it's normally dealt with by making it objective. It's why people don't talk about it.*

Similar reflections about the silence around psychotherapist suicidality entered the exchanges with Molly:

> *Molly: It's like a double whammy, isn't it?*
> *Martyn: It's like a double whammy.*
> *Molly: Which is terrible, really, isn't it, because we are… we're all human, even therapists are human (laughs).*
> *Martyn: And so as I've gone through this research journey I've been aware that I've been putting my heels in and going, do you really want to… go there? And what's that going to be like?*

As a therapist, there is a double-bind - of being asked to be vulnerable while grappling with fears around the impact of revealing one's fragility. The kinds of judgements revealed in the verbal exchanges indicates the presence of taboo. Molly talking about a '*double whammy*'; that suicide per-se is already taboo, but psychotherapist suicidality doubly so:

> *Molly: …what feeds .... the taboo [for therapists] is that somehow we're all beyond human.*
> *Martyn: Which puts you in an even more vulnerable position, ... the pressure … is to be in good mental health. Because I'm being measured, here….*

Molly recounted, summarising the living effect of stigma and taboo:

> *Molly: …somehow…not fit to work, or suffering from mental health problems, or, you know… and that… that's… because there's a negative connotation around that, that… I can't have mental health problems, you know, I'm a therapist.*

It felt like a triple-whammy for me regarding stigma and taboo. As I'd put it to Molly, in the context of the current research, auto-disclosing by writing autoethnographically, puts any researcher into a place of additional exposure. But the payback from having these kinds of conversations is profound.

Disclosures by other therapists, role modelling openness in discussing 'difficult subjects, 'was important for both Eve and me. But an expectation of judgement, particularly when contextualised by a setting where pathologising suicide was the norm, reinforced the propensity not to disclose. Eve's description of a substance misuse treatment setting in which she had worked highlighted this effect. The 'us and them' value system Eve described in that

setting, suppressed humility amongst the therapist team. The fear, as Eve described it, was that disclosing her suicidality would result in being thought of as one of ‘them’ (sic).

Subordinate rich point 1 (ii): Identity, suicidality, meaning and use of self

Although unintentional, I don't think I could have picked four more differentiated persons for this study, regarding personalities, contexts, histories, and suicidal experiences. Molly's stoic narrative of historical secrecy was very different to Eve’s openness:

> *Molly: …you're the first person I've ever told...*

Theo's agonising self-value negotiations created deep reflection about even the language used:

> *Theo: I didn't want to kill myself, I just didn't want to live this life…*

There were similarities, in that all four of us had experienced suicidality prior to becoming therapists that was connected to childhood trauma, but there were also a wide range of differences. For Theo, not wanting to exist had begun early in life, but was less a forefront experience anymore. For Eve, who declared:

> *Eve: …obviously I was thinking about suicide, because I was always thinking about suicide.*

…suicidality had always been familiar, right to the present. For Molly, suicide has been all around her and her suicidality had been a response to that - making it a lifelong feature. My own suicidal past was patchier; years of self-harm, attempts at suicide that would be

categorised in quite a dissatisfactory way as 'parasuicide,' then as overt suicidality as I entered psychotherapy/psychology training.

So, how can we know our woundedness and can it be useful when working with clients? There is a balance between woundedness being considered a burden or an asset. Molly was a trainee when she experienced the supervisory intervention of *'knock mourning on the head'*. I wondered if there was an unconscious communication passed down through therapist generations, about how we therapists should be? The message seemed to be that as therapists we need to be able to switch our emotions off.

> *Molly: It also feeds into the taboo of therapist suicidality … that somehow, we're all beyond human.*

Molly had described clients seeing her '*as human.*' While her therapy colleagues built structures to protect vulnerability, Molly engaged with her vulnerability. Molly had retorted to her supervisor, *'but your mother doesn't die everyday...'* …and so invoked her humanity.

Eve also spoke to this sense of psychotherapist humanity:

> *'There's this idea that we sit outside humanity, that we've got it all sorted … and there's something in walking the walk, isn't there ... but ... you walk into that vulnerability, don't you? As a therapist.'*

I found Eve's comment very powerful. As a therapist of only four years I'm learning that I do walk into vulnerability, that it can sometimes help, but not always. I'm also learning that

vulnerability hasn't always necessarily been embraced amongst psychotherapists. Molly described R.D. Laing's anecdotal accounts of *'super-duper'* therapists at 'The Tavistock' in the 1950's:

> *'But ... if you're not human, you shouldn't be there,' Molly argued. 'You'll end up ... hanging onto the chair... or having two phones to screen anything upsetting .... it's not being truly alive.'*

My own position has been variable. My initial belief before psychotherapy training was that I could attain a more invulnerable self. Through one lens, I'd set myself up through this expectation for deeper troubles; I thought I could become immune, but that was unrealistic. Further, I'm not sure that if I'd attained some 'super being' state that I would have been a very good therapist.

An interesting counterpoint came from Eve. While I have been wrangling with my acceptance of continued woundedness as expressed through my suicidality, Eve, who was the most at-ease about her own suicidality, gave a poignant reflection:

> *Eve: …it's harder to tell you… about my historical… sexual trauma, than it is to tell you about… my suicides. I'm happy for you to know, that's why I came, yeah… I need to feel honest and authentic, um… but equally those are my most vulnerable bits.*

For Molly, her eloquence in storying her suicidality, naming her suicidal parts, and reflecting on her survival, gave an impression of stoicism. But she had never told anyone before. Even in therapy, her suicidality had been disavowed, and such experiences caused her to keep her

suicidality completely to herself: *'the legitimacy of my anguish was immediately disenfranchised'* .Taking part in the study was healing for her: *'I felt being able to share made it less toxic…'*.

There is a cathartic power of speaking out and disclosing our own struggles as professionals (Goodwin, 2017). Talking openly and candidly together felt healing. Eve noted the unique opportunities wounded therapists have of being able to '*heal it backwards*' , using our clinical knowledge and experience to reach back and '*hold the hand*' of our past suffering.

Through the interviews, the issue of whether suicidality was either manageable or fixable ensued. This conversation was accompanied with discussions around the wellbeing concept, *resilience*. While being a concept that is there to help, resilience can be interpreted differently:

> *Molly: '…it's saying you're not strong enough …*
>
> *Eve: …you wouldn't recommend your clients to "just cope"... that's the myth that we're different…'*
>
> Martyn: But we're supposed to develop this sense of resilience, which puts the onus on us, as though it's about some kind of internal strength, nothing to do with context.*In the interviews I expressed that:*
>
> *Martyn: engaged with care and ethical sensitivity, practitioner woundedness isn't just healthy but essential ... denying our wounds is far more risky and potentially unhelpful for ourselves and clients.*

Regarding working with suicidal clients, there may be a usefulness, even necessity, around this kind of in-depth exploration to aid therapists in understanding their suicidality parts and being able to have rigorous, ethical, reflexive responses to the question 'does this help the client?' That seemed to come through in all my encounters and became an important key finding.

> *Martyn [to Theo]: … it's like the myth of cure, that therapists should be therapised…*

After qualifying as psychotherapists, the deliberation around the usefulness or otherwise about one's wounds, whether they could ethically be used in the service of therapy work with others, and who you would be comfortable talking to, didn't abate:

> *Eve: I think you open up to [therapists] rarely… it's about your fitness to practice and the judgement that can come. Like in training, you didn't tend to tell unless it was a real problem.*

> *Martyn: …and... and actually, you know, the... the depth of my wounds and the way that's played out in, for example, my own suicidal experiences, my suicidality, you know… is that really helpful? is that in the service of my clients, of the work?*

4.22 Superordinate rich point 2: Context, training, and organisational implications

'No self or personal-experience story is ever an individual production. It derives from larger group, cultural, ideological, and historical contexts.' (Denzin, 2013: 56)

What was more noticeable in the participants, rather than factors attributable to the person and their resilience, was the role of context. Systemic pressures impinged on each story. 'Context, training, and organisational implications' were the two subordinate themes: (a) Understanding psychotherapist suicidality: fear, stigma and taboo; and (b) Psychotherapist identity, suicidality, meaning and use of self.

Interestingly also, is how definitions of 'taboo' refer to "...customs of prohibition or restriction developed around physical exposure" (OED online, 2019). So, taboo, as discussed in section 4.31, is contextual.

Subordinate rich point 2 (i): Invoking structural and organisational factors

Theo, not unlike myself, experienced a life before training of organisational and societal meaninglessness:

> *Theo: …there's something wrong… yeah y'know I often… felt… uhhh… that I didn't actually belong to-the... to this… y'know it felt like society… I was really out of step... with society because it was... the values of society seemed so wrong…*

Theo responded to his '*meaningless existence*' working in I.T. by changing his context, re-inventing himself as a therapist, excelling as a counselling teacher, but while also struggling to break free of the phenomenological impact of archaic paternal neglect. Theo discovered his new sense of self for the first time following his first session as a trainee therapist:

> *Theo: But on the way home, on the train, very late at night, I just… a huge smile came over my face, I felt like I'd bought my ticket to the planet … it was OK for me to take up that space.*

Theo's social constellations were influential on his proneness to feeling suicidal. Indeed, feeling suicidal was never a surprise for Theo, particularly when his job gave him no meaning. For him, the void was never far away; he just called it something other than suicidality.

Molly had a context in which ways-of-working and professional pride were, themselves, important resourcing factors for her, but not necessarily in alignment with her therapist organisations:

> *Molly: I got into trouble a couple of years ago, for saying [to clients] I was at a funeral. Because it was such short notice I thought I had to give… I just felt I had to give that reason … a lot of my clients said they wanted to look after me. Because I'd looked after them. Which I thought was lovely, really.*

Of note was her sense of *rights* for both therapist and client; that disclosure, when used in the service of the client, set up a context that could enhance the therapeutic relationship, pulling the relational bond closer together, rather than being an inflexible, unproductive red line. Molly's

principled stance championed therapist disclosure, but with the caveat that it must ultimately be in the service of the client.

How each of the four of us dealt with impinging contextual forces, the meaning systems we created around them, and our own unique responses and strategies, were tempered by the values and cultural imperatives that modulated those responses. This pointed to *context* being a dominant factor, wrapping around all other factors.

Of all the context fragments notable regarding psychotherapist suicidality, our professional group identity, and the function of expectations around institutional identity stood out:

> *Martyn: What made it even more alarming … I didn't think this [suicidality] could happen anymore ... and I was ashamed to tell my colleagues.'*

Subordinate rich point 2 (ii): Training Contexts

During training, there is a double bind of being asked to be vulnerable while grappling with fears around the impact of revealing one's fragility. Training is also a period of personal change, which can come with increased vulnerability. The tensions in being in a process of change were summed up by Molly:

> *Molly: And training is dirty…'As my therapist used to say, you might have to change in a way you don't like.*

Much of the verbal exchanges focussed around the training experience. In fact, it felt like the topic of psychotherapist suicidality always had a natural drift back to the training experience. Yet, as with all the participants - including myself - suicidality lived pre-training. In the case of Theo, Eve, Molly, and I, in talking about psychotherapist suicidality, we were actually speaking about suicidality in four people who went on to train as therapists:

> *Theo: …this is where I struggle because really the… the suicidal thoughts… were, um, really just… something that happened way before I started training.*

But something that did seem apparent was how *much more* difficult it was to talk about our suicidality in training:

> *Martyn: … finding it difficult to talk to other therapists, and their expectations, and not being able to talk to them because of potential judgemental responses.*

The forces to stay silent were apparent through the verbal exchanges:

> *Theo: The start of this is around the suicidality and how that can lead… having had the suicidal thoughts, that led to a sense of… feeling like a charlatan, doing those induction courses. There were echoes of that in training and then in my novice years. But there's a wider picture of… a concern of charlatanism ummm, aroun… not just about suicidality, but what kind of therapist am I?*

For Eve, fear of failure was exacerbated by the sense of rejection that would come with it. They were both danger zones for me. That my attempt to become a therapist felt like the '*last bus* 'meant that if I was '*kicked off the bus,* 'I believed I'd have '*no chance.*'

I did carry a cosy belief that I would have to do something '*pretty drastic*' to be thrown off the training course. But I feared that being suicidal might be one of those drastic things.

Eve's take on disclosure with her peers in training was more about them attempting to '*therapise you... which is really uncomfortable.'* This fed a compulsion to be less than fully open. Like all the participants, Eve had her fears around telling anyone about her suicidality during the training program:

> *Eve: It… it made the stakes higher … Not really being able to talk to other therapists, necessarily. particularly trainee therapists, I think everyone's very guarded, aren't they?*
>
> *Martyn: This might mean that I don't qualify…*
>
> *Eve: Hide it…*

I was left feeling that openness and disclosure of personal vulnerability was OK up to invisible lines. But one of lines had 'suicidality' stamped across it:

> *Martyn: …what would be expressed quite a lot, um, ehh… during the training, especially, you know… …this thing about, you know, getting in touch with our wounds and… …and knowing our own suffering, and… But it was never taken to that point where… I*

> *don't… I don't remember a single conversation about anyone saying, you know, and I've… I've… I've been having suicidal feelings…*

The message that our wounds were an asset appeared to have a very particular caveat applied to it. At least, never hearing this from any of my training peers, would leave me thinking it's not acceptable to feel suicidal:

> *Martyn: …every year, you know, on my training, I saw people being shown the door, you know, for whatever reason. You know, they failed or didn't pass the required whatever, or it was felt that they… you know, there was something… sometimes, you know, it… it was… that there was a conversation about whether this was the right time for them, you know…*

But this wasn't always the case. Eve picked up on the subject:

> *Eve: what I really got a lot from when I was a trainee was people who were more established than me showing their weakness and their vulnerability and their, kind of, soft spots, and their trauma … I'd like to see [that] other people, my peers… and there sort of being something about encouraging… that.*

> *For me, the reality remained. I found it hard to hear people talking about their distress and not one person mentioning that they've had suicidality thoughts or feelings. And there was I, having those*

> *thoughts and feelings, while believing it would be a mistake to disclose that in the training room process sessions.'*
>
> *Martyn: I never alluded to it. Um. And when I think back… I think, OK, there's like, twenty of us in a room, and we're all… either trainee therapists, or qualified therapists, and psychologists, right. And there's someone talking about their level of distress and isolation, and not a single person said … are you thinking about killing yourself, Martyn? You know, and I'm thinking, you know, so now I look back and think… because that's what we do, now, right (laughs) you know, that's the… that's the sort of, the given with… with working with someone who may potentially be suicidal, is ask them, right…?*

So, it was left to hushed conversations in the corridors between sessions. I felt I absolutely certain I shouldn't be telling anyone about this except my closest, trusted friends.

> *Martyn [talking about fearing reverberations of impact]: …you know, those crazy things that you imagine, someone's going to find out, somehow, and… and that… could mean that I don't get a job, or that, or I don't qualify, or… um…*

And on the fear of being removed from training:

> *Eve: there's also something about, like you said, putting your… telling your tutors… you don't tend to do that unless it's a real problem. I mean, not that it wasn't a real problem… …unless they want something to be done. I dunno, like, it feels like I'd go and tell my tutor… because I wanted something to be done…*

I wondered about that. Certainly for me the *'something to be done'* would simply be a need to let my tutors and supervisors know that I was struggling and that my struggle included suicidality. But I also acknowledge Eve's point, that it might then be the people I tell that feel a need to do something, even if that wasn't my intention. So, there were many speculations and even fantasies to manage:

> *Martyn: I thought… you know… so this is happening right now… if I get through this… and I've told my tutor, I'm always gonna be the one that was 'suicidal in year three.'*

A brief conclusion was that more openness was needed, more encouragement to feel free to be authentic, without conditions. Otherwise, reality gets overtaken by fantasy. The fear of consequence, I surmise, is born and nurtured in the training environment:

> *Eve: Yeah, no. Exactly. I think that the way the training was done actually was a hinderance to being authentic.*

4.23 Superordinate rich point 3: Holding and regulating psychotherapist suicidality

My self-insights through this study have helped me accept for the first time that suicidality would always be part of me. Out of the three participants, only Eve felt the same, and our conversation about trying to kid ourselves otherwise was a significant moment of personal revelation for me. It encouraged a fresh healing activity as I reconsidered my own risks and triggers.
Couched within the superordinate theme: *Holding and regulating psychotherapist suicidality* were the two subordinate themes: (a) The struggle to be believed; and (b) Inter-personal factors dominate regulation.

Subordinate rich point 3 (i): the struggle to be believed

Following findings around the training context, additional pressure in the training environment brought with it an increased need to find good support. Within the training context, given a pressure to be well, finding interpersonal means of regulating suicidality was hard.
Paradoxically for Theo, although he wasn't able to talk about his suicidality during training, it offered him a new way of understanding his suicidality:

> *Theo: Just to put it in context, it wasn't like I had suicidal fee- feelings that initiated, uhh, in the… in the training, it was more that they had informed a lot of my... having suicidal thoughts…*

Part of that struggle to be believed came from a naive inflated belief in the healing power of our therapy models. I remember in training sometimes the power of the theories and strategies we were being taught could result in evangelical belief in them. For example, the universal power

of the therapeutic relationship was taught with such conviction, that it would be hard to believe it wasn't supremely effective, and *if your relationship with your therapist is good, you will heal* as I remember a tutor saying, on one occasion. Eve had a further take on this, expressing her fear of having peers try to fix her if she disclosed her suicidality:

> *Eve: …but it also comes with it's own difficulties because as therapists we are a bit of a fixy bunch when we're training as well [and] I'm not sure if that's a fixable… thing… really.*

Subordinate rich point 3 (ii): Inter-personal factors dominate self-regulation

> *Theo: Suicidality is a form of disconnection … If you're not feeling those connections, you're slipping through the net.*

For all three participants and I, disconnection had played a central role of in our suicidality. When I was suicidal during training, the pressure of placement work and academic submissions combined with fear of being judged negatively by the training institution if I disclosed my suicidality. This created the metaphoric pinch that froze my support-seeking behaviours. All of this when I was at the most fragile, formative state:

> *Martyn: Particularly trainee therapists … everyone's guarded ... this might mean I don't qualify... so I kept it to myself, I hid it.'*

> *Eve: The responses you get [from other therapists] are quite often judgemental ... all that stuff is amplified if you can't [speak] to someone, for that reality testing….*

But talking openly, even within a psychotherapy training context, can involve overcoming more than fear. The experience of trying to talk with others can be fraught:

> *Eve: When you talk about suicide with people who don't have an experience of it, you're often met by fear….*

There is also another fear, of becoming the 'unwell other' through disclosure of suicidality:

> *Eve: …the fear is, now I am seen as the other.*

In my case, degrees of interpersonal support often correlated with the ability to reality test, particularly during training. In the absence of interpersonal reality testing, my fantasies would become amplified and contribute to distorted decision-making, almost wholly based on fear of '*professional consequence and being dropped from training*'.

There was enthusiasm from the interviews regarding seeking additional professional help. All four of us talked about having sought support in the past and returned to therapy at times, and this would continue. In conversation with Theo, I disclosed:

> *Martyn: When I hit crisis, therapy helped contain my suicidality.*

Molly, talking about feeling suicidal over the previous summer, said:

> *'I came back to my clients from summer break and ... felt ... envious of them. So I thought, I'll go and get a therapist.'*

Our conversations about continued support erred towards managing reality rather than recovery. Eve's *coping* injunction was her awareness of being needed by others. That made Eve's personal suicide prevention strategy relational, and it worked for her.

For me, having the right therapist, or understanding supervisor, proved a strong feature for being able to stay alive. For Eve and Molly, *not* having the right therapist shut down channels for safe expression. For me, not having an affirming supervisor at times, was similarly disavowing and confusing. When therapy was good, particularly during training, it made a huge positive difference. However, as Molly reflected:

> *Molly: Even if you're in therapy you're still burdened. You can't get rid of this awful thing that's going on.*

Molly believed she needed strong direction in her supervision:

> *Molly: I needed to be... upright … not down on the tracks.*

Molly experienced taking part in the interactive interviews as a reminder to find the interpersonal support she needed, and to ensure it was the right kind of support for her.

> *Molly: It made me ask for another therapist … instead of hedging around. Cos that's what I've done. In my therapy. I've kind of, you know… I'm quite good at… I'm very slippery, as my supervisor said, I'm quite good at being slippery. And not…*
>
> *Martyn: So does... does it help... to be asked directly about it, knowing that this is the focus?*
>
> *Molly: Yes. Because there's [been]a lot of hedging…*

As Molly recounted, there is a big difference between having support and understanding, rather than being told by a supervisor, *'you've got to knock your mourning on the head*'.

Getting good support during the research process was also important, and interestingly the findings reconfirmed that the kind of support I need is interpersonal:

> *Martyn: So, so the supervisors, um, the mentors, umm, uhhh, being in therapy, you know, sort of, so actually I knew where to go, I knew who to talk to, and they were ready (laughs)…*
>
> *Theo: Your network was in place to catch…*

Martyn: …my network was in place to go, right, OK, you know, slow down, it's OK. This… this is… this is the research. This is good, this is great stuff to talk about…

Theo: and you just kinda go, no, you really need a lot of supervision around, uhh, this delivery.

Martyn: And support is absolutely necessary for us to be able to engage with that, sort of, uhhh, evaporating the distinction between us and them.

For Molly it was important to *'hold on to the therapists chair'*:

Molly: I'm not going to sit anywhere till you tell me (laughs)

Molly: I suppose why we do that it's the only sort of power we've got, isn't it?

Martyn: I think you're right that there is a power element to it…

Molly: But it's not a nasty power, but it's… yeah, so, it's like a sort of, um… it's a protection.

More than anything else, for Molly, having that anchor of agency was powerful. It made me reflect how, at training institutions, the trainees gain so much from the feeling of being 'on the

chair' with everyone else. It's a form of protection. The feeling of being an equal, a peer, part of the group, is like being on a big therapist's chair with everyone else. All training institutions should metaphorically and practically offer the big therapist's chair that can hold and contain. But it's also a case of knowing how to find the right kind of support, while destabilising forces are at work:

> *Martyn (with Molly):…with...anxiety, shame and stigma whipping around, I would need to ensure I had those safe people to tell.*

4.24 Superordinate rich point 4: Under-researched area of psychotherapist suicidality

This superordinate theme reflects the awareness the three participants had around the paucity of lived experience research on psychotherapist suicidality. It became a direct topic of discussion in each interview, as we examined the potential factors for this. Feeding into this superordinate theme were the subordinate themes: (a) Barriers to lived experience research (b) The importance of attending to language and terminology.

Subordinate rich point 4 (i): Barriers to lived experience research

In the first interview with Theo, we had a rupture fuelled by the two-way interviewing methodology. I had been reading from my journal from a time when I was suicidal during training, which Theo regarded as therapy being sought by 'the back door.' Theo believed it wasn't the conversation about suicidality that was the problem, but the method of interactive interviewing and the involvement of the researcher's story:

> *Theo: …(the problem is) less to do with the suicidality, and more to do with the method … the problem is autoethnography. It was your narrative not flowing that gave it an intrusive quality. The suicidality was not the concern.*

Although my view was that it was the method that got us deeper into the subject matter, I could see genuine discomfort in Theo. Getting deeper into the subject matter, then, had its own risks, which were evident in our exchanges during the second interview. The shift in the familiar resulted in discomfort:

> *Martyn: …but… when I left here last time, was… a strong compulsion to get away from this conversation.*
>
> *Theo: It was like, I don't want to go there…*
>
> *Martyn:… look what happens when you try to get together and try to… talk about this, you know, and... and… look at the risks, look at the trigger points, look at the…. you know, the ways in which we can immediately leap away behind a defence and say…*

Given that an assertion of this study is that psychotherapist suicidality is an uncomfortable topic to research, an almost predictable finding was that attempting to operationalise this research was always going to run into problems of anxiety and discomfort. The interactive interview was an unfamiliar method that created a depth that was unexpected, which

combined with the sensitive topic of psychotherapist suicidality, risked making the process troubled. This was apparent in verbal exchanges with Theo:

> *Theo: …there was certainly a part of me that was kind of going, no don't take me there… don't take… I don't wanna go there…*
> *I was sort of thinking, this sounds more like a therapy session and I'm not really sure if we're, kind of, keeping it on track. So, you know, it… it…. can kind of sort of work both ways with this style of…*

The troubled research topic and method had its own tensions:

> *Martyn: I would be more comfortable with… you… me … having a troubled relationship around… around that … But you know … my, my growing edge has been around not knowing. … …then I actually think I wouldn't be as good a therapist as I feel that I am by not knowing, by…*
>
> *Theo: …holding the doubt…*
>
> *Martyn: Right … isn't it actually, now, not so surprising that people don't normally go near this kind of research?*

With Eve, it was more about thoughts of potential judgement that became a potential barrier to participating in this research study:

> *Eve: I know practitioners who will be appalled if I tell them that I've done this. I know practitioners who won't. But there is judgement out there. You can find it; you don't have to look very hard (laughs).*
>
> *Mar: It's kind of the… th... the… the last taboo [in psychotherapy research] isn't it, I think.*

The intersection between the 'troubled' subject of psychotherapist suicidality and the way it's researched came out strongly in the findings. Hjelmeland (2010) identified an almost exclusive use of quantitative methodology in suicide research, focussing on *explanations* rather than *understanding.* But to employ a methodology that seeks to uncover *understanding* through personal disclosure has its issues.

In conversation with Molly, we noted:

> *[We're] not trying to see… well, how… how is this set of conditions different from that set of conditions. Yeah. But…but what we're… what's… what's… fascinating is hearing… your unique experience. Now. And how… how that… played out for you.*

Additionally, regarding suicidality, 'taken-for-granted' truths (Marsh, 2010: p. 5) could be critically unpacked into a historical view that shows how interested parties can dictate the social

construction, 'illness,' that requires expert diagnosis and management - the compulsory ontology of pathology around suicide locks down a contemporary 'regime of truth' (Marsh, 2010: p. 4) - one effect of which is the foreclosure and marginalisation of competing voices.

In conversation with Theo, I commented: *'...isn't it actually now, not so surprising that people don't normally go near this kind of research?'.*

Investigating psychotherapist suicidality was challenging and there had been a strong inclination for both of us to pull out. That we didn't pull out resulted in deepening the conversational exchange.

Eve and I had talked about psychotherapist suicidality being the 'last taboo' in research and how subjective exploration of difficult subjects comes with an anxiety that may often be dealt with by making the research more objective.

I'd often been vague about my research subject when asked, feeling more comfortable to say: *'I'm doing practitioner wellbeing orientated research'.* I described to Eve the fantasised response I would entertain of *'…expecting … waves of, kind of, shrieking and criticism, and 'what the hell is this?' 'why did you go there?''*

With that came the paranoia that the research subject could even affect my likelihood of qualifying as a therapist if I were to talk openly about it before qualification. Eve reflected on these fears:

> *Eve: I know practitioners who will be appalled if I tell them I've done this. I know practitioners who won't. But there is judgement out there. You can find it; you don't have to look too hard.*

The subject of taboo came up again with Molly:

> *Martyn: Experiencing suicidal feelings, but being a therapist… and something that's already taboo, you know, suicide…*
>
> *Molly: It's like a double whammy isn't it.*
>
> *Martyn: It's like a double whammy'.*
>
> *Molly: Which is terrible isn't it, because we are… we're all human. Even therapists are human.*

So the fear of taking part in this research subject, the potential consequences of feeling judged by peers for taking part, and the presence of an assumed taboo around psychotherapist suicidality, all stack up against participation itself. As Molly commented: *'It's what's not said. That's probably more important than what is said.'*

Research or Therapy?

An issue that nearly became a superordinate rich point, potentially understood as problematic for researching psychotherapist suicidality, was whether this style of qualitative interview could slide into becoming a therapy session. The short answer to this question following these interviews was *yes*. Both Eve and Molly came into their second interviews expressing how they'd found the experience therapeutic. Eve felt positive about this:

Eve: Well let's make a contract, then.'

Martyn (laughs): …you've put your therapist hat on!

Eve: …I have, I have! Um, but I think that's something I'd worry about, too. Is the kind of, um… and I think it's useful to talk about before it happens, is how to hold two different very painful experiences in the same room.

The likelihood of these interviews sliding into therapy wasn't received in a positive way by Theo:

Theo: But actually, in this context I'm going, hang on… what are we doing? And it's kind of, so… I, you know, this is where the ethical question that was being raised about the auto… I can't think of the word…

Martyn: Autoethnography…

Theo: …autoethnography, and the exploring with me… there's a… there's a subtle boundary … at what point does it… slide across… from a… a mutual exploration and slide into… it... th… it raises the question, how much of the autoethnography element is a less than fully conscious thing on your part to try and get some part of you healed, and heard…

Though I acknowledged Theo's discomfort, and as previously discussed we did a lot of work to repair our rupture, I'm not convinced this is an issue that apples only to autoethnography:

> *Martyn: Hmm. I mean, the issue of whether a qualitative research interview can slide across into feeling like a therapy session is one that exist in all styles of qualitative interviews.*

Eve and Molly's sessions, I felt, were at times therapeutic, for them and myself. In a way I would have found it counterproductive to the research process to shut the therapeutic aspect down as it would risk interrupting both the flow of the interview, but also steer the focus away from interesting and revealing process dynamics. I didn't make therapy an intentional act in my interviews and the guiding principle would be to go with what the participants were comfortable with. Theo found it uncomfortable, and we worked that out and adjusted around it. Eve and Molly were more comfortable with the therapeutic aspect of their interviews, so we ran with it, albeit with a mind to observing and containing it. I felt strongly that if participants found it helpful that was more than OK with me: '*Speaking to you last time really helped,'* Molly had said. Eve felt similarly, while also pointing out the therapeutic opportunity for me in: '*heal it backwards.'* When I disclosed my recent suicidality to Eve, her own disclosure of recent suicidality helped me allay any consternation. Talking through the support we had in place and the way we both managed those reoccurrences felt collegial as well as therapeutic.

Molly was the last of the three participants I interviewed, so I was prepared to make these issues explicit from the outset, starting with the seating arrangements. Inadvertently, this led to a poignant interaction in the second interview:

> *Molly: I'm not going to sit anywhere till you tell me (laughs)…*
>
> *Martyn: Sit wherever you like…*
>
> *Molly: I remember what you said last time … like, this is my room and it's the only certainty I've got [choosing her seat] while you're here. Because I don't know what else is going to happen.*

The seating arrangements brought a conversation in about power in the research relationship, comparing that to power in the therapeutic dyad. Molly saw her therapist chair as a source of certainty, using her analyst identity construction as a safe base from which to disclose her history of suicidality for the first time. Molly also reflected on a healing aspect of the first interview:

> *Molly: It's really helped me speaking to you last time. It should be possible in therapy … not just … do more exercise [or] take up a hobby… doesn't really help you when you're down and completely lost…'*

Subordinate theme 4 (ii): The relevance of language and terminology

From the beginning of these interviews, the importance of language choices became evident. Theo struggled to say that he was suicidal, or even use the word at all:

> *Theo: It makes it far more concrete to use that phrase, 'suicidality,' he explained, '...not the language I would have used… I didn't want to kill myself... just didn't want to live this life.*

Like Theo, I'd grown to dislike the term *suicide.* I saw it as a word worn out (Watts, 2011) from overuse and felt moved to retune the language, which longer expressed the meant sense, instead, presenting a socially constructed representation loaded with judgement. When language is used in a limited or over-worn way, it can precipitate the foreclosure of other ways of thinking and different perspectives: other diverse social constructions infused with localised, temporal cultural values. The term suicide is encumbered by semantic association; when it is accompanied by the word commit, for example, which in itself is a worn-out concept since, in the UK, suicide is no longer a criminal act, the meaning of what is being expressed takes on an inevitable unspoken aura of unacceptability. Suicide is a concept wrapped up in ba, guarded by silence, and when a psychotherapist commits suicide (sic) brings additional alarm, shame, taboo and, thus, a deeper silence.

Molly couldn't say, '*thinking about suicide'* or '*jump in front of the train*', instead '...*it would be easy to just, you know*...'. The observation is how difficult it is to say *suicide* or use sentences like: *I felt like killing myself*.

In talking about what could shift the *double whammy,* as Molly put it, of psychotherapists-with-suicidality, we considered the difference it might make in calling suicidality a metaphor for change:

> *Molly: Suicide is a metaphor, that you want things to change quickly.*

Suicide as an emotion or metaphor, I felt, exemplified how re-attuning language could shake up worn out ideas.

Another alternative was to think of suicidality as an emotion:

> *Martyn: So, what difference would it make if we engaged with it as an emotion?*
>
> *Molly: '...rather than panicking because you've had a suicidal thought, ...emotion is fleeting... transient, not stuck down ... [so] it softens it ... reframes it as more readily accessible than jumbled, distressed thoughts.*

My selection of the word *suicidality* was for a particular reason. I wanted to open up all degrees of suicidal thought and feeling. It was intended to avoid excluding any expression or experience that would come under the umbrella of the suicidal state.

Molly had a different perspective on language that was relevant for her regarding her suicidality:

> *Molly: There was a quote I wrote down after I saw you. I don't know if this rings true, it's talking about the limits of language… it's Nietzsche from 'Twilight of the Idles': '…"that for which we find words is something already dead in our hearts." There's always a kind of contempt in the act of speaking.'

Martyn: That's quite profound. How do you understand that?

Molly: Well I think it's partly to do with… when we say something, are we really saying what we mean. Because, in a sense, once you've put something into language… it's kind of lost something, hasn't it.

Molly took us to a place of questioning whether the words we use when we talk about suicide - and in extension, the word 'suicidality' itself - could truly reflect the emotion of that state of despair:

Molly: Because an emotion is fleeting isn't it. It's transient. It's not stuck down, it's… something that comes and goes.

Martyn: …and yet, if suicide is an emotion… if suicidality is an emotion, why is it that we find it difficult to bring that in as well…?

Molly: Well because we don't use the word emotion, we use the word 'ideation' … Which is different to emotion. Because ideation, as an idea and a thought, is something that's more processed, isn't it. Whereas an emotion is raw. And it's fleeting. And it's transient … it's interesting, if we had the concept of suicidal emotion, would it change this taboo…? … I suppose that's what I'm saying about

language. It's actually not what you say, it's probably more important in what you feel.

4.3 Verbal Exchange Coding, interaction dynamics and reflection

This section aims to address the research question:

How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?

The section talks about the styles of communication in the six interviews, filtered through the five categories of verbal exchange coding (see below). It then reflects the interactional dynamics. A verbal exchange coding protocol was followed to extract discussion and reflection points. The verbal exchange coding steps (a) and (b) are summarised here (described in more detail in section 3.11):

Step (a) involved writing out each interview in a novelistic way that brought to life 'what gets said between the speakers,' including nonverbal cues and pauses, as exemplified by Goodall (2000: 103).

Step (b) involved producing codes, and expanding on a description of those codes, following five categories of exchange typology: (**P**) *phatic* communion (politeness/ ritual); (**O**) *ordinary* conversation; (**S**) *skilled* conversation; (**N**) personal *narratives*; (**D**) *dialogue* (Goodall, 2000: 103-110). The coding then helped steer reflection points on the interactional dynamics in the interviews along with important clusters of verbal exchange. This yielded insights into the underlying tensions, fears, motivations, and courage, in talking about one's own suicidality as a professional psychotherapist.

The descriptive accounts of the interactive interviews with Theo, Eve, and Molly, were re-written and novelised shortly after transcribing them in the days following the interviews. This aided accuracy, particularly around the non-verbal cues.

Coding and reflections on the interview dynamics

The beginning of each encounter involved mostly *phatic communion* (Goodall, 2000), with practical considerations being discussed. There was also *dialogic* communication as we opened up to each other. In the early stages of the first interviews, we discussed the traps we might encounter, in particular to be careful the interview didn't fall into being a therapy session. While shaping the way I coded the interactions, I often *upped* the code from lower (phatic/ordinary) to higher-ranking (skilled/dialogic) in response to these therapeutic and logistical exchanges. An example would be:

> *Theo: Do you want to hang [the coat] on the back of the chair?*

This had the tone of an ordinary exchange, but the feel of a dialogic one. The initial interactions were interesting with all three participants because of the use of therapist vocabulary. For example:

> *Theo: You've come a long way… what do you need? …come into the room…(etc).*

The familiar language shifted the tone and meaning to something more ritualised (Denzin, 1997). It changed the way I coded much of the remaining conversation such that, for example,

'what do you need?' shifted from being coded as *ordinary* to *skilled* + *dialogic*. This is addressed further in the discussion as a potential limitation of verbal exchange coding.
Eve and I deliberated the impact of our specialist psychotherapist language in the first interview, and how our perceptions are shaped by it.

> *Eve: It's easy to forget we didn't always talk like this…*

Specialist language could function as a cushion disconnecting us from the rawness of our memories and experiences, or a hook pulling us into therapising each other. All three participants took the lead in the interactions from the outset and sank into their therapist identities to a greater or lesser extent. The stylised performance (Goffman, 1990) could be heard in the tones of voice and seen in the mannerisms.
All three were being interviewed in rooms they use for therapy. In the case of Theo, he sat in his therapist's armchair, and I on the client's sofa. In the case of Eve and Molly, we were in their therapy rooms but re-organised the furniture to break into the script and try to ameliorate our 'trained incapacity' (Goodall, 2000: 109) to authentically see and hear.
After the pragmatic exchanges, all three participants proceeded straight into their stories. Theo told his story in a fragmented way. He seemed uncertain about how to proceed and sought guidance. Eve came across as confident and was very open and eloquent in the telling of her story. Molly's *narrative* was bold, creative, slightly eccentric, but slow and precise.
Theo described a life-long disavowed self, and how he '*just didn't want to be living this life*.' He was uncomfortable about using the words suicide and suicidality. Eve's story was one of sexual abuse, substance misuse, trauma and being an outcast in her family. Molly painted a dark story, of dreary city streets filled with brutal realities: loss, death, fatal accidents, pub-toilet suicide attempts, loveless family life, compassionless responses.

Humour was a feature in each interview from the beginning, but particularly with Eve. It helped ease us through our anxieties into tentative initial disclosures. Eve and I quickly established a comfortable rapport and a more immediate route into exploring our suicidality. However, our sense of connection was double-edged; it aided *dialogical* engagement, which felt positive, but I was also anxious that our 'ease' could become like a therapy session. This anxiety was fuelled in part by Eve's first interview immediately following Theo's. In Theo's first interview, there was a rupture over the interpretation that therapy was happening *by the back door*. My concern was that this would repeat with Eve. However, the relaxed playfulness with Eve allowed us to speak openly about these concerns as and when the arose, helping us regulate the encounter holding these issues in mind.

The first interview with Theo was delineated by a rupture we experienced around turn-taking. Theo contended a 'rule-violation' (Goodall, 2000: p. ?) after I had read a piece from a diary describing my suicidality. The briefing information and phone conversation with each participant was designed to provide clarity that the interviews would be two-way interview, rather than a traditional one-way design. I'd noticed that turn-taking had been laboured until the point of the rupture in the first interview. Theo responded to my reading with clear discomfort and suspicion:

> *Theo: I became increasingly uncomfortable…… that this had become your therapy session... and I felt, hang on a second, that's not within the frame of this.*

Theo and I explored this more reflectively:

> *Theo: …at what point does it slide across from mutual exploration into therapy and how much of the autoethnography element is to get some part of you healed?*

This 'unexpected turn' (Goodall, 2000: p. ?) changed both the pace, flow and relationship between Theo and I, as we wrangled over whether there had been an ulterior motive to my diary reading. The interpersonal flow was disrupted by the rupture, and this issue became the dominant point of discussion. The second interview offered us an opportunity to reflect and understand the unseen dynamics that might have played a part in sabotaging a difficult conversation.

Consequently, in Eve's interviews, I was again anxious about the impact of my own self-disclosures. I wanted to be sure Eve was comfortable with me doing so. So we spoke explicitly at the beginning of the interview, and agreed to be mindful not to *therapise* each other, avoid *othering,* but '*be with* 'each others' experiences (not sure what is in quotation marks here and where italics should begin or end??). These exchanges moved us into dialogic conversation early on:

> *Eve: It's a heavy topic... painful to talk about …This is why people don't talk about it.*

With Eve, there was an apprehension about *what's going to happen* in the interviews. Theo appeared the least comfortable with the endeavour, whereas Eve took the lead, explicitly contracting around being able to' slow down 'or 'stop 'if necessary. Molly was the least bothered by the interview protocols and seemed content with the opportunity to talk about something she'd never told anyone before.

In the first interview with Eve, there was a noticeable shift of conversational form after we told our suicidality stories. The flow and responsiveness to each other's narratives deepened, and this remained alive throughout both interviews. There was a feeling of increased interpersonal confidence. It felt like any potential rupture or violation would be intercepted well before it became a problem.

In all the interviews, the psychological space where we joined and separated ebbed and flowed throughout. These shifts in the contact boundary (Yontef, 2001) became a strong point of reflection. There were times when I felt deeply connected, and other times it felt like a shutter had come down. Progress into *dialogic* contact was often tentative and sometimes abruptly disengaged with, particularly if the exchange headed into difficult territory. In Eve's case, the early contracting helped. For example, asking for a top-up of water could be an innocent event, but could also function as a delay in the telling of my story. Our contracting meant that we could notice this and understand that I might need time to regulate my anxiety and prepare. Probably because of the strong contracting, these moments were often accompanied by humour, which helped us relax back into the conversation, although it could also be a diversion in itself.

Talking about our psychotherapist suicidality was difficult no matter how we tried to make the event more comfortable. When *narrative* exchange took centre stage, as it often did in the early to middle sections of the interviews, we swung between story and explanation - *narrative* and *skilled* conversation - as we attempted to make sense of our experiences. We reflected on our psychotherapy knowledge, and what function that served, or how we could spot it drifting into the exchanges.

Eve seemed to need no guidance and no instruction, taking cues in the encounter mostly intuitively, and our rapport remained intact and consistent. I reflected on how easily and without a fight I seemed to hand my power and status over to Eve, even if temporarily - for

example, the opening contracting was initiated by Eve. For Molly, again, other than the humour we engaged in about what chairs to sit in, there appeared to be no issue.

In all the interviews, there seemed to be parallel threads of work taking place: the work of discussing psychotherapist suicidality and the work of regulating safety and flow in the interview. There appeared to be implicit knowledge from the outset that we needed to regulate emotions. Eve talked about '*three difficult weeks'* leading up to the interview, something that prompted a useful conversation about relational ethics and her right to see what's written about her, request changes or withdraw completely. Humour, again, helped us through these trickier details and it was noticeable how moments of humour led again to a deepening of the dialogue.

I was aware in Theo's first interview that I had been measuring his appropriateness for the study in terms of how much suicidality and when? As his story unfolded, I found myself contemplating: 'W*as this enough?'* Contrarily, with Eve I had been measuring my own appropriateness, in the context of Eve's powerful story. Conversations in the interviews themselves helped dissolve these concerns, as we concluded that suicidality was different for everyone, which helped us agree that all suicidality was valid. Theo's suicidality had always been there just beneath the surface, and could re-emerge if triggered, particularly by issues around his father. This had been very similar to my story, and so mutual understanding developed through empathy.

The opening verbal exchanges of the second interview with Theo were dominated by *phatic communion* as Theo and I talked directly about *the dynamics now known to us.* Getting things straight following our rupture in the first interview facilitated a more conscious exchange, free from the suspicion or double meanings that had dominated our projections in the first encounter. The amount of *dialogic* communication more than doubled from the first to the second interview.

Different degrees of interpersonal effectiveness in the exchanges brought up the potential of gender-based differences. The exchanges with Theo felt more competitive than with Eve and Molly. I wanted to appear confident and in control and was anxious about making any mistakes. I felt we were checking out each other's competence or proving oneself to the other. That feeling wasn't in the room with Eve or Molly. I reflected whether gender difference had an impact, or whether it was more simply about personality. It was noticeable that the comfort level improved in all the second interviews. So it could also have been about familiarity with the process.

These thoughts sit against a context; that changing a traditional social science interview into a bi-directional event requires a strong sensitivity and watchfulness over how it might impact the researcher and participants' relational dynamics. It's an unusual method in social science, and unfamiliar to all. Interrupting the traditional qualitative interview *world view* (Watts, 2011: p. ?) can create disruptions and challenges beyond mere practical considerations. This was Theo's first experience of two-way interviewing, as it was mine, so we both may have been primed with unease.

Ultimately this appeared to have positive outcomes, including the opportunity to notice from a process point of view how the two-wayness of the interviews changed things. The exchanges were unique, specific, and idiosyncratic, which was a win for interactive interviewing. But the discomfort of the process resulted in, for example, Theo defaulting to his therapy self. Conversations about each other's suicidality would never be straightforward but add in two-wayness and those conversations can get tangled-up with different expectations about interview procedure.

After Theo's first interview, I was more consciously aware in the other interviews that two psychotherapists in conversation would find it challenging *not* to be therapists. Being on the client's sofa in Theo's first interview was inadvertent, but again something that impacted and

shaped what could happen for us psychologically. Although the interactive method was in part an attempt to balance status, it created an anxiety that activated the more familiar therapist status. There was a soothing aspect to assuming one's therapist identity, as Molly pointed out through wanting to hang on to her therapist chair.

Given this, I felt that running two interviews per participant was particularly important. With all participants it gave us time to reflect and return to the conversation. With Theo, it offered a much-needed opportunity to repair our rupture. Each second interview felt very different as a result. The relational contact was more genuine and flowed better. With Theo, although we kept hold of our respective views on the rupture, we were better placed to hear and acknowledge the other's perspective. With both Eve and Molly, the second interview offered a space that had been tested out as safe and facilitated a greater depth of exploration. We were able to reflect, make sense, and better hold any distress or anxiety present after the first interview.

All the organising and clarifying activity was about benefiting the exchange and increasing the depth and detail of 'rich points' (Agar, 1994: p. ?). The room Eve and I were in was a group room, with chairs, cushions, a couple of coffee tables. On a few occasions we pulled some of the furniture about to get it more comfortable. It felt like we were making the room ours and, along with the contracting around breaks and pauses, this set a tone in our interaction of being relaxed and flexible, hence open to playfulness. I felt alive to that playfulness. There was a way of being together that we were attuning to. It felt like a kinship, so had a cultural channel that we both identified with. That intrigued me. When Eve disclosed that she had been a *British drinker*, it partly explained the playfulness. Not that playfulness has to be associated with alcohol, but it reminded me of a sub-cultural familiarity of gentle pub banter. This *allowed* creativity and set up a relaxed tone. With Eve, I didn't have a lot of concern about the potential for rule violation, because the 'rules' such as they were - mostly about boundaries, safety-valves, or breaks - were being oiled by our unspoken sub-cultural affiliations. The playfulness

lifted us away from formality and helped melt any notion of fixed identities and roles in a traditional interview setting. I fed from Eve's relaxed confidence, which made the experience enjoyable.

All the encounters had aspects of fun, creativity, and insightfulness. We were all aware that we were negotiating a difficult subject matter; the playfulness eased the process.

Something that I was left with following the interviews, was the enthusiasm from all four of us for a deeper sense of care within the psychotherapy world. All of us talked, almost inevitably, about our training experiences. We all felt that, given the experiential nature of the psychotherapy training we'd had, there was a missed opportunity to safely explore the characteristics of suicidality. It felt to us that fear and lack of understanding resulted in a reluctance to explore suicidality in general, but particularly regarding ourselves as psychotherapists. When I reflect on this missed opportunity in my own training, to explore 'whether life is or is not worth living?' (Camus, 1955: 5), I feel a sense of disappointment; I find myself asking, if not here, where else could we engage in a deep, reflective, compassionate examination of suicidality? This is a strong *rich point*, that is discussed further in the next section.

Reflection: An Autoethnographic Interlude

Before moving on to the discussion, I felt it was important to bring in some elements of my experience, and reflections on that experience, of running this research project. This taps into the 'what happened' (Goodall, 2013: p. 204) lens in this study, and I felt it important to include this as it enriched the relational-process aspect of the autoethnography.

This 'interlude' is in two parts: The first, 'The Abyss', is from an autoethnographic exploration of the early parts of my research and the fears and expectations I experienced, whilst the second part, 'When I got there it wasn't what I had imagined at all,' is a poem written at a time during my research journey when I felt let down by, and at times alienated, from the world of psychotherapy and counselling psychology training.

The Abyss

I remember many years ago attending an evening course on creative writing. One of the concepts I took from the course was a hypothesis of how drama is structured - I think it was called 'the Disney formulae' (though I might be wrong) and it went something like this:

There's a protagonist who, confronted (often unwittingly) with a conflict, has a number of failed attempts to solve the problem, resorts to back-up plans, has a breakthrough that works and finally wins out.

But... there's also a revision to these formulae:

After the breakthrough that works, when least expected, there is a catastrophic twist that throws the protagonist and the cause into the abyss. Dot dot dot...

Contemporary script writers and film makers can play around with what happens next. The Disney ending is to miraculously return fortune to its feet as the protagonist achieves something, often superhuman, and somehow saves the day. Alternative stories leave the protagonist and cause dead in the abyss. Some movie makers revel in this loss of hope (my current modern favourite is Yorgos Lanthimos).

One difference between story writing and real life, is that all us protagonists have no idea whether we're going to get the Disney ending or the Abyss. Further, even if we finally win out, it's possible that the trauma of battle takes such a toll that we simply no longer give a fuck. And with trauma and abyss on the *inside* often not apparent on the *outside,* all the people around us protagonists just don't get it. Consequently, trying to explain 'it' becomes tiresome and miserable, and simply adds to the desire to shut down contact with the whole human race and give in to sedation.

The truth was, I still found it hard to write about my own suicidality. My proposal and ethics applications were both signed off in July 2018. In the meantime, I had become aware of two competing feeling-selves. The first, stubborn and proud, wanting to strive on with the research, had kept going through the hard months of grinding out revised proposals, wouldn't accept defeat. The second feeling-self: raw and direct, was a version of me that wanted out, felt exposure from the stripped-back ozone layer, heeded what I believed to be an unspoken wish from my academic supervisors to give this up, whispered in my ear, '*you can still choose no, you don't have to do this, save your dignity*.' I felt the invisible eyes of judgement from academia and clinicians over how this might affect the image of their (sic) profession.

I lived out the anxiety of my research before the project had even begun. As a trainee psychotherapist, the forces that stopped me from opening up about my suicidality mostly orbited around a fear of not qualifying. As a qualified psychotherapist, writing these reflections, fear was still alive and scheming, squeezing my guts and clawing at my spine, hankering me to shut down

this ludicrous endeavour, afraid of the unknown consequences of saying the words 'sometimes when I'm really distressed I think about killing myself'. The difference between then and now was that...each...next...word...I...wrote... was not driven by stubbornness and pride, but by an earned conviction, born of and reinforced by the (conviction) that this research was vitally important. I could not justify backing down, particularly in telling this story in my own way, not in a way fed to me by an academic institution that hadn't courageously engaged with the suicide of one of their own, or even granted me a face-to-face meeting, after twelve months of asking. I could now re-assert... with... each... next... word... I... wrote, that I must rail against fear and honour the timely need for this research.

I can rail against fear, but the shame never leaves

Suicide falls into the category of secrets and shame (Reeves, 2010: p. 128). I felt an implicit judgement, just from writing the diary entries in this chapter. At the point of writing, no-one had seen it, no-one had read it. Still, the visceral pull from my fight-flight system, the cold wave that washed up my spine and into my neck and arms... that frozen disquiet, delivered terrible ignominy. The call from my bones to delete the prose, erase it, feel the relief, dodge the bullet; was powerful and compelling. But suffering has its own rights. This was the beating heart in the beating heart of my research. If the goal was to dismantle barriers, challenge stigma, engender mutuality and abridge *othering,* then *it* had to survive. And so did I.

When I got there, it wasn’t what I had imagined at all

The pictures I'd seen in the travel brochure portrayed
a beautiful enticing bay, with sandy shores and bathwater
warm, calm inviting shallows. When I got there, I found

a steep pebble beach, uncomfortable to navigate barefoot, the stones too hot and jagged for soft novice Devonian feet. When I waded into the water, it was deep beyond my stature, only several yards in, my toes lost the ground. I fought to stay afloat as the seawater, warm in patches, ran with icy currents that shocked my skin, while salt spray lashed from unsettled breakers, eyes stinging, expectations waning.

In the brochure, gentle tree-lined hills framed the beach, conjuring late afternoon daydreams, strolls up through easy-breeze, effortless well beaten paths, to peaks; where staggering views of the surrounding islands, palms and turquoise seas, would lift the heart to the heavens in disbelief, that there could be such beauty.

But the trees turned out to be thick and tangled scrub, hard to fight through, tricky to handle, bearings lost; the view obscured by a high dark green canopy, the air sticky humid haze, that made the pores pour and the clothes saturate.

No gentle climb, but sharply inclined, even vertical at times. Cut hands and blistered toes from an ascent that, far from being satisfying, took a heavy toll; not least, on the blown, battered expectations of a steady evening stroll, an exalting wilderness 'there and back home'.

Never did I imagine, I'd be gone so long.
The brochure was emblazoned with a slogan: we are already
friends, we just haven't met yet. I took that as reassurance,
a universal warmth of dwellers, as I saw, who's meeting would
be the biggest pleasure of all.

When I got there, things were not so simple, so straight forward.
There had been warnings from those who'd been before, people
who had stepped out into similar places sounded sirens and horns.
'*They hadn't been to my place, they didn't understand m*e'
I muttered away from hearing. I *knew* it would be different,
more friendly, less fraught. 'They think they know best'
I thought; they're just doom mongers, nay-sayers, judgement
passing, where they never ought.
But the brochure did not show the frowning and ghosting,
and being led with faith, to where mosquitoes plagued,
and being promised sunsets, but steered into rain.
And walked into nests of red ants that crawled,
up trouser legs and bit at soft skin;
nowhere were the warning signs, that the blue
cloudless skies could be marched upon in
minutes by thunder, bites and violent squalls.

When I got there, It wasn't what I had imagined at all.

CHAPTER 5: DISCUSSION

Throughout this discussion I will revisit and reflect on the interviews and their findings, using rich points and process reflections to frame the discussion, while revisiting the literature review to provide a context. I will review the relational ethics approach, which became a vital component for this study to be completed safely and successfully. I will explore the outcomes and experiences of the participants, including the meta-discussions about research that took part in the interviews. I will contemplate the experiences, challenges, benefits, and limitations of investigating psychotherapist suicidality and offer recommendations to the field of psychotherapy as uncovered by this study. Finally, I will provide a synthesis of the recommendations including aspects of organisational change in psychotherapy institutions and training.

5.1 Introduction

The aim of this study was to bring together psychotherapists, including myself, who have lived experience of suicidality, and ask them to talk about their suicidality in a series of discussions. I carried out semi-structured interactive interviews with three qualified psychotherapists, each of whom I interviewed twice, asking them to talk with me about their own experiences of suicidality, and inviting them to ask me about my experiences of suicidality. I then carried out two types of data analysis to answer each of two research questions:

- *'What do therapists say when they talk about their own suicidality?'*

- *'How are the accounts of suicidality co-created by psychotherapists with histories of suicidality?'*

The first question sought to uncover rich points (Goodall, 2000: 108) from the discussions, *about* psychotherapist suicidality; while the second focussed on the interpersonal process of doing the interviews: what happens *between* psychotherapists when they attempt to talk about their suicidality. Because 'autoethnographic writing is based upon and emerges from relationship and context' (Anderson & Glass-Coffin, 2013: p. 57), the relational narrative produced by the participants and the researcher, although contained and protected, *re*created historical feelings and urges, that both moved us away from narrating and brought us closer together. As well as posing in-the-moment emotional regulation demands, broader methodological considerations arose that form part of this discussion.

In order to explore the methodological challenges encountered in this study, the ontology and epistemology underpinning the research will be discussed.

5.2 Discussing and clarifying the ontology and epistemology underpinning this research

'Like autoethnographers, phenomenologists do not hesitate to write from their own point of view; in fact, they insist on it.' (Poulos, 2021: 15)

Amongst other traditions, autoethnography can trace its roots back to existentialism and phenomenology. Phenomenology is 'the study of structures of experience ... organised through the lens of conscious experience' (Poulos, 2021: 15). Heidegger spoke of being 'thrown into the world and left to carve out meaning from the raw material of existence,' (Poulos, 2021: 15). It is the sense of thrown-ness, of emerging into a clearing laid bare by worldly objects, a space of

uncertainty within which to construct self and meaning, that resonated powerfully. From a personal viewpoint, the researcher had always identified themselves with phenomenology, and when encountering autoethnography as a research methodology that has its philosophical roots in phenomenology and existentialism, a sense of *fit* was experienced. Something made sense in terms of placing the self at the centre of '...the demand to account for the co-construction of social reality in all human interaction' (Bochner, 2001). So, the researcher *felt* their way into a befitting epistemology, seeking out resonance with their core introspective values. As Pitard (2017) proclaimed, 'the positionality of the researcher in relation to the data is based upon philosophical beliefs and assumptions accumulated throughout a lifetime which inhabit the unknowing mind of the researcher' (Pitard, 2017: 2). Rather than a factual, academic search for the correct theoretical approach to this study, the researcher sought direction from '...own life experience, and unconscious assumptions, collid[ing] with a moment of cultural confrontation' (Pitard, 2017). This facilitated the researcher to discover, rather than identify, a sense of an abstract theoretical correctness, the philosophical heart of the study.

Camus stated, 'the existentialist project is primarily one of crafting or carving out a sense of meaning in an absurd universe' (Camus, 1955; Poulos, 2021: 15). It is '...stream of philosophical thought for the practice of working out ideas, cultural critiques, and insights...' (Poulos, 2021: 15). Rather than honing and polishing a work with a neat finish, I wanted to reveal the unfinished messiness of human phenomenology. I wanted to allow dialogue to be 'spontaneous, springing from a stillness of mind which allows our past experience to guide our present' (Pitard, 2017: 2) Poulos (2021) describes humans as 'storytelling creatures' (Poulos, 2021: 16). Following this, the researcher experienced a natural draw to write their own self-in-culture story. In the current research study, there was an intention to explore 'the symbolic, collaborative, performative, constructive, interactive, and often ritualistic nature of social engagements between human agents' (Poulos, 2021: 16). But, not with the aim of producing a finely honed set of answers or undigested themes, but to

show that human phenomenology, as explored via autoethnography, can 'reach beyond objective and realist constructions of texts' (Poulos, 2021: 15).

5.3 Methodological challenges

This lived experience interactive study was designed to access what Derrida (1974) referred to as *aporia*: the joy in celebrating the inherent and irresolvable internal contradiction or disjunction in a text, argument, or theory. The joy was to produce rich, meaningful dialogue, in which myself and my participants were able to feel *heard* in relation to our lived experience suicidality. That became a valuable commodity. I contended that the interactive element of the interview method was instrumental in achieving openness, and that trust achieved through mutual dialogue negated othering (Goodwin, 2017). Eve embodied this in a key moment in our interview: '…*when you talked about isolation, I suddenly felt understood,*' while Molly's epiphany around naming suicidality was, for her, transformative: *'I can finally talk about it.'* These words helped bring validation to this research endeavour.

In terms of generalisability, it wasn't desirable to establish whether psychotherapists were at-risk with suicidality. Literature pointed to a reality of psychotherapists being at least as at-risk in comparison with the general public (Pope and Tabachnick, 1994; Kleespies, Van Orden and Bongar, 2011). More relevant was how psychotherapists who experienced suicidality responded to it and were held by psychotherapy institutions (see section 5.9).

The choices made around methods and methodology aimed to create a more even research surface where researcher and participant could ask each other questions and explore each other's experiences of suicidality. The research aimed to initiate a process of reflection on the challenges of this style of investigation. It also increased the challenge in carrying out this study, along with the compulsion to head to safer territory – something I have touched on

previously when reflecting on the anonymity choices of participants and researcher/participants.

5.4 Discussing Verbal Exchange Coding (VEC) as the approach chosen to analyse conversational data, especially in how this focusses on use of language

Culture is more than something that people have, 'it's also something that *happens to you* when you encounter differences, become aware of something in yourself, and work to figure out why the differences appeared′ (Agar, 1994: 20 - original italics). Returning to this study, it is the impact of the differences as well as agreed meanings, figuring out, the 'speech acts' (Agar, 1994: 141) that became the subject of study. So, when considering the core event(s) of interest in this research - two psychotherapists together in dialogue - a number of things came to mind. There was an idiosyncratic language style of the psychotherapist that was not just about the vocabulary and language, but was evident in how the person held themselves, the vocal tone and style, careful auditioning of each next speech-turn, focussed attendance to their delivery, the potential impact of that delivery, etc. A psychotherapist in conversation with a kindred psychotherapist might in addition talk differently, act differently, feel differently, than when talking with a non-psychotherapist. A psychotherapist in conversation with another, but talking about a difficult subject, might experience differences and obstacles, revealed in how the conversation ebbs and flows. Psychotherapists, I had observed from the beginning of my training, had a way of being, or, languaculture (Agar, 1994). A psychotherapist joining voices with another psychotherapist, where there was an implicit awareness of sameness, was also stepping inside a mutual circle of culture. Both therapists were now adjoined in what Agar referred to as, 'inside the language circle' (Agar, 1994: 14). By this, Agar (1994) meant that the implicitly agreed way of doing things, as well as saying things, was based on 'what is comfortable for two speakers inside the same language'

(Agar, 1994: 14). The doing part of this notion, the 'sameness and comfort experienced,' (Agar, 1994) can be attributed to the culture inside the language and the act of speaking, as opposed to culture being something that happens separate from language. Knowing who 'us psychotherapists' are could ease the conversation via unspoken confirmations and agreements; the fluency in the dialogue - the vocabulary, grammar and the dictionary - activated a growing awareness in two speakers as they conversed, that they either come from a similar languaculture, or may come from different meaning systems, or *cultures*.

In this research study, there was a shared language and meaning system in the interview dyads. However, each core event in this study - the participant-researcher interview dyad - was being presented with a phenomenon to discuss - psychotherapist suicidality - that was not only likely to be a difficult conversation per se, but one that might be perceived as *not belonging*, or not being culturally welcome, to this idiosyncratic languaculture circle (Agar, 1994).

Suicide and suicidality were revealed to be more than words from a dictionary; they had human meanings that went far beyond their formal definitions, and those meanings were framed by languaculture. If suicidal phenomenologies were experienced uniquely by different individuals, then culturally located conversations about suicidality were likely to reveal shifting, contending, dyadic acts behind and through the speech itself. In this study, I wanted to explore how the shifting cultural meanings were dealt with by the participants, as much as what they said. This made Goodall's (2000) Verbal Exchange Coding system appealing in terms of a 'representational move ... [to] conceptualise forms of verbal exchanges as existing on a continuum between "phatic communion" and "dialogue" (Goodall, 2000: 102). Using this system, conversations were represented on a sliding scale through a continuum of five communication styles: phatic communion, ordinary conversation, skilled conversation, personal narratives, dialogue. There was an upward movement, from the 'ritual interaction of phatic communion through to transcendent higher levels of spontaneous mutuality' (Goodall, 2000). I was immediately drawn to the *fit* between

this analysis system and what I was interested in analysing. Using this lens would aid me in noticing the gradation between '*I-it* and *I-though*' (Buber, 2008).

In the *I-Thou* encounter, there was a togetherness that transcended basic interaction. What became essential was how one was with another, in their own heart, as well as mind. In the *I-It* encounter, one related to another as though a detached object. The key difference was that in dialogic conversation, the dyad was experienced as merged and spiritual, whereas in phatic communion, or 'ritual action' (Goodall, 2000: 103), each half of the dyad experienced the other as outside of their self.

The shift into dialogic communication helped to 'melt the circle' and jointly explore through contact boundaries that were permeable, as opposed to the separated, impermeable contact membrane that two people in phatic communion experience.

If 'culture has to do with who you are' (Agar, 1994: 21), then we might expect the *who* of being a psychotherapist to impact the flow and style of movement up and down the continuum, from phatic to dialogic and back, to shift depending on who you were, how you related or identified with an other, to ultimately, reveal culture. If 'problems in communication are rooted in *who you are*, in encounters with a *different mentality*, *different meanings*, a *different tie* between language and consciousness' (Agar, 1994: 22 - original italics), then analysing the shifting communication style, noticing problems that emerged, attending to how I-it and I-thou unfolded, noticing how problems were resolved, would yield insight into how a phenomena being discussed was managed in the dyad. It would reveal the inside-circle responses to the phenomena being discussed, given that the *problem* might be that the phenomena was not considered appropriate or wanted inside the languaculture circle.

Verbal Exchange Coding seemed a good fit to '"catch" the culture' (Agar, 1994: 24 - original apostrophes). It would reveal *Rich Points,*'tasty, thick and wealthy' (Agar, 1994: 100). 'The rich points in a languaculture you encounter are relative to the one you brought with you' (Agar, 1994:

100); it can mean the difference between 'servicing the relationship ... and assuming the relationship is fine' (Agar, 1994: 101). This in itself might be influenced by the topic of conversation and how each half of the dyad responds. Since '...conversations have permeable membranes...' (Agar, 1994: 142) and [don't] move in straight lines, it's "aboutness" drifts around' (Agar, 1994: 142 original quotations), the way a conversation mutates, drifts, slips through membranes, returns, with intention, without intention, sliding like a living creature into depth and back out - can reveal rich, *thick* material. 'The rich point isn't some particular word or grammatical rule; instead, it's something people are doing with them' (Agar, 1994: 144). When it comes to a topic being discussed that is difficult and having an impact on the way the dyad is functioning and flowing, 'the problem isn't a word; the problem is you don't know what's happening or how to do it' (Agar, 1994: 144).

5.5 Relational Ethics

The interviews I carried out for this research had unique relational and ethical challenges. In one sense, talking about psychotherapist suicidality was no different from talking about suicidality in general, in that people struggle with it as a subject to discuss. In another sense, aspects of identity and sub-culture made psychotherapist suicidality markedly unique, and those factors could render talking about it much more challenging. Maintaining relational ethics by keeping open channels of dialogue with the participants prior to and after the interviews proved vital. This allowed for a mutable responsiveness whereby any part of the research could be held to account against ethical considerations at any moment during the study. The importance of this was apparent in the first interview with Theo, which resulted in a rupture (described in 4.3 and 4.11), followed by correction and repair. It was my first interview in the study, and my intention had been to use creative, expressive channels (e.g. song, poetry, art, journal readings) to facilitate the dialogue and *shake open* the conversation. It was

my first and last attempt to do so and proved early in the study how carefully I needed to be in approaching these conversations.

Part of the justification for including my own lived experience was to avoid the participants feeling *othered*, which might then engender a more mutual interview experience via balanced dialogue, and facilitate greater depth and detail in the conversations. Yet, the first interview revealed that the two-wayness of my interview method required sensitivity and care in its approach, partly due to how uncommon it is as an interview method. Avoidance of othering couldn't come at the cost of a safe, ethical experience for the participants. Relational dynamics in the interviews, and expectations about what might take place in the conversations, needed to be ensured, including full and complete understanding that this was interactive and that details about my own suicidality would be disclosed. This hadn't been made as clear as possible with Theo prior to his first interactive interview. The reparation work between the first and second interview, which involved reviewing the information I had provided and making sure the language was plain and direct, was a priority. Conversations with Theo to get an understanding of what was needed and what further changes might improve the likelihood of this method being successful, were also essential. The relational ethics task became, simply, to hold this subject with as much care as was possible. It is important to say that autoethnography, with all it's progressive, pro-social justice approaches, has a clear therapeutic dimension to it. In defending the research-therapy binary objections emerging in the field work, autoethnographers are also obliged, via relational ethics, to make collaborators and participants clear and aware of this.

Anxiety and uncertainty were apparent in the interviews, often revealed via physical positioning and negotiating around such things as the room used, who sat in what chairs and where, and the aspects of the interviews that would keep people feeling safe, like refreshments, breaks and time boundaries. The reality was, I hadn't accounted for quite how

powerful the weight of the topic matter would be in terms of its impact on the interview dynamics. It became increasingly apparent once I'd commenced with the interviews that keeping open dialogue about the meaning of those safety needs was essential.

Beyond Theo's first interview, the resultant changes of employing straightforward language usage in pre-interview documents and information, combined with more frequent - and more direct/open - communications and check-ins with all the participants, formed a revised template for the research a whole.

Constructing these interactive interviews as *verbal exchanges* helped in applying a framework for systematically processing data from the interactive interviews. We were four people in a contained, ethically regulated research space. Yet the three participants, and I as researcher-participant, were also merely four people each with a shared part of their life history - the suicidality part - having conversations about it. We were each people who had trained as psychotherapists and had also experienced suicidality. Taking part in the exchanges was touching and powerful. On a personal and professional level, it felt important to have met these three people. Experientially, the endeavour could have stopped there. Yet all four of us agreed that these conversations needed to be constructed and presented as research. From a relational ethics stance, it was important and encouraging to have their blessing as well as consent. What was important for me was to get the balance right in honouring the participants' stories as they stood, while bringing to the surface knowledge and understanding that could influence the way psychotherapy and counselling psychology approached the *subjecthood* of suicidality.

5.5 The vital importance of attending to language choices

As I progressed through my research journey, I became more sensitised to the way language was used in broader contexts. For example, I became uncomfortable when I heard the phrase

'*committed suicide*'; at used work in my primary mental healthcare job. Further, I began to pick colleagues up when generalisations were made about what '*they*' might think or do. At a suicide prevention launch, I heard the clinical organiser, megaphone in hand, state '*they're not so different to us…*', which conjured up how subtle and stealth-like, if unintentional, othering statements could be. I noticed when language was avoided, often to prevent discomfort; for example at a memorial ceremony I heard that, 'Rachel *died*...' rather than '...Rachel 'completed suicide', or 'took her own life', or 'killed herself'. The power of language in reinforcing and perpetuating stereotypes, assumptions and unchallenged 'regimes of truth' (Marsh, 2010: 2) and the importance of challenging our use of words was, in my view, one of the most immediate tasks.

A final point about language involved the way therapists and trainees were responded to when they were in distress or experiencing suicidality. Grant (2001) argued that Rogerian influences pervaded [psychiatric nurse training] curricular and groupthink … [and] seep[ed] through module development and educational delivery (Grant, 2001: 4). I would similarly argue that the psychotherapy theories that are taught in training institutions, along with their idiosyncratic languages, were used pervasively in all aspects of the educational experience and beyond, with no demarcation. My conviction was that there needed to be a space where non-therapeutic language, based on ordinary (sic) conversation, existed. A co-production framework that strove to achieve this amongst medical trainees I worked with in 2019 was a coproduction framework, called a Community of Enquiry workshop, which allowed trainees to denote their own agenda and language to co-locate problems and solutions in the training regime. I have provided the protocol for this workshop-based focus session in Appendix F and would recommend this as a module in psychotherapy training programmes.

5.6 How the organisational/social role of being a psychotherapist relates to suicidality

'The situated individual is connected to others through a network of shared, mutually negotiated, and maintained meanings. These meanings provide location, identity, action, and purpose to the individual. They tell me where I am, who I am, what I am doing, how to do it, and why. . . . The network of meanings is not independent of the situated individual. It is the product of the interaction among situated individuals' (Anderson, 1987)

All individuals are situated in multiple contexts (Eisenberg & Goodall, 1997). As we develop through childhood and into adulthood, we 'learn about life in multiple organised contexts, each of which has its own constraints (rules, norms, and expected understandings) that make it unique' (Eisenberg & Goodall, 1997). Each of our multiple micro-cultures, each localised context, assembles a situated individual within a specific languaculture, as a person who is conducting the everyday business of constructing and maintaining the social realities in which they live (Eisenberg & Goodall, 1997). 'Difficulty is encountered when the multiple contexts impinging on an individual suggest inconsistent or conflicting communication or behaviour' (Eisenberg & Goodal, 2015: 100). Agar (1994) discussed the location of culture, where it resides, and offered the concept of *languaculture*: that *my* culture is so intimately wound into *my* primary language, and in a way that isn't directly available for us to see *in* myself, that it leads me to turn away from myself and see culture as 'something "those people" have' (Agar, 1994: 27).

This research has shown that there is a strong urge, a tendency to perceive suicide and suicidality as something "they" have, something out there, the "other". It has also shown how psychotherapy training constructs an acute sub-culture of shared beliefs, values, perceptions and demands-on-the-person, fears and anxieties, that to complete the training can involve a kind of becoming, the complete adoption of a new identity marinaded in the languaculture of psychotherapy-hood. This

person cultivates the social role of *being* a psychotherapist, steeped in psychotherapist languaculture. The organisation - the training institute, regulatory organisation, accrediting body, ethical standards bodies, professional affiliations - merge. They are the guardians of the *way* of psychotherapy-hood. They form the superego of the person in the social role of psychotherapist. But they are also fuelled and perpetuated through relationship, within the psychotherapist languaculture.

When I am in full psychotherapy-hood, I offer this: I am stable, well, creative, empathic, compassionate, regulated, inspiring, a good role model, a healthy individual, a non-addict, someone who is skilled at making healthy choices in his life. When I'm introduced socially as a psychotherapist, I could be having the worst day of my life, but something activates in me, a switch is turned on, and I mould into the cast. I become the psychotherapist role model. I aim to please and indulge the psychotherapy-hood.

I am *not* inclined to say that I suffer with Borderline Personality Disorder, experience chronic suicidality, self-medicate, struggle with addiction - I have actually, when I felt it was safe and appropriate, disclosed some of these things. Anyone reading this research will learn these things. Although, I only expect people within interested academic circles to read this, mostly. I wouldn't tell this to prospective clients; I would honour the psychotherapy-hood. And when we psychotherapists get together, we yield to the cornerstones of this social role so closely that we would even deceive ourselves that somehow and in some way we are resilient to the kinds of fallibilities that those "others" outside of our languaculture experience. And at the top of the list lies suicidality. My conviction, as an outcome of this research, is that the notion of suicidality is still so bloated with stigma and taboo, that there is a compulsion for the suicidal psychotherapist is to hide it, keep quiet, suffer in silence, while adopting the organisationally and institutionally desired social languaculture role of psychotherapist. Trainee psychotherapists are even less likely to disclose suicidality.

5.7 The pull to detach from the subject of suicidality

Shneidman said *'The suicidal act is both a moving away and a moving toward,'* (Shneidman, 1996: 157*).* I also found this to be the case when exploring psychotherapist suicidality. Because 'autoethnographic writing is based upon and emerges from relationship and context' (Anderson & Glass-Coffin, 2013: 57), the relational narrative produced by the participants and I, although contained and protected, *re*created historical feelings and urges, that both moved us to flee from the subject, then pulled us closer together. Between interviews, the participants and I found that old wounds became somewhat raw again and distressing thoughts and images bubbled up into dreams at night, then distilled into thoughts in the day. The second interview, then, became vitally important as a space to get closer to the subject, along with a container to process the images, urges and emotions.

The impact also radiated outwards, beyond the participants and me. One of my thesis readers, a qualified psychotherapist, stated '*I found I needed to detach myself from suicidality to work on it.'* I was aware that I had carried that need to *detach* with me through the whole of this research journey. At times I was able to. At other times, it was necessary that I didn't. In those moments, I had to *wring out* the resistance in me to engage with the subject matter. I had to bring the whole of me into a discussion about suicide and suicidality that a significant part of me didn't want to enter.

The resistance I experience when engaging in this research reminded me of the difficulty I had in expressing myself when I slid into my own suicidality. It came with an automatic mute switch; when I was feeling suicidal, my voice stopped working, and I found it difficult to speak up. These research findings identified that psychotherapists experiencing suicidality found it similarly hard to speak up. From a research point of view, psychotherapists had rarely been asked to. When they were given the opportunity, it wasn't straightforward.

There were likely to be several additional factors driving a therapist's compulsion to stay silent. The literature held clues about this: how professional identity, organisational feeling rules (Fineman, 2003), fear of speaking truth to authority, or repercussions of suicidality disclosure (particularly in training) might fuel silence in the psychotherapist suicidality sufferer (discussed further in 6.4). For the suicidality researcher, it might also have resulted in a pull towards more traditional, 'safer' methodologies and away from less well established, more contested approaches. I experienced this tug and often found myself desiring a more straightforward research topic and methodology.

5.8 First-person suicidality writing, narrative entrapment and composite (hybrid) identity

As a psychotherapist, writing about suicidality from a first-person viewpoint posed unique challenges. There was a cultural grip in the act of researching and writing these accounts that activated 'emotion scripts' (Fineman, 2003: 20) unique for psychotherapists, and could deter the endeavour through fear of setting oneself outside the organisations' expectations of emotional acceptability. One particular script I noticed through introspection was the *recovery* script, which went: "this was all in the past, I'm much better now". The discomfort in setting myself on the outside in the present moment, was something I carried with me throughout the research journey.

This touches on the debate regarding novice autoethnographers, around the vulnerability of those implicated in first-person research – those written about, and the writer. Grant (Grant & Young, 2022 - in press for publication), critically reviewed Martin Tolich's (2010) critique of current practice, that warned autoethnographers of potential long-term harm to their careers in choosing 'to write about their bulimia or attempted suicide, or any other stigmatized experience' (Tolich, 2010: 1605). Tolich invited potential autoethnographers to 'imagine dressing up in

sandwich boards and walking around the university proclaiming their stigma' (Tolich, 2010: 1605). Grant, an autoethnographer who writes extensively on personal experiences such as alcohol addiction, suggested Tolich was 'promoting epistemic violence towards critical and creative analytical autoethnographers' (Grant & Young, 2022: 1). Almost as an act of defiance, Grant's critique is a collaborative autoethnography written in-conversation with Susan Young, a Doctoral candidate who, in the paper, discloses her lived experience of the mental system in the aftermath of sexual abuse by a psychiatrist. Through Tolich's lens, Young has permanently donned a sandwich board proclaiming her stigma. Yet, Young's disclosure offers a lived context within which concepts such as 'narrative entrapment' (Grant & Young, 2022: 10) are brought alive and understood at an emotionally subjective, lived level. Indeed, we can dwell in Young's autoethnography with a sense of authenticity and empathic knowing, in ways that other research approaches don't reach.

That said, from a relational ethics stance, and from a personal perspective, I found Tolich's (2010) message useful, though slightly alarmist. It helped in informing my own choices around whether to use my own lived experience, or otherwise. My choice to don the sandwich board was won over via heeding the call of a 7th Moment in qualitative inquiry (Denzin & Lincoln, 2011), to embrace new ways of researching, including 'breaks from the past, focus on previously silent voices and a concern with moral discourse' (Denzin & Lincoln, 2011: 2-12). I felt I wanted to honour the participants' courage and openness by finding mine.

At times during the planning of this study, I was drawn towards using composite narratives both as a way of protecting myself from the rawness of first-person work, or to yield an amalgamated participant and participant-researcher hybrid voice to adequately summarise the study. Although the participants and I, as researcher-participant, were all middle class, white English people living in a particular time in history, the individual differences that became known through conversation, took us beyond these over-generalised labels. Attempting a

composite research narrative with three others, two female and one male psychotherapist, all from different backgrounds and life experiences, to produce this discussion and conclusion would, to a degree, represent a ‘false study’ (Klossowski, 1969: 1). In my first attempt at this research thesis, I wanted to leave the dialogue as it stood, without any reductionist analysis or discussion. I held the view that presenting a *result*, or a summary of *findings*, or a *conclusion*, would be a misrepresentation, or a distorted hybrid. So, I arrived at an uncomfortable state of liminality, something I eventually saw as the optimal, desired state. In one sense then, this study is incomplete, yet importantly it also synthesises strands of experience and understanding into a coherent whole (Moustakas, 1994).

5.9 Psychotherapists and suicidality

In this study I engaged in conversation with three psychotherapists, with myself as researcher-participant making a fourth, all of whom had experienced suicidality. We were unique individuals, as our stories described, who experienced vastly different events and contexts, resulting in the production of unique stories. Suicidality didn’t define us, and the reality of suicidality, as had become apparent in this study, was contextual.

We were wounded healers. Or were we impaired healers? According to the literature, the distinction between the former and the latter demarcated those who could continue to work ethically, so long as their wounds were processed and therapised, while the latter should be identified by colleagues and encouraged to cease working (Huss, 2020a). But should *anyone* who had been suicidal, or continued to have the potential to experience suicidality, work as a psychotherapist? In his book 'How to Flourish as a Psychotherapist', Brett Kahr (2018) add to References argued that stable, securely attached upbringings were the key to being a good therapist. Miller (1979) argued that using our clients solely as a form of catharsis for the narcissistic wound was inappropriate.

While I didn't hear those phenomenologies in the verbal exchanges, what drew all of us to become therapists, and how we engaged with our *selves* as therapists, was more subtle and complex. As Eve remarked: '…*being a therapist supports the adult part of me ... [but] ... I wouldn't be doing [it] just to make me feel great*.'

But how did the discussion about woundedness engage with psychotherapist suicidality? Was suicidality one step too far? Should psychotherapists who have experienced suicidality continue seeing clients? Molly said '...*I'm not sure it helped, seeing clients, but I was seeing people through this. And in some ways, it did help, it was the only time I could forget about myself... that's really not healthy, it's really not good. As soon as I finished I'd feel bad again*.'

The battle Molly experienced was like my own when I was suicidal during my training. I felt supported by continuing to see clients, particularly with the backing of my supervisors. I felt that being sensitised to my wounds left me feeling more attuned. However, I did carry a lot of guilt at the time, along with a sense of incongruence - akin to Theo's comments about charlatanism. It created a tension in me that, even though I was encouraged by supervisors to continue working, left me uncertain. However, I feel that engaging in this research helped me find a very different phenomenological space where I can hold and observe my suicidality reflectively, in a way that helps me live better and engage in the distress and suicidality of others in a different and productive way.

So, our *wounds* shouldn't play too much the therapeutic relationship as they don't help clients. Having a robust observing ego, as demonstrated by Eve, might be a decisive factor for wounded therapists to create reflexive space between their wounds and their reactions to them. In other words, the space not to get hooked. This might constitute the difference between being a wounded practitioner, or being an impaired practitioner (Huss, 2020). Bager-Charleson (2010) pointed out that although woundedness equipped therapists with an acute sensitivity that could be clinically useful, their wounds, or shadow, '*are hooks onto which*

projections easily get caught. ' There is value in *….'knowing and utilising our vulnerabilities… '*but *'woundedness [is] an area in need of ongoing attention, [of being] repeatedly examined and challenged, since it will invariably be provoked*' (p. x).

5.10 Holding and regulating psychotherapist suicidality

An important question that arose during this study was how psychotherapist suicidality could be held and regulated. From the interviews, there came a sense of caution around other therapists, of the potential for lack of acceptance or understanding, or for unhelpful responses. To that extent, Molly had never told anyone about her suicidality before, including her therapist; Eve kept silent for fear of attempts by peers to fix her; Theo wanted a change in terminology that would help construct his experience away from 'suicidality'. At the same time, all the participants wanted a change in the forces and dynamics that constructed their cautious prudence, and it was my conviction that thinking about our suicidality, as a collection of practitioners with stories that had something in common *in the context of life urges and death urges (why is this in italics?)*, could only benefit psychotherapy. Creative thought might be required to do this (psychotherapy-hood?). Caution would also be needed, since there was unlikely to be a consensus in this being a healthy endeavour. Goodwin's (2017) 'us and them' research demonstrated the potential for negative perceptions within the profession towards therapist mental illness and distress; an experience that both Molly and Eve discussed in the verbal exchanges. Further, a parallel literature around medical doctors woundedness (e.g. Elton 2018) showed how colleague perception difficulties that doctors faced in response to their fallibility. The broad interpersonal processes might map onto how therapists viewed each other. In the context of colleague intolerance to mental illness, the dichotomisation of *us-and-them* might extend into the professional group.

As the verbal exchanges unfolded, it seemed a new approach with respect and acceptance at the centre was needed, one that elucidated and enlightened the sufferer and their *world-hood*, in a way that could only come from our profession. I believed we were a community of people who could wholly and ethically investigate and shine light on the experience of living and dying a human life, and it was my conviction that we should be charged with doing this, for the benefit of ourselves, the people we work with, and humanity as a whole.

Something I noticed during the study, which had been a clarion call for Goodwin (2017), was the 'cathartic power of speaking out and disclosing our own struggles as professionals' (Goodwin, 2017: 9). In our interviews, there was a sense of healing to be found in talking openly and authentically together. There was enthusiasm regarding seeking additional professional help. All four of us talked about having sought support by returning to therapy at times. '*When I hit crisis, therapy helped contain my suicidality,*' I'd told Theo. Molly, talking about feeling suicidal over the previous summer, said, 'I came back to my clients from summer break and ... felt ... envious of them. So, I thought, I'll go and get a therapist.' Our narratives were ones of optimism that continued support helped manage our realities of suicidality.

As part of any new ongoing conversations, a debate over the term and concept of *resilience* and its implications would add value to increasing our understanding of psychotherapist suicidality. The term resilience was disliked as a whole, mostly regarding its implied onus on the individual, '…i*t's saying you're not strong enough*...' Molly had reflected. '*You wouldn't recommend your clients to "just cope"... that's the myth that we're different*,' Eve had said. '…*we're supposed to develop this sense of resilience … as though it's about some kind of internal strength, nothing to do with context*.' I'd added.

A personal context for me was how I'd naively conjured a self-myth, of how training as a psychotherapist would guarantee my own resilience. Instead, I'd found myself struggling to

maintain a veneer of professionalism around my suffering. Theo had described his battle to stay fully *resourced,* and I found this term preferable to resilience, as it opened the frame to something more contextual or holistic and less individualising. *'That awful word, resilience... as though you've got to be a bit tougher,'* Molly had said. *'But actually, as a therapist you need to be more vulnerable and open.*'

Vulnerability could be understood by reframing or re-imagining it interpersonally and collectively. The way vulnerability was responded to by tutors, supervisors and leaders would make a difference. As Molly recounted, the difference between experiencing support and understanding, rather than being told by a supervisor, *'you've got to knock your mourning on the head*,' could shift the balance between distress being kept silent or shared and held. A powerful part of Webb's (2010) story of suicidality, was his discovery of the supportive power in finding good people who listened non-judgementally. This came in the backdrop of having had psychiatric interventions that were purely intrapsychic.

5.11 Medical parallels

Medical literature showed how in training contexts, qualities which might be initially viewed as strengths, such as conscientiousness and being driven, might become counter-productive and turn to weaknesses during times of stress (Ross, (1973); Grant (2001)), researching psychiatric nurse training, demonstrated how psychiatric nurses might experience 'tensions between what they feel privately and express publicly, and strategies to help them maintain good face in the organization '(p. 4).Is this quote from Ross or Grant? In the case, then, of the conscientious, driven psychotherapy trainees, this might move them to stay silent about experiencing suicidality: an ambivalence evident amongst the research participants, galvanised as an association of both strong positive and negative emotions with some target (Pratt & Doucett, 2000: p. 205) add to References, in this case, the target being the symbol

and practice of openness. The result was a manufacture of authenticity (Ashforth & Tomiuk, 2000: p. 185) add to References, i.e. saying what one felt ought to be said; or being how one felt one ought to be, and the ensuing emotional labour (Blake and Tomiuk, 2000: p.184) amplified emotional distress.

Pessimistic expectations about what the responses might be if distress and suicidality were disclosed to training staff were evident. This pessimism was in part reinforced because as therapists, both in training and beyond qualification, we worked in a culture, as already discussed, where often the message was to attend to one's intrapsychic health structures, as though our psychological functioning is isolated from our social and professional context. A personal example of this was when I sought therapeutic support in my NHS job as a psychotherapeutic counsellor and was informed there wasn't anything the NHS could offer, and that I should find a private therapist.

Between 2019 and 2020 I worked for a year as a Darzi Fellow explain what this is here in Kent, Surrey, and Sussex, investigating suicide amongst medical students and trainees, and designing support structures to help reduce suicide rates. This initiative was part of an across-the-board move spurred by Health Education England to improve staff experience. Positive healthcare staff experiences of feeling supported and cared-for has been shown to reduce sickness rates, improve performance and morale, increase productivity and retention and improve safety and improve patient experience (Starling, 2018). These outcomes were exemplified in a journalistic feature (Reynolds, 2017), in which clinician, 'Sarah,' (anonymised) described the huge difference it made when she found an employer who viewed her mental health history as an asset.

5.12 Groupthink and the basic assumption group

Being a psychotherapist is a group-context phenomenon and when something is unspoken in a group, particularly out of fear or discomfort, the group might 'act unconsciously with an impetus to minimise anxiety and preserve self esteem' (Goleman, 1997: p. 181)I put quotation marks around what I think is being quoted by blocking open discussion and perpetuating avoidance. This *groupthink* (Janis, 1972) response could be disenfranchising for the *silenced* individual within the group. It could act as a tacit unspoken pressure. Bion called this the *basic assumption group* (Bion, 1961: p.?) why is Wetherell added? Use Source material if you can;, that could behave in ways starkly antithetical to the original group task - which for psychotherapists included the healing power of talking. Psychotherapists avoiding open reflection on suicidality amongst themselves was an example. The group task for psychotherapists, and for counselling psychologists, was to engage with aspects of human life in a way that could provide greater depth of understanding and the opportunity to use that understanding to benefit struggling humans. Avoiding turning the lens on ourselves or engaging with our own questions about life and death, appears antithetical to the group task. But having completed this study, I also understand how and why this could happen.

Anxiety can create a progress-opposing agenda, which then becomes the implicit, unspoken basic assumption of the group (Potter, 1996: p. 97).What is being quoted? Basic assumption groups make unconscious grabs for power-knowledge and construct structures to dominate information, all within plain sight of the conscious main group. An example of this in the study was how Eve, Theo, Molly, and I, often veered away from our main task - the anxiety-inducing work of discussing our suicidal selves.

In broader settings, particularly training settings, the concept of the basic assumption group could explain in part why students might not disclose suicidality. Additionally, indecision around whether to disclose to tutors and/or supervisors, to discuss openly whether to continue working with clients or not, were also impacted by fears of how those disclosures might be measured.

The antithetical message might be, keep quiet for fear of exposure and potentially not qualifying as a psychotherapist. Eve summarised this position; '*it's frightening,*' she said, '*kinda plays into the isolation.*' When the basic assumption group joined hands with an anxiety-provoking subject like suicidality, in a context of being assessed and measured for competence, it was easy to see why silence, and further isolation for the sufferer, might be the outcome.

5.13 Structural power and psychotherapy-hood

While analysing the interviews, it seemed clear that Grant's (2001) construct of *structural power* was valid when exploring organisational shaping experience and practice of psychotherapy student relationships with tutors and clinical supervisors. In response, I conceived the metaphor of 'the big therapist's chair,' on which everyone in the training setting could sit. The equanimity of tutors, professors, doctors, trainees, supervisors, and all other staff sitting at the same level on the big chair, seemed like an empowering metaphor. This would flatten temporary positions of subordination and minimise the realities of power imbalance, noted by Vasquez (1999). A broader commitment beyond training to support everyone in the therapy world through mutuality and empowerment should be a core aim of psychotherapy and counselling psychology.

I also found it helpful to locate my thoughts by contemplating the entity 'psychotherapy' as a totality, or whole. This drew on Button & Marsh's (2019) social justice view of suicide, as contemplated in the literature review, where the sphere of psychotherapy might be considered as a set of 'constitutive interactions between individuals and the entrenched long-term social-structural conditions and processes in relation to which individuals live' (p. 2). Another way of conceptualising this uses Heidegger's (1953) add to References and use source material if possible notion of 'world', i.e., not a physical space but a context of meaning that incorporates … 'a structure articulated in terms of all the different modes of organising life in terms of work

objectives, social roles, personal interests,' (Watts, 2011, p. 44 using secondary source here – not advised). This … creates a space of possibilities, in how we think and talk about our lives, that arises … from our world and cannot be disentangled from it, (p. 45). It's that space of possibilities that I believe needs to shift to challenge entrenched structural power (Grant, 2001) with regard to psychotherapist suicidality, since one particular space of possibilities might mean certain conversations running counter to the *worldhood* of 'psychotherapist' and be avoided; while a shifted space of possibilities might create a different frame of reference that integrates suicidality as a valid experience that can be discussed ethically.

Our psychotherapy world-hood, or *psychotherapy-hood*, has huge gravitational impact, pulling all members into orbit around it's values and practices. The impact and power of the gravitational pull, of belonging to the psychotherapy-hood (or psychology-hood) was eloquently encapsulated by Counselling Psychologist, Goodwin (2017), who described wanting to write an article about her personal history of psychiatric illness:

'*I knew I wanted to write for The Psychologist. Only later did I start to get nervous about the wide exposure that publishing here might bring - perhaps it would be better if it was destined for life on the shelf, as so many of mine [copies of psychologist] are. But I do want to change the system from within, partly by outing myself, and that would require the article to be read, not put on the shelf*' (p. ?).

Goodwin's (2017) doctoral thesis addressed the stigma inherent in the wounded healer status by investigating the prevalence of intolerance shown by mental health staff towards colleagues who experience mental illness. The structural power (Grant, 2001) of the psychology-hood to pull Goodwin back into orbit, away from a trajectory for change from within, was evident, as it

was in the narratives of all the participants in this study who often struggled against the gravitational pull of psychotherapy-hood.

5.14 Institutional transformation and psychotherapist suicidality as a contextual wicked problem

I envisage this work contributing to debate and discussion around institutional transformation, as a dynamic, continuing conversation that seeks to aid progress in our field of work. Goodwin's (2017) reticence in leading the way and urge to encourage more top-down action from institutions, joins hands in asking how institutional change can come about. 21st Century organizational change in the NHS has seen a growth in the promotion and implementation of collaborative working, or co-creation in healthcare. This promotes the idea that the most effective change takes place when, from the design phase through to implementation and maintenance, organizational systems are grown through a joint bottom-up and top-down collaborative process. This can be particularly effective and ultimately necessary when developing the notion of psychotherapist suicidality as being a *wicked problem* (Sobelson, 2019) add to References characterised by high levels of uncertainty and interconnectedness with other problems (or contexts), and high potential for political conflict. I have come to believe in the light of this research that the most effective approach in engaging with it is collective discussion, debate, followed by cooperative action and change.

The conversations psychotherapists might have about their own lived experience of suicidality could be enlightening, even ground-breaking, and have the potential to advance more general understandings of the suicidal state. But there were specific factors at play with psychotherapists as a cultural sub-group, with their own idiosyncratic identity dispositions, that could prevent, distort and/or disrupt those potential conversations. These factors could add to the *wickedness* of the problem. To illustrate this, questions around how to break into the myth

of common humanity in the world of psychotherapy, of the *we're human too* movement, and to dismantle the tacit othering within the field, demonstrate the challenges of the way ahead. The lived experience narratives revealed an unacknowledged cultural NIMBYism[1].

When contradictions and tensions exist within an institutional structure, change can be triggered endogenously (Glucker & Lenz, 2018), as existing practices and beliefs are reinterpreted and renegotiated (Seo & Creed, 2002). An aspect of psychotherapist suicidality existing as a wicked problem is that endogenous change is unlikely to take place via this kind of institutional drift (Glucker & Lenz, 2018). Institutional change is required in psychotherapy with regard to the conceptualization of 'psychotherapist' which is a socially constructed, defended and preserved image that suits the purposes of psychotherapy's institutional members, i.e. that typical human psychological and existential vulnerabilities no longer apply to psychotherapists, and that image upholds a protected status professionalism for psychotherapy. Glucker & Lenz (2018) identify how shifting form and function in an institution requires transformation. I propose that a roots-up examination by psychotherapy institutes, including accrediting bodies and training institutions, of their understanding and handling of psychotherapist suicidality can result in a transformed worlding? (Heidegger, 1953) add to References of psychotherapy-hood that will better match the demands of our era, transform psychotherapy, rightfully, into the breeding ground for new and optimistic way of understanding suicidality, and provide a social justice element to the endeavour by engendering an integrating, including culture with regard to suicidality.

5.15 Participant feedback on completed thesis

[1] NIMBY is a recent UK/English colloquial acronym for Not In My Back Yard.

As part of the relational ethics approach, I sent each of the three co-participants a copy of the completed thesis to read. Below are their comments.

Theo wrote: I'm happy for you to proceed as is. I personally hold a different view of one thing. Where you say I am avoiding referring to my thoughts as suicidality my view is that it is not avoidance but a different definition of suicidality as one that includes thoughts of wanting to kill yourself and I didn't have such thoughts. Your thesis, your perspective.

Eve wrote: I wanted to get in touch again, as I've been thinking a lot about your thesis since it landed yesterday and I fired off a quick reply but afterwards it just felt kind of… insubstantial. It is a funny time to read it, as it both feels an enormously long time ago but also there are parts of our encounter that remain really vivid in my mind.

Lots has happened since, but one of the main things has been that I have taken a break from practice for various reasons and actually one of the lovely things about reading it is seeing and remembering myself as a competent and thoughtful practitioner and remembering how much I enjoyed my work. It was important for me too to talk vulnerably about our shared woundedness and I remember that feeling like a big relief. It was interesting to see the encounter through your eyes too, we never get to see that, do we! And you really brought it to life!

It was also fascinating reading about your experiences with Theo and Molly and how different we all seem personally and also the common themes that you found too, of secrecy/ isolation and shame and the expectations that we put on ourselves (or are put on us!) as practitioners to be somehow more than human.

Molly wrote: I have had a look through and liked your use of poetry very much and it was interesting to read of the impact of the interviews, participants and research on yourself - a freedom afforded by autoethnography, a very rich experience for you. I was struck by how different we the participants are and your experience of us was.

5.21 Summary

My thoughts are cast back to the suicide of Petruska Clarkson and the institutional silence that caught my attention and spawned this research. I place that starting point into a context of the overt institutional resistance and doublespeak I experienced towards my subject and methodology as I progressed through my research journey. I think of the alarm bells from Tolich (2010) warning of the permanence like an inked tattoo of publishing evocative autoethnographic work. I think of the delicately held traumas and distressing memories revisited in the interviews and narrated in this thesis.

I don't believe we could have achieved this research without whole-being immersion. The experience of joining with the participants in our interactive interviews, and for us all to head with whole-being immersion into a world that felt at times in opposition to the psychotherapy-hood gravitational pull – to silence this melee and adopt a conformed notion of me-as-fixed-therapised-therapist – left powerful reverberations.

The words I produced to convey the experience of the six interactive interviews, would never adequately convey the *experience of self*, standing at the endpoint of six years conducting a research study that often felt like it wasn't wanted.

Reconceptualising that perception, of research not wanted, instead as a psychotherapy-hood gravitational pull urging me to drop my study and get back into orbit, helped result in me seeing this as events consistent with groupthink (Janis, 1972), feeling rules (Fineman, 2003) and

worldhood (Watts, 2011). It also reinforced my sense of *the psychotherapist* as being a fully-fledged wicked problem.

An important emphasis is that this research has identified a strong institutional worlding? (Heidegger, 1953) which can only be addressed by institutional transformation of form and function (Glucker & Lenz, 2018).

5.22 Limitations of thesis

Hughes and Pennington (2017) describe how, within academia, '...scholars argue that autoethnography should assume a more traditional, qualitative direction' (2017: 178) and question 'the notion of autoethnography as an empirical research endeavour' (Hughes & Pennington, 2017: 178). They describe a movement of qualitative scholars arguing for 'the removal of all autoethnography from the lexicons of critical social research' (e.g. Delamont, 2009). In terms of the limitations of the thesis, the removal of this work 'from the lexicons' would be quite a catastrophic one. Yet, this movement base their exclusionary pursuit on what they see as strong concerns about autoethnography as research.

A perennial concern is autoethnography's 'strong emphasis on self,' (Mendez-Lopez, 2013: 283). Autoethnographies have been criticised for being self-indulgent, narcissistic, introspective and individualised (Atkinson, 1997; Coffey, 1999). Following these claims, a limitation of the thesis could be the 'narrow, subjectively filtered reality personal narratives or autoethnographies represent' (Mendez-Lopez, 2013: 284). The use of 'I' exemplifies this limitation. In the eyes of autoethnography's critics, 'the use of "I" in a dissertation is inappropriate and wrong; there are no "'I's in academic writing' (Adams, Jones & Ellis, 2015). The use of I, and the inherent *subjectiveness,* can call into question '...how much of the accounts presented as autoethnographies represent real conversations or events as they happened, and how much they are just inventions of the authors' (Mendez-Lopez, 2013: 284).

Limitation, it is claimed, arises from the criticism that the empirical strive for objectivity is lost in the autoethnographic endeavour. That 'a social research report should aim at presenting organised, logical claims supported by empirical data' (Mendez-Lopez, 2013:285) exposes autoethnographies for their lacking in empiricism, exacerbated by the closeness of the researcher to the research. In other words, 'if researchers are supposed to be as distant as possible from the research in order to present as objective a truth as possible, how can this be accomplished by autoethnography? (Mendez-Lopez, 2013: 284).

Another limitation arises from a potential blurring in terms of the impact of the research. Making a connection to the reader can help him or her to think and reflect about his or her own experiences. This has led to the criticism of the main goal of autoethnography becoming 'therapeutic rather than analytic' (Atkinson, 1997). This thesis is about a personal wound experienced by the researcher. But critics of autoethnography argue that 'the personal and emotional involvement of the researcher in autoethnography contrasts with the distant and objective role of researcher's goals in a positivist stance' (Mendez-Lopez, 2013: 284)

A further criticism of autoethnography as an academic endeavour is the difficulty in evaluation. Autoethnography '...cannot be assessed for its explanatory power, scholarly insight, or ability to cultivate social change' (Adams, Jones & Ellis, 2015: 99). In other words, *evaluating* autoethnography is problematic, because 'including storytelling and first-person narration in research sacrifices the analytic purpose of scholarship' (Adams, Jones & Ellis, 2015: 99).

A distinction has been made between evocative autoethnography (e.g. Ellis, 2004) and analytic autoethnography, with the latter being designed and favoured by Anderson (2006). Anderson argues that autoethnography ought to be applied through a 'traditional realist empirical lens ... to reduce ambiguity and to exhibit precision' (Hughes & Pennington, 2017: 178). Evocative, performative or social justice approaches to autoethnography are specifically critiqued under the realist empirical lens, for its lack of explicit and precise cultural analysis.

Limitations are often responded to in the from of prescriptions as antidotes to those shortcomings, typically in the form of bullet-pointed lists of essential criteria, that formalise the prescriber's viewpoint vis-a-vis quality control. For example, Richardson (2000a: 254) suggests any evaluation should consider autoethnography as science and as art, and proposes five criteria against which to evaluate any autoethnography: substantive contribution, aesthetic merit, reflexivity, the impact the narrative causes the reader, and how much the narrative expresses a reality. This quality control provides a framework to aid the autoethnographer attain quality, but can also be received as exclusionary and punitive, right and wrong, that restricts and excludes 'innovative forms of autoethnography, along with novel forms of representation' Sparkes, 2018: 259). Rather than place ticks against bullet-points in the plethora of available lists, (Pelias, 2011; Tracy, 2010; Richardson, 2000; Barone and Eisner, 2012), Megford (2006) suggests autoethnography should be evaluated against ''an ethic of accountability,' in which the writer should write his or her truth as if all the people involved in those events were listening to him or her (Megford, 2006). Further, in order to show methodological integrity, autoethnographers should focus attention directly on the approaches to inquiry taken in the work. In other words, there needs to be an increased effort in justifying the methodology, including that: the research designs, procedures, goals, and the characteristics of the subject and author be sometimes attended to explicitly in a methodological statement... (Poulos, 2021). For Ellis (2000), a good autoethnographic narrative should be able to engage your feeling and thinking capacities at the same time as generating in the reader questions regarding the experience, the position of the author, how the reader may have experienced the event described, or what the reader may have learned (Ellis, 2000).

5.23 The researcher's toll as a limitation - a personal reflection

There is another lens through which I'd like to expand the notion of *limitation* in this research project. As I sit, writing this section, at the finishing line of my doctoral journey, my enthusiasm for

continuing to work in the research area of practitioner woundedness and suicidality, is running on empty. I feel washed away in 'a sea of anomie' (Agar, 1994: 25). Carrying out this research has taken a staggering toll on my professional career, my professional identity, my personal life, my personal identity, my emotional and cognitive stability, my overall wellbeing, my paranoia over things like potential professional attack, and my suicidality. All these "my's" are vastly overshadowed by the carnage all the "they's" have experienced by my pressured, stressed, unregulated peaks, most of which coincide with increased pressure from the doctorate. I can't lay all of the blame for the four failed relationships I have had at the door of my professional pursuit. I can't claim that the research solely caused all my calamitous decisions and actions while attempting to complete something that, along the way, I could no longer fathom, understand or explain, in terms of my stubbornness to keep going. I can't say that the ten homes I've lived in over the past seven years - all that moving and lugging and dumping, wasting and screaming - are solely down to my tenacious grip on this ambition-turned-madness of a doctorate. Along the way I discovered that I had Borderline Personality Disorder. I can't put that solely down to carrying out this research. I can't claim that baring my deepest most shame-ridden secret: that of the growth and establishment of my chronic suicidality, is just down to doing autoethnography. I can't truthfully say that this is the singular cause of my flourishing professional paranoia. But I'd love to see a parallel me who didn't go through this research journey, to catch a glimpse at how things might have turned out. I think I'd be very different.

So, why am I couching this as a limitation?: I used to dream about taking my cause out into the broader world, to suicide prevention symposiums, autoethnography conferences, training establishments, mental health services, hospices, the Samaritans, political arenas. I'd dream about the journal articles I would write, inspired by those that I used to read. I am the autoethnographer of this work. This thesis is me. It's not a paper to be read, it's a person behind the paper to come

and meet, to talk with, to gently explore these fresh clearings. That's what I imagined I would be doing.

So, here's the limitation: I feel too exhausted to do any of it, and I believe that the added all-round effort to justify my choice of methodology, and battle with the detractors, is a limitation of doing autoethnography as a professional doctorate. I don't have the motivation to. Again, without a parallel me to observe, I don't know if the degree of research burnout would have been substantially lessened if I had chosen a more conventional qualitative research approach than autoethnography. However, my experience has been that employing autoethnography has drawn such intensive inspection and call for justification that it has contributed to my current state of malaise. My hope is that beyond the 'finishing line' I will be able to regroup and recharge.

5.24 Synthesis of recommendations for psychotherapy-hood and its deep relationship with suicidality: language, individuals, institutions, and training establishments

Following this research discussion, I propose the following changes and recommendations about psychotherapist suicidality:

- That the reality of suicidality in general be further understood as a contextual phenomenology, which will aid in any approach and understanding of psychotherapist suicidality. For a critical suicidology/suicide and social justice approach to be embraced to further that understanding.
- For this research to inspire and generate a dialogue within the psychotherapy community around psychotherapist suicidality as a neglected and potentially avoided aspect of psychotherapist phenomenology.
- For the *human reality* of suicidality to be the subject of a specific training module in psychotherapy training institutions, that embraces critical exploration and analysis of this highly relevant area.
- That the concept of psychotherapy-hood (section 5.9) be adopted by psychotherapy institutions and training establishments, along with their practices and subcultural norms and values, in an effort to develop ownership and ethical responsibility regarding psychotherapist suicidality.
- To understand concepts like groupthink (Janis, 1972), feeling rules (Fineman, 2003) and worldhood (Wats, 2011) in their approach to discussing, debating, and changing our understanding of suicidality in general and psychotherapist suicidality in particular, and how that is avoided or engaged with in the psychotherapy-hood.

- For suicidality to be treated as a serious topic in the *psychotherapy-hood:* training, recruitment, progress, professional practice, continuing professional development (CPD), research, and therapists own self-care should be recognised and understood as an organisational, group-contextual responsibility.
- For suicidality to be understood as a pervasive aspect of psychotherapist phenomenology (i.e., it's not something you either have or don't have), since everyone is on the spectrum of suicidality, and for this assertion to be critically debated. For this to happen and make a difference for the next generation of therapists and trainees, for the *psychotherapy-hood* to experience a shift in its approach to suicidality.

In training institutions:

- Tthe metaphor of *the big therapist's chair* (see section 5.9) on which everyone in the training setting can sit, to flatten temporary positions of subordination and minimise the realities of power imbalance, noted by Vasquez (1999) and promote a broader commitment beyond training to support everyone in the therapy world through mutuality and empowerment, and that this should be a core aim of psychotherapy and counselling psychology.
- For a space where non-therapeutic language, based on ordinary (sic) conversation, exists, utilising, for example, a community of enquiry co-production framework (Muirhead, 2018).
- For a transformation philosophy to be explicitly encouraged and actioned in psychotherapy institutions, including accrediting bodies and training establishments.
- For the language to be challenged, since terms like 'commit suicide' are still pervasive amongst therapists, NHS staff and mental health professionals. To engage in discussion more broadly with cynicism? over these challenges.

- To extend research and broaden research methodologies into suicidality amongst psychotherapists. Following Dutheil et al., (2019) extend research into other healthcare fields, particularly practitioners in the psychological helping professions.

CONCLUSION

This has been a long and difficult personal journey on an exploration into suicidality among therapists, inspired by my own personal experience. It has been a difficult subject, not just considering the personal difficulty of it, but also the professional challenges, the taboo - not just in the world, but inside psychotherapy organisations, within the fraternities, amongst colleagues, in supervision sessions, and with personal therapists.

My approach was to consider my own suicidality through my training and through my work as a psychotherapist, and to explore it with other therapists with suicidality in their histories. It was difficult to find those participants. It was difficult, then, to have conversations with them. My choice to make this interactive, to include my own story hand-in-hand with the stories of my participants, made it challenging methodologically, ethically and ontologically.

The literature review identified a large body of quantitative data that was useful. But it also identified a diminished body of qualitative data and an almost non-existent body of lived experience research. The epistemological view of this study was that a greater understanding of suicidality, and specifically psychotherapist suicidality, could be achieved by talking with people who have been suicidal.

This research was carried out in part completion for a Doctorate in Counselling Psychology. Counselling psychologists are trained to work clinically, and in my case, my psychotherapy training took part as an integrated training programme towards a counselling psychology qualification. Therefore, these research recommendations were also relevant for counselling psychology training establishments. As shown in the literature review, this research aspired to impact and implicate broader areas of psychological practice, including clinical and counselling psychology. The review pointed to the structures and institutions of psychotherapy as a relevant area of contextual interest, particularly on organisational dynamics and change, therapist

identity and culture. This would therefore be of interest to the wider community of psychological healthcare bodies and training institutions. It would encourage psychotherapists, psychologists and other professionals who work clinically with psychological change models to reconfigure themselves in ways that moved beyond ‘what had existed previously’ (Freeman, 2004: 77) and encourage ‘a transformation that is resolved in coherence and integration' (Lightfoot, 2004: 63) regarding stress, distress, and suicidality in psychological healthcare professionals.

EPILOGUE: AN INNOCENT PROPOSAL

My aim in this research was to employ autoethnography to produce an engaging immersive story that could help imbue a shared known sense of the phenomena of psychotherapist suicidality. In doing so, I aimed to move psychotherapy as a profession away from thinking about suicide as an abstract and taboo illness that happens to unwell others. I wanted to foster a sense of mutual identity around psychotherapy and psychology as being a profession that embraced and integrated shadow-side human experience and vulnerability with human health and wellbeing into its own sense of identity that includes all realms human experience. In doing so, I wanted to expound the importance of woundedness in any transformative experience and challenge the prevailing dualistic us and them split between well practitioner and unwell practitioner. I felt compelled to take a rich, qualitative, deep dive into my personal suicidality to achieve this endeavour. Durkheim stated: *'It isn't society that sheds light on suicide, but rather suicide that sheds light on society'* (2008: 7; in Grant et. al, 2013: ix). In a parallel way, I found through this research that psychotherapist suicidality shed light on the experience of being a psychotherapist within a psychotherapy-hood that finds suicidality within its' own ranks discomforting and an issue to be avoided.

As I re-read these words that I have written, I sound certain, processed, clear and confident in my endeavour. My words don't do justice to the messiness, daily anxiety, unbearable ambivalence, powerful urge to stop my research and not expose myself – not tattoo myself with my wounds for all to see – and provoke my worse trigger, be adversely judged. With that, I wanted to let a piece of autoethnography wrap up, in a very personal way, the struggle I had from day one in getting research approval for this study. So, I'm closing this thesis with an autoethnographic narrative entitled 'An Innocent Proposal', being my way of expressing through direct lived experience writing,

the seemingly perfect storm of combining two challenged and problematic propositions: psychotherapist suicidality as a genuine and relevant phenomena that can be talked about in a way that grows and evolves psychotherapy; and the use and legitimacy of autoethnography as a research method to most effectively discover more about phenomena such as psychotherapist suicidality.

The poem at the end of 'An Innocent Proposal' has already featured in this thesis, as a forward. I feel it will be experienced somewhat differently now that the reader has taken this research journey with me and new light has been shed.

An Innocent Proposal

Seeking approval: reflections on the personal and institutional challenges of seeking academic approval for 'Encounters with suicidal psychotherapists'

Introduction

This writing is how I am. This writing is my style. This writing is mine. It consists of what would be considered non-academic writing - prose, poetry, song writing, acted identities, fragmented narratives, my own multi-voiced subjectivities, the messiness, inconsistency and fragmentation of thinking, feeling and doing. Hence, the photo of me above is blurred out, depicting the way I feel blurred out by academia when I write in my style. In this story of mine, my relationship with time folds and interweaves, back and forth, in the order and disorder of my mind, my story, of mine. It demonstrates the non-linearity of human mental life. In this… mine…, I want to bring the essence of my subjectivity in order (and disorder) to perform and

show as best I can my humanness… human-mess… and step away from academia. In this mine?? mind? I reject the 'expert researcher' position.

Exposed

I'm stood outside the door of the training institute in west London, having just finished my program approval panel (PAP), trying to get the go-ahead for my research....

I am laid bare. What just happened?

Eight years of training and I just wanted it done. Standing there, I felt exposed. It was like a shot of radiation from the sun had torn a hole in the ozone layer and peeled back the atmosphere's protective barrier. The sun's rays were shining straight through, unfiltered, and I was condemned to its radiation. God looked straight into my soul and saw everything I'd tried to hide. I asked myself, *why am I doing this?*

I expected the PAP to be a straightforward affair. I'd proposed thematic analysis to investigate the lived experiences of suicidal therapists. It would be a conventional qualitative research venture, uncover some patterns and common meanings... I'd present findings and get my doctorate in Counselling Psychology. Painless, right?

Here's the original abstract I submitted to the PAP panel in June 2017:

Title: co-encountering suicide in psychotherapy

My qualitative research project will explore in-depth the lives of psychotherapists who have experienced suicidality, focussing on the psychotherapists' meaning-making... including joint meanings with colleagues and clients. I will investigate suicidality 'as a genuine and authentic human experience ... honoured and respected rather than suppressed and denied' (Webb, 2010).

Using a qualitative thematic analysis methodology, I aim to uncover meanings made by therapists with a history of suicidality.

One of my presentation slides indicated I'd had my own lived experience of being suicidal whilst in the third year of therapy training; I stated I would carefully acknowledge my experience but keep my own story to a minimum.

After my presentation I waited for the panel's response. One of the panel members, a newly qualified counselling psychologist, asked, '*Why aren't you in the story? It's a missed opportunity... give us reasons why you've left yourself out? There are ways of doing this, you know. You could use autoethnography to explore your own suicidal experiences alongside your participants*.'

I sat nodding, keeping a smile on my face. The whole point of being here was to get my research approved and signed off (*wishing, wishing*) with limited fuss (*wishing...*)... get the ethics signed off (*easy process, please...*), do my research and get qualified (*must get qualified... must get qualified...*).

Behind the facade I was panicking. I didn't want to be *in* the picture and was happy a few paces back, out of the spotlight, illuminating the stories of my participants who would be protected from the sun by an ozone layer of anonymity. How could I put myself and my own story into this and be similarly protected? The answer is I couldn't... *my name will be on the front of this piece of work. People will know.*

I told the panel member I'd experienced resistance from within the institute around this research proposal and wanted to stick to conventional methodology to minimise risk of opposition.

'*Fuck them!*' she bellowed, drawing murmurs of consternation from the other panel members - and surprise from me - *'don't be held back from doing the research you really want to do in the way you want to do it... honour the subject matter!*'

I'm stood outside the front door of the therapy training institute, having left the PAP...

The truth was, I was afraid of doing the kind of research she'd suggested.

I'm paused, frozen, on the pathway...

I didn't know much about autoethnography, except that it would involve honesty *(...?!!...),* transparency, congruence... *(fuck... fuck... fuck...*). It seemed dangerous and absurd, because of the rigour I was asked to show in my ethics section around anonymity. Telling my story would surely blow anonymity away, for me, anyway.

'Describe what happened and how you felt, what it was like going through training and being suicidal...' the panel member said. I was thinking... *yeah, but the story of that isn't a great one for the institute; it's a story of scepticism and fear*... I didn't feel safe telling my story, here.

'Petruska was a flamboyant, brilliant person, but could be equally terrible.' The words of one of my tutors in 2012. Petruska Clarkson's suicide was a tragedy for her colleagues, the institute, and for psychology. But, in my experience, Petruska was barely mentioned. When I talked to staff, I drew friendly warnings: *'This is sensitive, people don't talk about it, Petruska's colleagues and friends still get upset.'* I decided I would tread carefully. But now, with the fresh injunction of the panel member, I couldn't see how I might avoid upsetting people.

I'm stood outside the front door of the training institute in west London...

The PAP outcome was technically good. I was told that my project was approved in principle, with some conditions and recommendations to consider. One of those recommendations was:

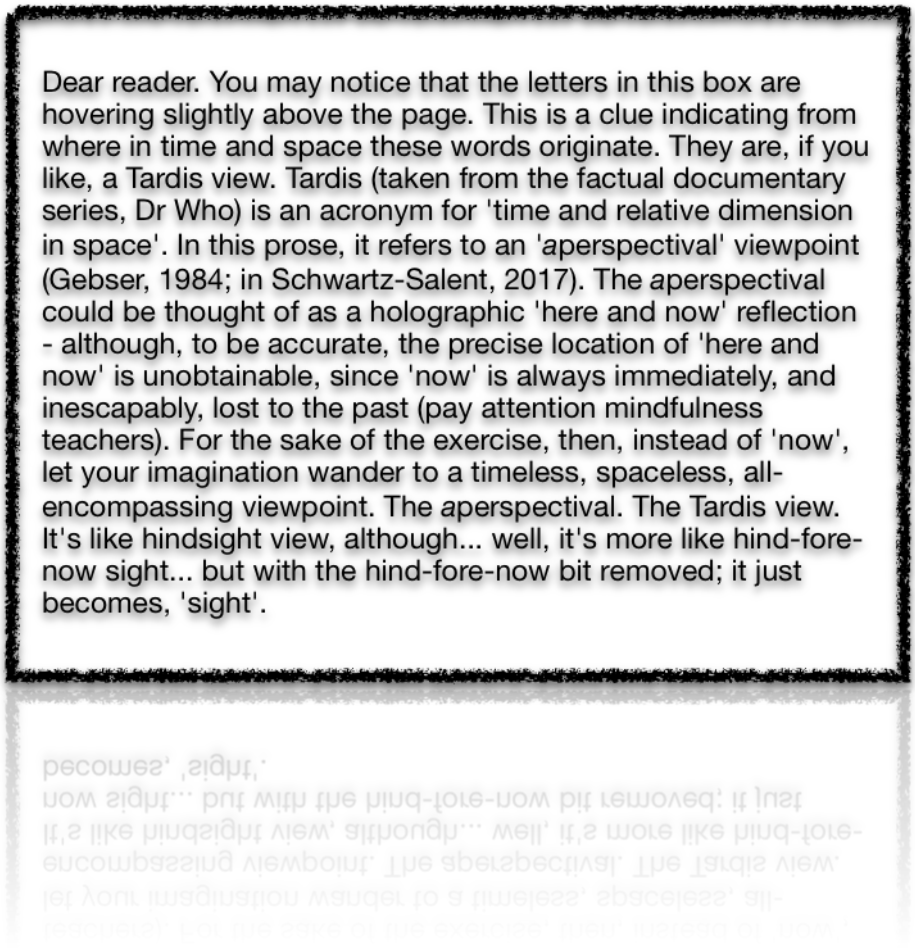
'*...you need to free yourself to carry out the research you really want to do irrespective of methodology and consider how much you do or do not want to engage directly and take ownership of your own research question.*'

...And another: '*...consider using autoethnography*'. (PAP Outcome letter; July 2017).

I'm stood on the pathway ... my imagination disappearing off into a fearful future where people will see that I, Martyn Oakland, psychotherapist, have been suicidal...

My family and friends would know the full extent of my internal chaos. I imagined my nieces reading, one day, about Uncle Martyn the fuck-up. While these thoughts sprinted across my mind, I found myself contemplating whether it was all worth it. *Why would I do this to myself? Why would I bare my stricken soul to a judgemental and unforgiving world?*

There was another realisation that burst into my thoughts, causing my head to droop, my face to squeeze tight and me to groan. *If I was changing my methodology, I would have to re-write my research proposal.*



Connections #1

Schwartz-Salent (2017) described the holographic nature of the universe, that 'separate parts contain all the information of the other parts, but in a less available and clear form' (p. 21). He writes about this in his book, The Order-Disorder Paradox, a fascinating exposition of the notion that disorder is a natural and inevitable aspect of order and that, once recognised and acknowledged, can be a useful lens for change.

Imagine you have just built a boat and launched it onto a lake. As the gleaming vessel motors along, pushing through the water, it creates a large wake in its path. This wake spreads outwards and behind the boat. Ripples stretch far and wide, disturbing the calm lake surface, licking the quiet shores with unexpectedly strong pulses that have been gathering momentum on their journey to the shore.

Now, imagine that you are the whole scene: the boat, the boathouse and boatbuilder, the launch jetty, the lake, the boat's *her*story, the driver, the small creatures on the shore now swamped with unusual disturbance in the water; the canoeists and dinghy sailors bothered and irritated by the loud engine noise and being nearly capsized; the murky glistening, purple trail of unspent engine fuel forming a slick as the water calms after the boat's passing; the Canada geese with oil in their feathers; the lake attendant cursing the breaking of an ancient speed limit more appropriate for craft long past, river barges and steam vessels; the pollutants from the engine's exhaust billowing up into the air, dispersing into the sky and clouds, infecting the rain drops and surrounding hillside brooks and gurgling streams, contributing to environmental decline; the holiday-makers lining the lake side, admiring and photographing the impressive shiny motorboat as it passes, driver waving, flags bold and flapping in a gentle breeze.

Returning to Schwartz-Salent, the order in the scene is reciprocated by disorder, and the evidence for that is contained in every element; the heavier waves lapping the lake-side shore, for example,

contain all the information of the other parts - the presence and movement of the speedboat being driven too fast, the twitch of the driver's hand on the wheel, the erosion of the shoreline, the decrepit addiction to fossil fuels. In every tiny part exists all the information of the other parts, but less available and therefore hardly noticed.

The panel member's vociferous comments in the PAP and the silent discomfort of the others: each part may hold clues to a holographic whole, not directly and immediately accessible in the present, so potentially passing unnoticed. I wondered if I had witnessed a manifestation of the impact of Petruska Clarkson's suicide. I wondered what suicides or serious incidence of practitioner/trainee crises I didn't know about but may have affected the peopled university. I had already noticed the blind spot that the institution located around Clarkson's suicide, whose *her*story manifested in subtle avoidance spaces and fidgeting silences (evident in the discomforted minds bodies of three frowning panel members). I wondered if an aching and irresistible slide into forgetting had been rudely disturbed by the inception and proposal of my research. The highly vocal PAP panelist may have been frustrated with such veiled forces herself. She may have endured a combination of lacuna culture common in many institutions; blind-spotting, protection of the group, soluble problem handling ('plink plink' and hope it fizzes away). In her protestations, I wondered if she was channelling the re-emergence of a powerful suppressed suffering on behalf of the institute's holographic whole.

Curl

Most mornings I awake with a deep sense of dread,

a whole-body melancholy that

traps me under the duvet, pins me to my bed.

I roll over, I try to sleep, I don't want to get up

and show myself to the world.

I disappear back into my dreadful fears,

I shrink into a foetal curl.

Loophole

That morning, I didn't feel the *curl*. Instead, I was excited, pleased with myself, a little bit giddy at the conjuring act I believed I had devised in the small hours of the night. What I thought I had done was find a way to keep myself protected from the full force of the sun's rays. I had come up with a strategy that would allow me to shelter from exposure. I couldn't believe I hadn't thought of it before: I would carry out an autoethnographic study, but I would part-fictionalise the story. This would still require me to re-write a lot of my proposal, but I was up for it. Part-fictionalising would provide a loophole that allowed me to write autoethnographically but maintain some protection from the sun. No-one would know whether the 'me' in the story *'really did that...'.*
I set to work, and this is what I came up with, my revised research proposal abstract:

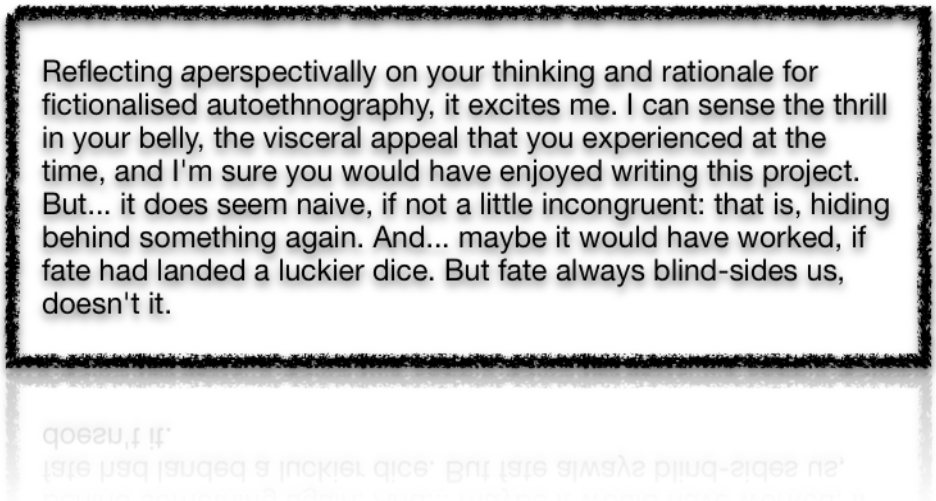
Title: Researching the Suicidal Healer - an autoethnographic novel

While reflecting on my own experience of suicidality as a trainee psychotherapist, I will draw on dialogue from six interactive interviews with psychotherapists who have been suicidal, or as Ellis (2004) calls them 'suicidal healers' (p. 66). The interviews and reflections will help me create characters that will populate the cast of a fictional group who embark on a walking expedition in the South of England. The story will be written as an autoethnographic novel with myself at the centre, as a researcher who has selected via interview the group of 'suicidal healers' and brought them together for this journey. I want to convey what it is like to be a person and practitioner in the context of a self-suicidal story - the phenomenology and existential life of the suicidal healer - while bringing alive the internal and interactional worlds of the characters through the conversations and

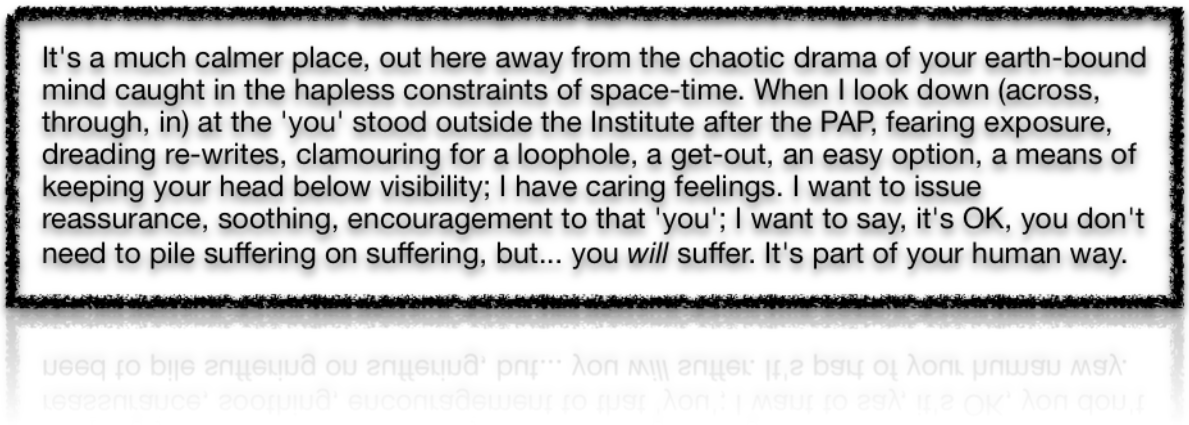
events along the way. I want also to convey what it is like to be a researcher exploring this phenomenon. The fictional trek will give me the opportunity to investigate this phenomenon through the richness provided by the imagination (Ellis, 2004).

The decision to fictionalise my personal odyssey in autoethnography frees me up to do the research I want to do and tell the story I want to tell, while maintaining confidentiality and protecting participant identities. 'How the story is told' is central to getting inside and generating insight (Chang, 2008, p.?).

This sounded so much better than my original project; it was exciting, daring, cutting-edge. The fictionalised aspect would allow me to get beneath the skin of what can't be expressed, necessarily, in an interview. I could weave in my own imagined worlds and offer something additional to standard qualitative research, freeing up the constraints of silence and barriers. I could also be explicit in how this model achieved my own self-care through part-fictionalising my own character in the story.



Triple Trouble



I'd taken some time out over the summer following the June PAP. It was nice to let the idea of fictional autoethnography melt in and to get more comfortable with it. In September, as I made the final amendments to my revised research proposal, I received an unexpected email from the institute. A number of senior members of the academic team had resigned. This hadn't been completely unexpected as rumours had abounded amongst my peers about changes at the institute. But it did mean that the team who had taken me through to the PAP were gone. I would be working with some new names from now on, which excited me, since I believed new energy and a fresh perspective wouldn't go amiss.

I contacted the team member assigned to me. I was slightly apprehensive because, if I'm honest, I wasn't wholly convinced by my fictionalised autoethnography idea, and I felt it would be easier to sell it to the 'old team' rather than people I didn't know.

There was another issue. The maximum time allowed by the institute to finish the doctorate was eight years. So, my thesis had to be submitted by August 2018. It was the beginning of October 2017 when I had my first phone call with Metanoia. I had a radically revised methodology for my project; someone I didn't know who would have the final say in sanctioning it, and the deadline was

approaching fast. A sense of discalm niggled at me; I'd thought project approval would be the easy bit... '*Triple trouble*' I muttered under my breath, as I prepared for the call.

Connections #2

When K. looked at the castle, he sometimes thought he saw someone sitting quietly there ... at peace ... looking into space ... This impression was reinforced today by the early coming of darkness. The longer he looked, the less he could make out, and the further everything receded into twilight (excerpt from The Castle by Franz Kafka add to References).

K., the main protagonist in Kafka's *The Castle* arrives arbitrarily in a village set in the shadow of an inaccessible fortification - Count Westwest's castle. K., forms relationships with the villagers, gets a job, falls in love. But 'the achievement of his goals depends (ultimately) upon the Castle, which is literally above and beyond the village, remaining more or less inaccessible to the villagers' (Goldman, 2010 add to References).

Throughout the novel, there is an aching hopelessness and alienation to K.'s quest as he pursues his ill-fated goal to access The Castle by trying to communicate with the elusive Klamm, who represents the castle authority. Klamm endlessly holds K. at a distance, down in the village, liaising only via unpredictable and inconsistent bureaucratic processes.

It is poignant that Kafka never finished *The Castle* due to his death by tuberculosis, 'breaking off in mid-sentence' (Robertson, 2017, p. ? add to References), ironically leaving his main protagonist eternally adrift from his objective.

I was about to enter a period of my life for which *The Castle* offered a useful allegory. I, too, had found a new village, got a job, fallen in love. The training institute, with its' unfamiliar new guard, loomed atop an inaccessible hill in my phantasy life' (is this where the quotation ends? And cite what you are citing and which page here), and that pejorative impression was about to deepen.

The first phone call with the research co-ordinator didn't go well. The second was worse. My idea of semi-fiction was firmly rejected and instead of providing an elegant solution to my fear of exposure, it seemed to instil a sense of mistrust in my ability to come across as a serious researcher, at least on the part of the new research co-ordinator. Over a period of months I fought, on increasingly less common ground, to maintain a relationship with the institute and research co-ordinator. I dropped the semi-fiction idea, but then it appeared the research co-ordinator had a problem with autoethnography per se. I offered to drop autoethnography, while appealing all the while that it was the PAP panel who had suggested it in the first place. Month after month it became increasingly difficult to get hold of the research co-ordinator, who turned, with increasing suspicion, against my project. By March 2018 I had reached a wretched impasse. My response was to go back to the books; I researched autoethnography and completely re-wrote my research proposal (the one that had, ehem, already been approved six months before!).

All through this, while feeling that I had lost the core focus of my research and why I was doing it, I also felt like I was slipping into a state of disconnection with the institute that should have rung alarm bells. Because, for me, disconnection was the seat of suicide. To understand this, I had to go back.

Foregrounding: The Suicidal Trainee

Rewind the tape...

Let's foreground the background. Where all this began. My starting point: where this research was conceived. Without my knowledge that it had, of course. *How could I have known?*

A Sudden Ending: Diary Entry 16 September 2012

They are the memories that endured, the burn memories. Alongside the irrepressible loneliness and horror of isolation, the petrifying insomnia, the wild, tormented internal rages, the screaming into my pillow, the planning and plotting my self murder. The burn memories: *standing on the second-floor landing, calculating if it's high enough; looking at the motorway bridge barriers, wondering if they're hard enough; counting the pills, figuring if they're deadly enough*.

It's hard to recall exactly how and when it started, when the collapse into my singular conclusion began. I remember having a good summer, then enjoying the autumn storms. I felt excited about my imagined future. But... where my future was bright and promising, my NOW was anything but. I had successfully avoided directly addressing how things were right in that moment, and when I was nudged into doing so, I was immediately felled.

The savage torment began the week I got a 'refer' for an assignment I'd submitted as my first piece of graded work for the year. It was accompanied by some scathing, brutal feedback. That week I also had the final sorry phone call with my ex. The twist of it was knowing it was over, that she had moved on, that we would never again be together. But it wasn't.... her. Our relationship had been short. It was more... the realisation of where I'd landed - in my lonely flat in a corporate suburb, a place and a culture with which I had no connection. My 'people' had gone - the songwriters, the

musicians, the artists, writers, the thinkers. I looked out every morning at my neighbours togged up in sharp suits, climbing into flash German sports cars, or heading out onto the commuter trains. I saw things in binary ways and felt so alien to it. I just didn't belong in this place, this now... and I extrapolated that to: *I didn't belong in this world*.

It wasn't the first time I'd been suicidal in my life. Now, with the threat of failure hanging over me, the future went dark. There was a finality to it. Me, alone in my flat, disconnected from hope.

Connections #3

When I was a child I had a recurring dream. I was traversing a steep hillside, with the peak of the hill up to my left and the valley down to my right, below. In the dream, elevated parts of the hillside up to the summit constituted the living world, and the valley below was the afterlife. As I edged along, it was possible that I could easily slip down, over the invisible threshold, into the death valley. An aching, invisible force acted on me, colluding with gravity, swiping at my feet, urging me to tumble helplessly into the void, where I would still exist, but with no way back to living. I could walk up past the border line and approach other people, but they wouldn't see me - how could they, I'd be dead - I'd be invisible to them. So below the line of death I'd stay. From there, I could watch the others traversing the hillside, their living presence tormenting me as I mourned my fate. In that deep valley there would be no demons, pits of fire, grim reapers or ghouls. The raw terror of the place was in being utterly alone.

In wretchedness during that time, I felt completely isolated and disconnected from the human world. Even at the institute, I felt as though I were an invisible presence, wandering amongst the living who, despite the gestures, smiles and polite interactions, I concluded, could not see me.

I put a lot of thought into whether I considered myself mentally ill when I was suicidal. Every episode of suicidality I experienced had such strong social contexts, often orbiting around

relationship break-down, alienation, interactional powerlessness, disconnection. I struggled to reduce it to a malfunctioning intrapsyche.

Like one of Kafka's central characters, I found myself depersonalised, marginalised, deconstructed and interpersonally invalid, and those feelings crystallised into suicidality. The impact of interpersonal and social *dis-affect* manufactured in me a death of desire to live. Like the invisible, spirit-me in the dream, I wandered dead amongst the living.

Kafka's protagonists are often unable to give up climbing further into the nightmare, deeper into their futile cause. The horror intensifies as their tragic momentum keeps them moving, even while all hope is gone, as though driven into insanity by an invisible death force. The protagonists act out a mournful, helpless sleepwalk; the feet keep stepping on, long after the announcement of hopelessness.

Through this deathly enchantment, I survived. I instinctively knew that the problem was a relational one and had a relational solution. I'd lost touch with a lot of friends and I'd ostracised myself from my birth family. So I turned to others for support. My primary clinical supervisor at the time, Haich, was someone who I came to value dearly, because she was the epitome of an integrated practitioner, someone who bore their wounds and acknowledged them, was able to sit with fragility and express her own vulnerability while displaying a strength and compassionate sense of humanity. Haich gave me a burn-memory with her words, 'Stay in mess, Martyn,' a welcome counterbalance to the more typical therapeutic response to risk, of crass protocol, disenfranchisement and an urge to rescue.

Marble was a psychotherapist who I got to know through my time working in drug and alcohol treatment centres. He had a brain the size of Jupiter and was capable of endless giving. Marble told me to aim high and recommended the doctorate program at the institute. In one of the first conversations I had with him, he quoted Petruska Clarkson. I'd never heard of her back in those days, so when he said, 'Clarkson says, "the unspoken relational content of any therapeutic

encounter always holds sway over any technical intervention'", I remember thinking, '*Jeremy Clarkson said that??!!*'.

I met Kristen through Marble. She was a family services therapist, I could be excruciatingly open and honest with her, and we became close friends. Coming from Finland, she could drink me under the table too and, well, that seemed to help from time to time.

So, I believed that when I was suicidal, I was experiencing an interpersonal problem with an interpersonal solution. I never thought I was mentally ill; just fucking lost, lonely and pining. When I didn't have access to my life-saving connections, I reached out through bleak verse, that oddly helped.

Done

I remember, it was September, The clouds took on a harvest glow
of barley brown and fooling around, of last year's fucks in snow.
But each late summer fight, I swore, in secrecy; one more, *I'm done*.
Each time we trashed the hope of love, while tearing out our tongues.

I remember, now October, driving crazed, stalking my confusion,
The echoes of our jokes, a respite; momentarily, I dreamt of healing.
But when I got home and saw you writing, you hadn't known I'd gone,
I waited for your carriage break, then coldly, said *I'm done*.

I remember, bleak November, walls crumbling around,
Of fantasising fucks in flashbacks, cumming up and
crashing down.

I'm on the edge of losing hope; I'm on the edge
of losing hope. I'll never make December.
The void awaits my wretched eyes,
the devil shapes me clever.

I remember, getting there, while wishing
that I hadn't. And howling at how
cowardly, I begged, please take me, serpent.
When things got bleak, I felt a brief caress from heaven.
There was a mercy in relief, that God knew I was falling.

I remember Christmas eve,
when I got your email, You said 'life's good,
but *I'm not done*; I'm hoping we can talk now'.
I wrote straight back, I stayed polite,
and gently turned you down.
The chance of hope or finding peace,
might fuck my new life underground.

I remember January, turning thoughts
to summer, Then I knew that season warms,
but winter is forever.
I'm past the point of losing hope;
I'm past the point of losing hope.
Fuck my absurd survival.

I wasn't supposed to carry on;

Now I am *done*.

Dis-connection

Forward-wind the tape...

It was June 2018, nine months on from the first phone call I had with the new DoP after my PAP. It had been a desperate nine months that left me feeling embattled and losing grip on the meaning of it all. Prior to that phone call I had been hoping for a straightforward project approval. *I'll be interviewing by Christmas*, I'd thought to myself. That optimism had been lost to an extended period of excruciating frustration.

Gone Crazy

I have a scruffy brown folder stuffed away out of sight in a cabinet in my study. I think of it from time to time, but I don't want to take it out or have a look at it. The folder contains all the correspondence, email prints, phone call notes and letters between me and staff at the training institute from the period October 2017 to June 2018.

I had collated the folder at the beginning of June 2018 (one year since my Program Approval Panel), in preparation for an official complaint I was intending to make against the institute. When I sat down to write these reflections, I knew I would have to go and get the folder. I felt more emotionally equipped to see it again, but I wasn't filled with joy at the prospect.

The folder was thicker than I had remembered, jam packed with pages of printed correspondence. It told part of a story - the official, carefully worded, relatively adult side. But just holding it in my hand triggered feelings from different, darker, turbulent, less-adult version of me. I turned the folder over and saw that I had scrawled in permanent marker across the front, 'GONE CRAZY'. I hadn't remembered doing that, but the words resonated with me. The words compressed my chest. The words squeezed my throat. The words emptied me of me.

I pulled out the first sheet. It contained the email arranging the phone call with the research co-ordinator, October 3rd, 2017. I recalled the apprehension I'd had before the call - though now, reflecting, I would never have believed that, while having the ever-present August 2018 deadline hanging over me, it would take the best part of another year for project approval.

I remembered October 2017 being the start of the lost months - a deepening sense of helplessness and distress - as though a helium balloon filled with all my future hopes, whose string I had been trying to grip onto, was pulling away up into the sky as the thin twine slipped through my fingers.

I grimaced at those scrawled words, GONE CRAZY. They were not an exaggeration. When I collated that folder, I had, simply, *gone crazy*. And it hurts too much to say it. I feel too ashamed to say it, I'm scared to say it... what judgements?... what consequences?... My fingers are leaving sweat on the keyboard.... My fingers are burning....

[2] What Fresh Hell...??

It's the 5th of June 2018. One year since my PAP. I'm sat in a supermarket carpark, having a coffee break. I'm on my way back from some NHS training on suicide prevention. The fucking irony. It was awful; the instructor on this two-hour abomination did and said everything that I loath about stereotypical gone-bad mental health care workers attitudes towards the suffering and dis-stressed people they are supposed to be looking after. Everything he said was about 'them' and 'what they'll try to do if you don't watch out for it', and how 'they don't seem to get how they're affecting others'... and war-stories, like 'I heard about one time on a Psych ward...' and, 'this patient was being watched twenty-four-seven by three MH nurses, but still managed to...' and all of the

[2] A wonderful exposition of the potency of staying in touch with vulnerability is offered by White, 2012.

savage details of the deaths and attempted deaths, and 'they this...' and 'they that...' all object, no subject. I fucking detest the othering (Goodwin, 2017) that goes on in places where it should be stupefyingly obvious that such an inhumane attitude towards vulnerable people is abusive.

I distract myself from my internal ranting by getting from my bag a well-thumbed printout of my research proposal. I haven't looked at it for a couple of weeks and I'm perusing a small section of my methodology chapter, feeling quite pleased with what I'm reading.

An electronic ping: new email. Oh... it's from DP.... this is what I've been waiting for. I open the message, full of hope, that '*this is it... I'm near the end...*.'

DP thanks me for sending my 'interesting proposal' and ethics forms. He has some questions. I scan through them. Most of them are fairly reasonable, but my eyes settle on his final question:

Have you gone through the PAP process, and if so, what were the outcomes...?

(I'll write that again, in bigger, shoutier letters):

Have you gone through the PAP process, and if so, what were the outcomes...?

It's the 5th of June 2018. I'm sat in a supermarket carpark, having a coffee break. I'm staring in disbelief at that question, over and over... **Have I gone through the PAP process?**... is this a joke? A year of hell after that fateful PAP and I'm being asked this...

I drop the phone in my lap and throw my hands over my face. An eerie squeal breaks out from the back of my throat; I'm listening to it... it's me... I'm making the noise... but it sounds like a wild animal... it won't stop... it's getting louder... it's me... I'm shrieking....

I'm in a state of crisis. I feel like a vat of molten lead is being poured through a hole in the top of my skull and is melting through me. I start to break down. I phone the admin office... DoP 'is working from home today'... that's an all too familiar line. I ask for the senior academic co-ordinator (SAC) - another familiar missive: he's away from his desk, I'll patch you through to his voicemail. I leave a

message... I need to speak to you or DoP urgently*. I start the car and drive, fast, heading for home. Ten minutes later, the phone rings... it's the SAC. I pull into a lay-by:*

SAC: *You said it was urgent...?*

Me Gone Crazy (MGC): *I need to speak to DoP*.

SAC: *She's not here. You said it was urgent...?*

MGC: *It is urgent*.

SAC: *Can you tell me why it's urgent?*

MGC: *Look, I need to speak to someone... if DoP isn't there, can you find someone else on the program team?*

SAC: *There's no-one around. I'm phoning you back because you said it was urgent. What's urgent?*

MGC: ....

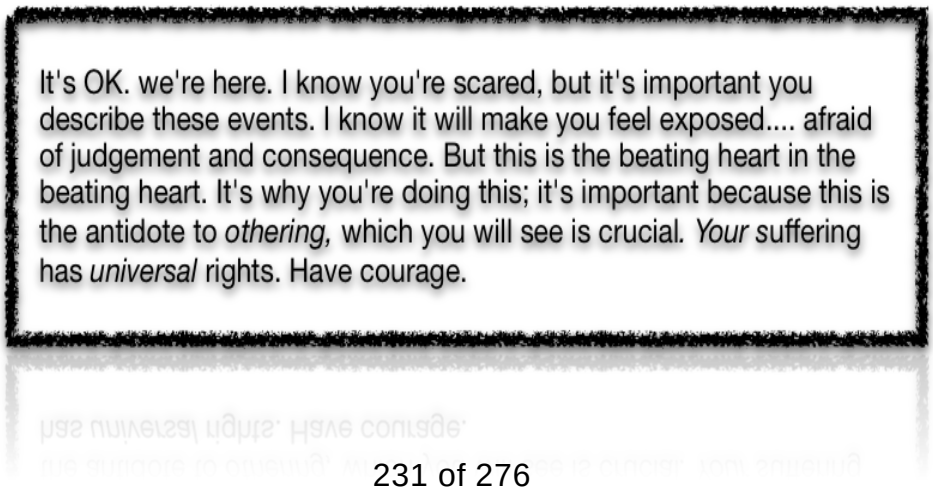
SAC: *What is it?*

MGC: *I'm struggling...*

SAC: *Have you tried emailing DoP?*

MGC: *Have I....?!! I'm.... it doesn't matter. I'll email DoP*.

I start the car. Race home.... I write an email to SAC, copying in DoP, saying I'm going to instigate complaint proceedings. Then I spiral down.



I remember many years ago attending an evening course on creative writing. One of the handful of burn-memories I have from the course was being shown how drama is often structured - I think it was called 'the Disney formulae' (though I might be wrong) and it went something like this:

There's a protagonist who, confronted (often unwittingly) with a conflict, has a number of failed attempts to solve the problem, resorts to back-up plans, has a breakthrough that works and finally wins out.

But... there's also a revision to this formula:

After the breakthrough that works, when least expected, there is a catastrophic twist that throws the protagonist and the cause into the abyss. Dot dot dot...

Contemporary script writers and film makers can play around with what happens next. The Disney ending is to miraculously return fortune to its feet as the protagonist achieves something, often superhuman, and somehow saves the day. Alternative stories leave the protagonist and cause dead in the abyss. Some movie makers revel in this loss of hope (my current modern favourite is Yorgos Lanthimos).

One difference between story writing and real life, is that all us protagonists have no idea whether we're going to get the Disney ending or the Abyss. Further, even if we finally win out, it's possible that the trauma of battle takes such a toll that we simply no longer give a fuck. And with trauma and abyss on the *inside* often not apparent on the *outside,* all the people around us protagonists just don't get it. Consequently, trying to explain 'it' becomes tiresome and miserable, and simply adds to the desire to shut down contact with the whole human race and give in to sedation.

No Disney Ending

The truth was, I still found it hard to write about my own suicidality. My proposal and ethics applications were both signed off in July 2018. In the meantime, I had become aware of two competing feeling-selves. The first, stubborn and proud, wanting to strive on with the research, had kept going through the hard months of grinding out revised proposals, wouldn't accept defeat. The second feeling-self: raw and direct, was a version of me that wanted out, felt exposure from the stripped-back ozone layer, heeded what I believed to be an unspoken wish from my academic supervisors to give this up, whispered in my ear, '*you can still choose no, you don't have to do this, save your dignity*.' I felt the invisible eyes of judgement from academia and clinicians over how this might affect the image of their (sic) profession.

I lived out the anxiety of my research before the project had even begun. As a trainee psychotherapist, the forces that stopped me from opening up about my suicidality mostly orbited around a fear of not qualifying. As a qualified psychotherapist, writing these reflections, fear was still alive and scheming, squeezing my guts and clawing at my spine, hankering me to shut down this ludicrous endeavour, afraid of the unknown consequences of saying the words 'sometimes when I'm really distressed I think about killing myself'. The difference between then and now was that...each...next...word...I...wrote... was not driven by stubbornness and pride, but by an earned conviction, born of and reinforced by the twelve month battle I had since the PAP in June 2017, that this research was vitally important. I could not justify backing down, particularly in telling this story in my own way, not in a way fed to me by an academic institution that hadn't courageously engaged with the suicide of one of their own, or even granted me a face-to-face meeting, after twelve months of asking. I could now re-assert... with... each... next... word... I... wrote, that I must rail against fear and honour the timely need for this research.

Ashamed

I can rail against fear, but the shame never leaves.

Suicide falls into the category of secrets and shame (Reeves, 2010: p.128 if this is a quote, put quotation marks around the words you are quoting). I felt an implicit judgement, just from writing the diary entries in this chapter. At the point of writing, noone had seen it, noone had read it. Still, the visceral pull from my fight-flight system, the cold wave that washed up my spine and into my neck and arms... that frozen disquiet, delivered terrible ignominy. The call from my bones to delete the prose, erase it, feel the relief, dodge the bullet; was powerful and compelling. But suffering has its own rights. This was the beating heart in the beating heart of my research. If the goal was to dismantle barriers, challenge stigma, engender mutuality and abridge *othering,* then *it* had to survive. And so did I.

The Complainer

Through the twelve months between my PAP and getting research and ethics approval, I couldn't believe what was happening. But while getting caught up in a vicious cycle of feeling unheard and unmet, I'd also started to think, am I just turning into '*that*' student, the thorn in the side, the '*complainer*'...? I imagined my name reverberating around the institute admin office every time the phone rang, '*oh for fuck's sake, it's him...*' and that no-one wanted to deal with me, because I was *the complainer.* The more I asked, the more mud clung to my name, I fantasised; the greater my ill-repute, the lesser the compassion. An already unhelpful interpersonal pattern of mine - *where there is silence, imagine the worst* - whipped up into a spiralling storm.

I got caught up in a seesaw between two poles: was I principled, or pig-headed? Was I justified in my persistence and complaints, or just a pain in the backside? Was my dissatisfaction legitimate, or was I expecting too much? Was this just an average PhD experience?

And what of my emotional response? Mental Health advocate, Fiona Malpass, talked about the unhelpfulness of the term 'resilience' when applied to living with mental health. She called it the modern version of 'chin-up' or 'snap out of it' and a measure against which one can be evaluated as 'not trying hard enough' or 'resistant to change'. A favourite (dis) missive of mental health workers currently, when responding to a depressed person, is 'couch to 5K', as though all the problems in the depressed person's life can be cured by running. I'm not (dis) missing the helpfulness of exercise in managing depression, but both exercise and mindfulness practice have become singular monolithic responses to depression in the contemporary wellbeing industry.

All that said, I judge myself as having low resilience. I am vulnerable to feelings of perceived attack. I struggle hard in managing (dis) stress; I feel I do OK with it, mostly, but sometimes I fail.

Research Approval Epilogue

Closer... pause... further away... pause... there's a film I remember from childhood. Someone has to get to a door at the end of a corridor. They start running and as they do the corridor stretches away in front of them. The door recedes, the faster they run. Time always moves forward. Life doesn't.

I have described how the discomfort and resistance I anticipated around researching psychotherapist suicidality recapitulated through academic processes of research project approval, akin to a parallel process (Morrissey & Tribe, 2001). I expected the methodological and ethical aspects of my study to be scrutinised, and it was, but there seemed to be something else going on, an additional contributing factor creating misfires, signal failures and inconsistencies in the scrutiny process. It felt at times like there was a subtext to the delays, miscommunications, silences, absences, and U-turns. A covert force pressed me into walking away from this project while the overt message from the institute was that they wanted me to complete the program and qualify. Time and time again I had to pull myself out of a state of deep confusion and urge myself to believe the latter, because their resistance and disengagement seemed to overwhelmingly belie that message.

A parallel explanation was that the institute was in disarray following high profile resignations and hadn't got back on the horse; that it was bad luck and bad timing that this happened. At least the holographic view helped me render the journey, in this way, *a*perspectivally.

I'm not a fan of statements like, 'it was a great opportunity for learning and growth.' I'd have chosen not to be driven to crisis anytime. That said, one positive outcome was that those nine months had yielded a more 'quality assured' research project, and I had a better grasp of my methodology and the kinds of critique I may encounter. I also felt incredibly happy, in the end, at being nudged

towards autoethnography. By then, I couldn't imagine engaging in research in any other way, to be congruent with my goal of dismantling *othering*. My focus had changed from, *What can we learn from the experiences of psychotherapists who have been suicidal?* to *How, through dialogue with others, do I make sense of my own experience of being a psychotherapist who has experienced suicidality?*

The focus shifted from '*those suicidal therapists out there*', to '*us suicidal therapists together*,' and felt more rounded and complete, as well as open and mutual. And I had experienced a leap towards fearlessness - not complete and, I imagined, never would be. What changed was that, rather than being afraid of and hung up over being a touchy fucker, I was now able to celebrate it. I saw my vulnerability as a superpower. The surprise, and delight in that surprise, was now understanding how learning about myself through the process of a research journey was possibly the most valuable outcome of all. I saw autoethnography research as an opportunity to study and understand something out there by changing '*something in here*'.

I'd had a rare phone conversation with (another) temporary head of programme, in which he said, '*you seem to perceive everything as an attack.*' Ironically, and unexpectedly, the head-shaking gall of this statement had the effect of releasing me into a psychological space where I could access a more balanced sense of reflection on the research approval journey, the *a*perspectival, if you will. That might have been 'giving up' in part, but the effect was ultimately helpful. He told me someone was being recruited to head the programme, and shortly after I was contacted by that newly appointed program team member, who brought with them a timely and a blessed sea-change. They responded to my initial emails promptly, agreed to meet me... met me... liked my research proposal and read 'An Innocent Proposal' with interest and appreciation. They continued to maintain regular contact, fed me useful and interesting papers to read, and willed me on. It made a remarkable difference.

Throughout those twelve unexpected, difficult months, I had repeatedly cried, '*I just want to get started with my research*'. Actually, my research had started before I even knew how to string that sentence together, before this touchy fucker responded to the harshness of the world by hiding away his fragile self. With my new collegial relationship with Sophie BC, my viewpoint on research had changed; I now understood it as an opportunity to use my-self-as-cultural-filter, in *relation* to the phenomenon under investigation. I felt like a very young and very old part of me had been reunited, a connection activated, I had been holistically actualised. Still, I was far from journey's end.

When I got there, it wasn't what I had imagined at all

The pictures I'd seen in the travel brochure portrayed
a beautiful enticing bay, with sandy shores and bathwater
warm, calm inviting shallows. When I got there, I found
a steep pebble beach, uncomfortable to navigate
barefoot, the stones too hot and jagged for soft novice
Devonian feet. When I waded into the water, it was deep
beyond my stature, only several yards in, my toes lost the
ground. I fought to stay afloat as the seawater, warm in
patches, ran with icy currents that shocked my skin, while
salt spray lashed from unsettled breakers, eyes stinging,
expectations waning.
In the brochure, gentle tree-lined hills framed the beach,
conjuring late afternoon daydreams, strolls up through
easy-breeze, effortless well beaten paths, to peaks;
where staggering views of the surrounding islands,

palms and turquoise seas, would lift the heart to the
heavens in disbelief, that there could be such beauty.

But the trees turned out to be thick and tangled scrub,
hard to fight through, tricky to handle, bearings lost; the
view obscured by a high dark green canopy, the air sticky
humid haze, that made the pores pour and the clothes
saturate.
No gentle climb, but sharply inclined, even vertical at times.
Cut hands and blistered toes from an ascent that, far from
being satisfying, took a heavy toll; not least, on the
blown, battered expectations of a steady evening stroll, an
exalting wilderness 'there and back home'.
Never did I imagine, I'd be gone so long.
The brochure was emblazoned with a slogan: we are already
friends, we just haven't met yet. I took that as reassurance,
a universal warmth of dwellers, as I saw, who's meeting would
be the biggest pleasure of all.

When I got there, things were not so simple, so straight forward.
There had been warnings from those who'd been before, people
who had stepped out into similar places sounded sirens and horns.
'*They hadn't been to my place, they didn't understand m*e'
I muttered away from hearing. I *knew* it would be different,
more friendly, less fraught. 'They think they know best'

I thought; they're just doom mongers, nay-sayers, judgement

passing, where they never ought.

But the brochure did not, show the frowning and ghosting,

and being led with faith, to where mosquitoes plagued,

and being promised sunsets, but steered into rain.

And walked into nests of red ants that crawled,

up trouser legs and bit at soft skin;

nowhere were the warning signs, that the blue

cloudless skies could be marched upon in

minutes by thunder, rain and violent squalls.

When I got there, It wasn't what I had imagined at all.

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Appendices

Appendix A - Participant recruitment notice

Appendix B ; Participant Information Pack

Appendix C - Psychotherapist Suicidality Research Study

Appendix A – Participant Recruitment Notice

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET

Research into the suicidal experiences of psychotherapists

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

It is very important for you to understand that the interviews you will take part in will be a two-way focussed conversation with us both 'telling our stories' rather than traditional 'researcher asks question, participant answers'. This is explained in more detail below. *Thank you for reading this.*

What is the purpose of this study?
The purpose of this study is to jointly explore our experiences of being psychotherapists, or psychotherapists in training, who have been suicidal. We will meet in an interactive interview setting, which means you will have the opportunity to ask me questions about my experience as well as me asking questions about yours. The study aims to provide an in-depth and intimate understanding of therapist suicidality. The background for this study is noticing the lack of lived experience narratives from therapists. The study will require you to meet me for two interviews and will take place during the summer of 2018. Our interviews will be written up as an autoethnographic account of the stories that emerge, and meanings explored in our conversations.

Why have I been chosen?
You have been chosen because you meet the requirement of being a psychotherapist who has had been suicidal during your career or your training. I am planning to recruit three participants for this study.

Do I have to take part?
It is up to you to decide whether or not to take part. I will recruit participants on a first-come-first-served basis and have a short initial telephone conversation with you to assess for suitability. This will mostly be about establishing any current suicidal feelings, which if present, would preclude you from continuing as a participant.
If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

I will adopt an approach of ethical vigilance towards issues of good practice in line with BACP, UKCP and HCPC code of ethics. As such I will be bound to report any incidents of serious malpractice, including historical malpractice.

What will happen to me if I take part?
If you take part, you will be invited to take part in two interactive autoethnographic interviews (see below) on times, locations and dates convenient for you. The first interview will happen within a month of your agreeing to take part and the second approximately three weeks later. The interviews will take place in a private confidential room at a location agreed by both of us and will last between one and two hours. During the interviews we will have a conversation with the focus being on each of our personal suicidal experiences. I will ask you in advance of the interview to reflect on your experience, prepare questions, and bring any artefacts, self-reflection/self-interview material, poetry, music and art relevant to your suicidality experience. I will similarly prepare and bring material relevant to my experience, along with interview questions to ask you. Please include fifteen minutes beforehand for introductions and settling into the interview setting, and some time after the interview for debriefing. Each interview will be recorded.

Interactive autoethnographic interviewing:
Unlike traditional one-to-one interviews, interactive interviewing involves both me and you asking questions about each other's personal experiences.

We can both disclose to each other details about our lived experience/s of being suicidal. This may be anecdotal, in conversation, reading diary/journal entries, poetry we have written at the time of our suicidality or post-experience, songs we may have written, art we may have created in response to our suicidal experience/s. I will be talking to you directly about my suicidal experiences as a trainee/psychotherapist; I will be bringing material with me to read or perform or show to you, and you have the space to do the same.

In contrast with traditional qualitative semi-structured and unstructured methods, interactive interviewing allows me to foreground my own story as well as you foregrounding your story. We will be paying attention to what is learned from the interaction between our mutual disclosures and expressions in the interview setting, collaboratively engaging *both* stories brought to the research encounter. Rather than the usual sole researcher-participant endeavour associated with autoethnography, interactive interviewing allows me to co-construct a narrative with you that will provide the raw data for my autoethnographic text: in other words, telling the story of 'the sharing of stories'.

What do I have to do?
I am asking you to take part in two interactive interviews. The reason I'm conducting two interviews is to offer us a chance to reflect after the first interview then come back together to talk about our reflections. It is important that you feel safe and comfortable in the interviews, so I will offer you the opportunity for breaks for comfort or refreshment.

What are the possible disadvantages and risks of taking part?
There is no known risk in participating in this project. However, should telling your story, or hearing my story, bring up anything that upsets you, or if you re-experience distressing emotions as a result of 'opening up' to painful experiences, I will provide a framework for continual support in the interview and post-interview environment. Prior to interview I will request your next-of-kin

contact number and permission to contact them; I will also request your GP details and explain a confidentiality policy that includes my obligation to call emergency or crisis services should the participant become actively suicidal. I will be as transparent as possible about any need to contact your next of kin and will endeavour to engage openly with you about any concerns I have and any subsequent safeguarding / risk management. At the beginning of the study, I will provide you with an information sheet outlining crisis support resources, locations and telephone numbers, telephone access to myself, allowing you opportunity to discuss anything triggered by the experience.

What are the possible benefits of taking part?
We hope that participating in the study will help you. However, this cannot be guaranteed. The information we get from this study may help us to be more informed and think more clearly and openly about therapist woundedness in the future. It may help with future research into practitioner lived experience.

Will my taking part in this study be kept confidential?
All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. Every effort will be made to ensure your anonymity is maintained, to the extent that you request. Choices will be offered to you as to how your stories, and other people in your stories, are represented in the text.

All data will be stored, analysed and reported in compliance with UK Data Protection legislation, and will be destroyed after thesis examination.

What will happen to the results of the research study?
This research will be published as part of a post-graduate doctoral dissertation. This is projected to happen late 2018 / early 2019. I will inform you when the research is published and let you know how you can obtain a copy of the published study. You will not be identified in any report/publication.

Who has reviewed this study?
The Metanoia/Middlesex University Research Ethics Committee has reviewed this study.

Contact for further information
For further information I, or my supervisor, can be contacted through via:

Martyn Oakland
Metanoia Institute
13 North Common Rd.
Ealing, London W5 2QB
+44 (0) 20 8579 2505
martyn.oakland@metanoia.ac.uk
Participant information sheet date: [10-5-18] Version number: 1.1

You as a participant will be given a copy of the information sheet and a signed consent form to keep.
Many thanks for taking part in this study.

Best wishes,

Martyn Oakland

Appendix B – Participant Information Pack

PARTICIPANT INFORMATION SHEET VERSION 1.1, May 10th, 2018

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

Research into psychotherapist suicidality

CONSENT FORM

Participant Identification Number:

Title of Project:

Suicidal Therapists: an autoethnographic exploration of psychotherapist suicidality using interactive interviewing

Name of Researcher: Martyn Oakland

Please initial box

1	I confirm that I have read and understand the Information Sheet that is dated ....**1st August 2018**..... for the above study and have had the opportunity to ask questions.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.	
3	I understand that my interview will be taped and subsequently transcribed.	
4	I agree to take part in the above study.	
5	I agree that this form that bears my name and signature may be seen by a designated auditor.	

_____ _____ _____

Name of participant Date Signature

_____	_____	_____
Name of person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Name of participant's next of kin (NOK)	NOK Contact number	Permission to contact NOK (Y/N)
_____	_____	_____
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

Appendix C – Interactive Interview Schedule

Research into psychotherapist suicidality

INTERACTIVE INTERVIEW SCHEDULE

This is a guiding framework for initial questions to be drawn on as needed.

Because this is an INTERACTIVE INTERVIEW the questions are posed to both participant and researcher and the direction of discussion is two-way and likely to become more fluid.

I will be talking about my own lived experience of being a trainee/psychotherapist who has felt suicidal as well as asking you about your experience.

Ideally, the interview will work better as a bi-directional 'synchronous' discussion ('interviewer' and 'interviewee' both contribute to each question as they arise – e.g., one talks about how it affected their professional life, then the other says what it was like for them).

1. I'd like us to talk about our experience(s) of being psychotherapists, or trainee psychotherapists, who have been suicidal. I can start the discussion by telling you a bit about my own experience, then you could tell me your story. If there is any journaling/writing, poetry, songs, creative/artistic material that emerged from the suicidal experience, we could start by reading or listening to that.

Other useful prompts might be:

Background, history, attempts, thoughts, context, relationships, domestic/professional situation etc
What was it like at the time?
How did it affect everyday life?

2. How can we reflect on the specific experience of being a psychotherapist who has been suicidal?

Prompts:

Emotional and professional impacts and reactions?
Effect on sense of identity, self-image, mental health, wellbeing?
What sense can be made of psychotherapist suicidality?
Do any words or images come to mind when thinking about being a therapist with a history of suicidality?
What kinds of self-talk (things you might say to yourself) might one have about having been suicidal and working as a psychotherapist?
Has the suicidal experience changed personal/professional identity? If so, how?
How would things be different if you hadn't ever had a suicidal experience? Do you imagine you might see your professional identity differently?

Are there any positive or beneficial things arising from having experienced suicidality? If so, what?

3. Is there anything different about one or more aspects of the suicidal experience that can be attributed to being a therapist as opposed to a non-therapist?

4. In the context of being either a trainee or qualified, did you do anything differently, interact or communicate differently with your peers, tutors, supervisors, or mentors, or worry about the consequences of what you were going through?

5. What has been the impact of suicidality or suicide attempts?

Prompts:
In career/work life.
In leisure activities.
In peer settings (e.g., CPD/training).
In your family.
Socially.
In relationships.
How have other people (colleagues, friends, family members) responded to your experience of suicidality?
Negative judgements.
Fear of negative judgements.
Increased empathy or more defensive practice.
Any key moments that stand out in your professional/personal history?
Any contact with mental health professionals and services, G.P.'s etc, regarding your suicidality?
future projections, fears?

6. What has helped when dealing with difficult memories?

Prompts:
How have you coped with memories and any consequences in personal and professional life?
Self-management/resilience/coping strategies?
Psycho-medical help?
Practical and emotional support from others?
What helped when addressing concerns about professional practice?

7. Is there anything else we feel might be important to express or talk about?