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Therapists' Experience of Working with Suicidal Clients

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Abstract

This paper is based on a study of therapists' experiences of working with suicidal clients. Using a hermeneutic-phenomenological methodology informed by Heidegger, the study provides an understanding of the meaning of therapists' experiences from their perspective as mental health professionals in New Zealand. In this regard, the findings of the study identified three themes: Therapists' reaction of shock upon learning of the suicide of their client; Therapists' experience of assessing suicidal clients as a burden; and finally, Therapists' professional and personal crises as a result of their experiences and struggling to come to terms with events.

The study sheds light on how the experiences of therapists whose clients have committed suicide can be understood. The findings show how mainstream prevention and intervention strategies result from the misrepresentation and misinterpretation of our traditional way of knowing what it means to be human. When therapists discover that phenomena are not necessarily what they appear to be, they feel unsettled and confused about their responsibilities and what it means to live and die as a human being. The study reveals that therapists experience a profound legacy of guilt, doubt and fear when a client commits suicide. Finally, the study proposes that the time has come for the profession to care for its own in order to allow therapist, in turn to care for (and about) the vulnerable other.

Introduction

Researching suicide is challenging as the person most able to relate how the death came about is no longer alive to provide an account. However, therapists who treat suicidal clients share the process and the experience. A therapist's professional expertise is invested in the prevention of suicide and when a client takes their own life, the therapist often experiences an accompanying sense of failure. Therapists ask themselves questions such as: What did I miss? How could I have done better? What could have prevented this suicide? Rossouw (the lead researcher of this study) has been practising under the auspices of District Health Boards (DHBs) in New Zealand since 1996 and recalls his experience of working with clients who committed suicide whilst in his care. He was taken by surprise by the authorities' anxious emphasis on the administrative and documented evidence related to the cases. It seemed that the institution's priority was to ensure that it could put forward a defence against possible culpability. His personal experience of the tragedy appeared to be of minimal interest to his colleagues and superiors. Further, there was little encouragement to try to understand how the client had arrived at the decision to take his or her life or to discern the meaning behind the formal assessment forms. Rossouw's doctoral thesis attempted to understand therapists' experiences of their clients' suicide by listening to accounts of the therapists' experiences. The quest was to both understand the impact of a

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suicidal event on the lives of the therapists, and to recognise insights gained from being in therapeutic relationships with clients prior to their suicide.

Rationale of the Study

Despite considerable efforts in the last decade, suicide remains a significant problem in New Zealand. In 2005, in comparison with 13 OECD (Organisation for Economic Cooperation and Development) countries, New Zealand had the second highest suicide rate among male youth (15-24 year-olds) and the fourth highest female youth suicide rate. Research at a national level has explored trends and possible correlations between a range of societal, interpersonal and intrapersonal variables and increased risk of suicide (Beautrais, 2000a, 2000b, 2001; Beautrais, Collins, Ehrhardt, & Ehrhardt, 2005; Beautrais, Horwood, & Fergusson, 2004; Beautrais, Joyce, & Mulder, 1998a; Beautrais, Joyce, & Mulder, 1998b; Fortune & Clarkson, 2006; Fortune, Seymour, & Lambie 2005).

Prevention and intervention strategies in the public health system in New Zealand are largely based on the outcomes of correlation studies. The strategies recommended by the Ministry of Health (2004) demonstrate this reliance. Gould, Greenberg, Velting and Shaffer (2003) and other authors encourage further research focusing on developing and evaluating 'empirically based' suicide prevention and treatment protocols. New Zealand coroner Warwick Holmes (The Dominion Post, 2006) believes that New Zealand is not making any progress with suicide prevention amongst young men and proposes that more attention be given to the problem. A similar trend has been observed in Canada, where numerous empirically orientated studies and interventions appear to have made no significant difference to managing the problem of suicide in practice (Cutcliffe, Joyce & Cummins, 2004). According to Cutcliffe et al. (2004), one of the main reasons for this management failure is that a natural-scientific mode of understanding says little about the particular lived experience of suicidal clients and is consequently not taken into account in practice by therapists.

In this article we argue that positivist orientated research findings fail to reveal 'the world' of the suicidal client in practice. Practitioners make use of correlation studies to explore the ways in which various factors predetermine, precipitate or maintain suicidal thoughts and attempts. Those factors that are deemed to contribute to the client's suicidal thoughts and behaviour (such as symptoms of depression associated with suicidal ideation) become the focus of treatment and are the practitioner's primary concern. Therapists thus concern themselves with treating and addressing factors associated with suicide prevention. It seems that institutions believe that there is no point in attending to suicide itself as the client is now deceased. Questions relating to the meaning of life and death for the suicidal client and the meaning of being the therapist who was expected to prevent the suicide find little place in the institutional review of safe practice. In this context, being is overlooked, both as a question for the therapeutic encounter and as ground for insightful reflective analysis. Despite this oversight "it is vital for psychotherapy that the work of helping our patients with 'the question of the meaning of Being' is attended to because it is a question at the heart of everything our patients bring" (Loewenthal & Snell, 2003, p. 26). It is also important to understand what it is like to be the therapist who receives news that a client has committed suicide. How does this news impact on the therapist? What is the on-going experience of living through the aftermath? The phenomenon of suicide is not just about the person who takes his or her own life.

A world understood in accordance with the laws of natural science is not the same as the life-world of being human. According to Wrathall (2005), in order to understand a world we must somehow find a way into the world and attempt to understand the experience of things born into that world. In a natural scientific paradigm of understanding there is only one world (Willig, 2001). Failure to entertain the notion of many different worlds and the many different meanings individuals are able to extract from dwelling in these worlds may be one of the reasons mental health professionals are struggling to address the problem of suicide in New Zealand. The purpose of this study was to attempt to find a way into the worlds of being human and the experiences that are born of these worlds. Finding a way into the world of therapists' experience of working with suicidal clients may reveal understandings that could augment our traditional way of understanding and dealing with the problem of suicide.

A Heideggerian Hermeneutic Phenomenological Methodology

From the outset, this study was guided by a hermeneutic phenomenological methodology. Understanding how therapists experience working with suicidal clients and avoiding the pitfalls of a natural scientific epistemology – particularly the notion of a single world – demands an epistemological position that attends to phenomena in themselves and the reality that is theirs. Heidegger's phenomenology of *Dasein* (being human) makes this possible. The branch of research that calls itself phenomenology aims "to let that which shows itself be seen from itself in the way in which it shows itself from itself" (Heidegger, 1962, p. 58). According to Heidegger, in

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order to understand how human beings make their world intelligible and determine what to do and how to live, it is necessary to first have an understanding of the being 'that' is making meaning and deciding. Thus, understanding therapists' experiences of working with suicidal clients begins with understanding the person who is experiencing, giving meaning and deciding.

Hermeneutics is the science and practice of interpretation (Van Manen, 1990). Heidegger (1962) asserts that the understanding of our being is never fully accessible because it is obscured through conflation with our doing, which occurs as we go about our everyday lives with familiarity and self-evidence and in an unreflecting matter of fact manner. This phenomenon thus requires interpretation. While there is reference to 'who' we are in what we do, it is important to distinguish between how something appears to be and what it is in itself. This distinction allows for a better grasp of the meaning and significance of what we do when we also have a clearer understanding of who is performing the doing.

A qualitative inquiry is inductive and conducive to new understandings and meanings. In this study we argue that a natural scientific enquiry is founded on a philosophy of mind that decontextualizes the lived world of the being that is there and is thus not appropriate for this study. "Scientifically relevant 'facts' are not merely removed from their context of selective seeing; they are theory-laden, i.e., recontextualized in a new projection" (Dreyfus, 1991, p. 81). The danger is that self-understanding no longer belongs to the 'being', but instead belongs to the existence of science. The theory of mind philosophy that underpins a natural scientific enquiry diverts the research's focus and attention in a theoretical manner that no longer matters for the experiencing person. Phenomenology, in contrast, seeks to stay as close as possible to experience itself (Heidegger, 1962).

Method

Ethical approval was granted by the Auckland University of Technology Ethics Committee for this research. Protecting participants by maintaining confidentiality was a key consideration. Therapists are in a vulnerable position when they speak about their assessment and treatment of suicidal clients, especially when some of their clients committed suicide despite their therapeutic endeavours. Participants were assured of the use of pseudonyms to protect their identity and their locations and ages were changed to ensure confidentiality.

The data for the study was gathered through the use of semi-structured conversational interviews. This data collection method appears to be the most widely used data collection method in qualitative research in psychology (Giorgi & Giorgi, 2003; Smith & Osborn, 2003; Willig, 2001). The use of semi-structured interviews allows the researchers to enter into the life-world of the participants, thus providing results that are compatible with interpretive phenomenological analysis (Van Manen, 1990; Willig, 2001).

Participants

To ensure that potential candidates were able to participate without feeling coerced into participation two sampling approaches were used. In the first approach we told colleagues about the study and provided them with a participant information sheet and a copy of the questions, with the request that they contact the lead researcher in their own time if they believed they were eligible and willing to participate. The other approach involved attending one of the regular morning meetings of colleagues working in other mental health units in the District Health Board with making the same request. Potential candidates could thus simply choose not to respond to the invitation if they were not interested in participating.

Thirteen participants between the ages of thirty and fifty took part in the study. All the participants offered their stories spontaneously and freely. The sample group consisted of seven male and six female participants. The participants were all of European descent with more than five years' experience in their respective professions. Six of the participants qualified in New Zealand. The participants were all employed by District Health Boards (government funded free public health service) at the time of the interviews. Five of the participants were psychologists, seven psychiatric nurses and one a psychiatrist. The participants had all worked with suicidal clients and all but two had experienced a client committing suicide while in their care. All have had clients who have threatened and attempted suicide.

Process

The semi-structured interviews were between sixty and ninety minutes in length. At the beginning of each interview the participant was asked to talk about their experiences of working with suicidal clients. The study focused on the participants' subjective experience of events, and participants were therefore frequently asked to return to what they had said and to talk about how they felt rather than what they thought of an experience. It was hoped that returning to these moments of significance would allow the participants to elaborate on their experiences as fully as possible.

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The interviews were recorded and transcribed verbatim. All the participants were given a copy of the extracts from their narratives that were most likely to be included in the study. Participants were thus able to verify their statements, make comments and request that certain extracts be excluded from the study (Caelli, 2001). The participants' narrative accounts were then analysed in four steps (discussed below).

During step one, the therapists' conceptions or understandings of what they had encountered were identified. At the conclusion of this step a number of statements were identified for each participant that described the way in which he or she went about making the encountered phenomenon intelligible for him or herself. This step consisted of the following main elements:

- Listening to the audio-taped interview and reading through the transcription to gain a sense of the participants' experiences (Smith & Osborne, 2003).
- Making margin notes where it was observed that something was taking place that the "participants themselves are less aware of" (Smith & Osborne, 2003, p. 51).
- Noting statements conveying themes, paradigms and exemplars (Conroy, 2003).
- Taking note of ambiguities, modalities, fluctuations and commonly used terms in order to trace them back to their origins in life experience (Conroy, 2003; Crowe, 2006).

The second step in the analysis consisted of gathering the statements identified in the previous step into extracts that focused on a theme, paradigm or exemplar. These themes were then pasted onto a separate Microsoft Word document (Caelli, 2001). Although care was taken to retain the words and essence of the original statements, minor punctuation and grammatical changes were made for ease of reading (Caelli, 2001). The initial interpretations were entered at the point at which the extracts were commenting on the person's doing, thinking and feeling (Heidegger, 1962). These seams of doing, thinking and feeling within the extracts were followed, allowing thinking to find its own way (Smythe, Ironside, Sims, Swenson, & Spence, 2008). At the conclusion of this phase there were many explications of narrative extracts for each participant, with a rich mixture of rough philosophical and psychological ideas ready to be refined.

The third step consisted of an interpretation-writing-dialogue spiral (Conroy, 2003; Smythe et al., 2008) in the same manner described in the previous paragraph. However, during this phase the writing and interpretations became more halting and tentative, with many apparent 'dead ends', confusions, ambiguities and uncertainties that directed attention to Heidegger's philosophy itself and publications in psychology, psychiatry and philosophy with a Heideggerian imprint. The first analysis of an extract generated comment, critique and thoughts from all of the researchers. Counter arguments, provocative questions and statements would frequently re-ignite discussion and result in a re-write. Using this input, the lead researcher worked through all the narrative extractions, examining the transcript of each interview before moving on to examine the next interview. The interviews were thus examined on a case by case basis (Smith & Osborne, 2003). The intention was to begin with particular examples, while slowly building up to more general categorisations or claims. At the end of this phase, a collection of extract analyses emerged for each narrative.

The fourth step of analysis began with the question: "Have any general themes in therapists' experiences been revealed through analysis of all the extracts?" Three prominent experiential themes that unified all the participants' stories were identified. These themes were labelled: being shocked and confused; being responsible therapists; and feeling confused as a result of their experiences with suicidal clients. During this phase certain pivotal Heideggerian notions were used as a broad guide for writing and reading.

Findings and Discussion

The analysis resulted in the identification of three themes common to therapists' experiences of working with suicidal clients. In the sections below, these findings are discussed in more detail. In addition, commentary is offered on the ways in which these experiences reflect on the therapists' understanding and work.

Shock and surprise

The therapists all followed widely recognised and endorsed professional assessment procedures with their clients. According to their assessments, none of their clients who committed suicide exhibited the signs and symptoms traditionally associated with suicidality. In the extract below the therapist speaks of a client who said he was going to commit suicide (and did), but because he showed no signs of a mental disorder his threat was deemed to be empty and insubstantial.

> We were there to assess him and had the power to commit him against his will if he were to be a danger to himself due to a

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> psychotic or mental illness or danger to the community. But he wasn't. There was not a mental health status [suggesting a psychiatric disorder] that we could commit him.

The participant therapists naturally reacted with shock and surprise to these unexpected and seemingly unpredictable suicides. The analysis then focused on understanding the therapists' way of seeing and interpreting this phenomenon (someone in suicidal despair who does not appear to be suicidal according to traditional psychological and psychiatric assessments), and in so doing attempted to better understand the phenomenon itself.

The analysis found that therapists find themselves 'thrown' into psychiatry and psychology's traditional ways of understanding suicidality and that they practised accordingly. Psychology, and the other disciplines represented in this study, appears to be dominated by suicidality research which correlates its manifestations, i.e. what it 'looks like'. Therapist practitioners in this study invariably adopted a similar dispassionate and objectifying spectator attitude towards their 'subjects', and understood suicide phenomena as they appeared, literally and without interpretation. Encouraged by this critical mass of opinion, therapists assess clients for risk of suicide using standardized methods and procedures, measuring and weighing them against 'known' suicidal factors. This appears to be the day-to-day practice of assessing suicidality in institutions of mental health, and these standardized methods and procedures of assessing suicidality are passed along as 'best practice'.

The repetition of 'best practice' develops a language, a 'common discourse' that speaks about this way of being with a client and articulates their know-how; it affirms the purpose and meaning of being therapists. Everything these therapists have encountered in this sub-cultural domain of know-how is then passed along as self-evident and already known. If there are signs and symptoms of a mental disorder the likelihood of suicide is increased. If not, these signs and symptoms are absent and the person is 'not at risk'. When the therapists encounter something that does not fit their framework of understanding it is reduced or transformed. For instance, when a participant said she felt that there was a danger of suicide despite the absence of symptoms, her colleagues told her that she was just worrying.

> I had a gut feeling from the beginning that something was wrong, but all the other staff said don't worry. I often wrote things in the notes and wondered why I bother because no one is going to read them.

Based on this undifferentiated status of being therapists, united in understanding and practice, participants often found that they cared about matters that concerned the institution rather than the client. However, a few of the therapists demonstrated a commitment to practicing in a manner that focused on the client. This manner of practice created difficulties for these therapists in the face of institutional fears and concerns.

> It is the whole issue of outcome-based short term focused therapies. I slipped into the mode of the *zeitgeist* of the District Health Boards which is not depth orientated or wanting to embrace the other. That is where I failed her and I was angry with myself as well. It is an ongoing pressure which I slip in and out of and I catch myself doing it. There is the pressure to identify the problem and sort it out. So that if suicide was expressed, that I have addressed it tick, tick, tick. So then you are fine. I fell into that mindset.

Thus, when a client committed suicide in the absence of the self-evident and 'already known' factors associated with suicide, therapists were surprised and shocked. They were unable to articulate the meaning of phenomena that violated their pre-understanding. This confusion may have its roots in a natural-scientific attitude of understanding, which fails to reveal the life-world of being human. It is a mode of understanding that leads to a misinterpretation of what it discovers because it identifies properties and functions as if human beings are self-sufficient and independent entities. However, in reality humans are not self-sufficient and independent entities who are constant and predictable in mood and time. Instead we are unique beings who will "forever remain indefinable [and that] "my existence and the content I try to give to that [is a] gap [that] will never be filled" (Camus, 2005, p. 17).

Responsibility, fear and guilt

The second theme identified during the analysis concerned the extraordinary sense of responsibility – imbued with fear and guilt – that the therapists experienced towards their suicidal clients. They faced a number of dilemmas as a result of their wish to be responsible and caring practitioners. However, no matter how much they cared people still committed suicide. The extract below serves as an example of this theme:

> Shit what now? Is my neck on the line here? And I had these bureaucratic concerns about how responsible I have been as a clinician, appropriateness of treatment, etc. It brings an added pressure and I see this in all the District

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> Health Boards, they are risk averse and you should protect yourself. The question of how to open myself up to hearing the person without [institutional investigation] creates conflict for me. It interferes with spontaneous practice. That need to feel safe steers you in the direction of being prescriptive and covering your arse; and that is not care.

During the interviews it became clear that the therapists could not live or die for their clients and that it was the specific client who decided to end his or her existence. Their powerlessness to assume this responsibility created turmoil and conflict for the therapists. They felt burdened by a Sisyphean sense of responsibility, convinced with scientific faith that they could overcome the impossible with will and idealism, only to find the reality of their human frailty sometimes haunting them in guilt and fear.

> The guilt was almost like a survivor kind of guilt, I don't know. In my intervention something went wrong and I lost a life. If you look at your role you are supposed to talk people off that bridge in a moment of crisis and almost heal them. That is what people expect of you; to prevent people from going to their death by whatever means.

As a result of this belief of being able to go beyond their human limitations, therapists found themselves 'falling' into the misinterpretation of their own being. They found themselves swept along by the tradition of Western thought and philosophy – appearing to be Godlike with a "narcissistic ego [that] takes itself to be the centre and the all" (Levinas, 1969, cited in Peperzac, 1993, p. 49). The therapists in this study found themselves resonating with the traditional psychology wish of wanting to be seen as a 'medical' discipline (Hillman, 1992). While the primary intention of the medical profession is to save life, and the profession often succeeds in this goal through extraordinary feats of practice and knowledge of the neurobiological functioning of a living organism, therapists actually encounter a human existence that is different from the medical view of human life as a vegetating biological organism. These two very incompatible horizons of understanding are at the root of professional and institutional anxiety about caring for suicidal clients, which the profession attempts to resolve by interpreting human beings as if they are constant and unchangeable substances, calibrating their moods on a ten-point scale in order to predict what they may or may not do in future.

> There are times when you realise that everything has its limitations. You learn the theory of what to do; A B or C and then realise that it all becomes null and void. You realise that theoretical models cannot help you now and it is only you and the person.

As part of their routine of being therapists in mental health institutions, the participants went about their tasks of assessing, intervening and completing forms to demonstrate they were complying with 'best practice' methods and procedures. However, when their 'equipment' of understanding and practice failed and a client committed suicide despite 'best practice' predictions, the inherent ambiguity of the situation was illuminated. That which was concealed by tradition was suddenly revealed. The therapists discovered that the Vail Model (Evans & Fitzgerald, 2007) of psychological care used in research and practice in New Zealand enters into conversation about matters that do not matter for the person present. They found that the medicalization and classification of psychological disorders could not account for the cultural and spiritual factors associated with problems of living. The Vail Model of practice, with its positioning of practitioners as 'consumers of science', leads therapists to believe that it is just a matter of 'knowing which buttons to push'.

> Whenever I would see him I would run it by one of my colleagues and say these are the buttons I pushed and this is how he presented and this is what I had done, how does it sound to you? Then I know I have been using my skills and I have done what I could [checking for symptoms of psychosis and suicidality]. That is all I can ask of myself.

This is where therapists can find themselves at the outset of their day-to-day work in institutions of mental health care. Therapists are reassured by this clear and unambiguous culture of care and responsibility. In this culture there are rules and formulas for managing people, just like there are rules and formulas for managing unchangeable substances. It is a recipe for aggregate responsibility and care, instrumental and mechanistic in nature. The therapist can immerse him or herself in this culture of care and be relieved of taking responsibility for the 'history that we are' (Crowe, 2006). This undifferentiated mode of being 'one' in mental health institutions reflects the extent of institutional fear and anxiety concerning caring for suicidal clients. Institutions, such as District Health Boards, try to avoid being blamed for suicides by having formulas and protocols with which they can comply as evidence of their concern and care. Institutional fear and anxiety about caring for suicidal clients flow through therapists and can compromise a therapist's wish to respond specifically to the needs of the person that is there and present in front of him or her. Therapists are caught up in embodying the anxiety that lives between the

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two incompatible horizons of understanding in the profession, between a biologically 'sick' organism and being human. This anxiety leaves them confused about whether they are responsible for the wellbeing of their suicidal clients or for the wellbeing of the profession and its institutions.

> Strangely enough, if there is a high risk of someone doing that [committing suicide] I probably feel less [anxious] and go straight into management mode … I mean, sorry we can't let you do this … rah rah rah … and I go into a bit of a self-protective thing.

The burden of responsibility appears to be out of balance, weighted in favour of the formulas and protocols of the profession and institution rather than the suicidal client. The guilt therapists feel towards the profession and its institutions conceals the guilt and responsibility that appropriately belongs to their vulnerability towards the needs of the client in despair. Therapists are probably aware of this reality but seldom become conscious of it due to the societal and institutional pressures to appease their anxiety and conform to their self-protecting expectations.

In the usual culture and mode of care and concern, the majority of the participant therapists were not responding to the vulnerable mortality of the other, the 'who' behind the face, or the "nakedness of the face and its mortality" as Levinas (1969, cited in Peperzac, 1993, p. 49) puts it. In concert with the institutionalised fear of caring for suicidal clients, therapists often fall back into the comfort of the collective where they are unburdened and accommodated by a present-at-hand mode of care. Heidegger (1962) refers to this as an inauthentic existence in which *Dasein* seems to win itself. It is a way of avoiding our basic unsettledness.

> I also routinely give them a spiel that is quite condemnatory of suicide. I talk to them about the possibility of developing a code to just see their life through to its natural end, for better or for worse. One could see that it is a reasonable kind of social responsibility to the people around us. They have a responsibility toward people around them, even me. I am working with them and wow, they kill themselves and I have to live with that. I have had colleagues who have been unable to work after an experience like that.

Therapists often sensed the spectre of their clients' existential despair in themselves and became afraid for themselves. Most therapists found themselves in a dilemma; where to challenge the tradition is to challenge that which sustains their existence. It was a challenge that required them to understand themselves in addition to understanding who the profession may think they are. This tension manifested as confusion about their meaning and significance as therapists. In challenging the existence in which they already live and do with unreflecting familiarity, they were beckoned by the being that is possibly theirs, which Camus (2005, p. 17) describes as the "very heart of mine which will forever remain indefinable to me. Between the certainty I have of my existence and the content I try to give to that assurance, the gap will never be filled. I shall be a stranger to myself".

Being unfamiliar

The third theme revealed that the crisis of existence suicidal clients talk about in therapy – not knowing what to do and how to live – often resonated within the therapist at a very personal level. Working with suicidal clients confronted therapists with professional, institutional and personal issues that brought them to experience their own crisis of existence during the course of assessment and treatment. They were confronted by their own humanness and mortality, which lay concealed under institutionalised models of care and challenged with what they understood regarding the meaning of life and death, not only the life and death of a suicidal client, but also their own life and death.

When the 'equipment' of institutionalised care and responsibility broke down, issues were revealed that were very unsettling for these therapists. We argue that these issues were the result of the tacit idea in the profession of psychology that therapists are able to control other human beings, a notion endorsed by the critical mass of the profession that we can 'seize and enumerate' another human being. However, when the participant therapists' professional 'equipment' failed to give proof to ability to control they were faced by the fact of existence that human beings will forever be indefinable and strangers to themselves.

> It is very intense. You see a man jumping right in front of your eyes and you know he is going to die in a matter of seconds. I felt shocked, confused and disorientated. I felt helpless and thought what the hell is going on here?

Participant therapists found themselves confronted by the possibility that the meaning and worth of human existence is to be found in our multiplicity and the way we are beyond cognition and volition, in our lack of definition and strangeness. This revelation runs contrary to the *zeitgeist* of mainstream psychology and psychiatry, which believes that there is unity and clarity to be found in our multiplicity, that there is a singular principle of understanding that will reveal the worth and meaning of human existence.

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Suddenly and without warning therapists found themselves in an 'obtuse world' stripped of its involvement-totality as they encountered an existence that was different from their way of existing. In this mood of angst they felt uncanny or unfamiliar. In angst they came to face themselves anew, from the beginning so to speak, in order to redefine and understand who they are.

> This one affected me badly. I was just in a mess really, it was pathetic. I couldn't function properly. I was doing the job but to the detriment of my own health. Realizing that I had a problem for starters was a positive step because I was just going through this turmoil.

In this moment of unfamiliarity some therapists experienced a 'call of conscience' as they struggled to reconcile this anxious and unfamiliar situation. For some it was a 'life intensifying moment' that interrupted their 'downward trajectory of inauthentic life' where they seemed to have won themselves by merging with the *zeitgeist* of the profession and its institutions. It is as if they were summoned by their experiences to carry out a modification of the 'One-self' they were being, their 'falling' momentarily arrested by different possibilities of being therapists.

One therapist was able to reconcile himself with the meaning and significance of this 'life intensifying moment' through supervision that 'helped me to rediscover that I am a mere mortal'.

> You almost transcend yourself and when something like this happens you realise that you are only human. It [supervision] was a release and I felt more comfortable with myself. It is part of the process of letting go; I remember asking myself what is it that I am trying to control here? What was I holding on to? And I think it was the thought that in this job I am not supposed to make mistakes.

The majority of therapists in this study were left floundering in their own personal crisis in the aftermath of their experience of working with suicidal clients. They found that supervision and debriefing involved going over their assessment findings and the associated forms and procedures to ensure that they were 'safe' from retribution and that the institution was not liable.

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

The way in which their experiences affected them personally was generally not attended to in supervision. This finding is in keeping with the results of a recent study by Kazantzis, Calvert, Orlinsky, Merrick and Ronan (2009), which compared New Zealand psychologists with their counterparts in Canada and the United States of America. The study found that New Zealand psychologists consider personal therapy (the primary focus of personal therapy is self-understanding) to have only a modestly positive influence on their professional development. The dominant theoretical orientation of cognitive behaviour therapy in New Zealand places a stronger emphasis on training and supervision in the development of psychologists' technical skills and less emphasis is placed on personal therapy as part of professional development (Kazantzis et al., 2009). It is perhaps for this reason that the participant therapists struggled with their crises on their own. Supervision in New Zealand lacks this dimension of attending to the 'voice of conscience' in its practice. A therapist's practice is an extension of how that therapist chooses to look at things at the outset. This study has shown that the misinterpretation evident in the ascendant positivist mode of enquiry concerning what it means to be human flows through all its practices of understanding and into supervision. The notion that therapists exist in self-understanding and self-interpretation is overlooked in supervision, which primarily attends to the technicalities of professional development. However, Howard (2008) has drawn attention to the observation that it is possible to attend to the wellbeing of the therapist supervisee without violating the primary concern of clinical supervision with professional effectiveness and technical rigour.

Concluding Remarks: Implications for Practice

This study demonstrated how traditional methods of assessment lead to misinterpretations. The study raised the question of how a therapist can come to know a client in the context of a psychiatric and clinical assessment that would prevent these misinterpretations.

A hermeneutic phenomenological mode of inquiry offers an epistemological framework to offset the dominant natural scientific orientated psychiatric interview. Although both modes of enquiry endeavour to describe what they encounter, they differ in that the hermeneutic phenomenological mode asks what this may mean for the person experiencing a particular psychiatric symptom. Moreover, the hermeneutic phenomenological mode avoids answering with the voice of the already-known and instead enters into ambiguity and ambivalence through the use of an invitational stance towards an understanding of the person who is encountering. According to Bradfield (2008), a therapeutic invitational stance is an important constituting factor in the person's narration

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of being-in-the-world.

A hermeneutic phenomenological psychology creates the opportunity for the client to reflect and re-interpret him or herself within the referential network of their world. It creates this opportunity by making explicit what a client may mean and signify in their thoughts, feelings and behaviours. This therapeutic activity is what Sutton (2008) refers to as opening the interplay of being and world.

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

In Sutton's (2008) view there are some 'fundamental dynamics' that are central to the way in which a client understands him or herself. The 'fundamental dynamic' signposts to being-in-the-world that are of particular value for the practitioner orientated towards hermeneutic phenomenology are care, commitment, time and returning again. With circumambulation (returning again) something new is revealed in each passing. The accumulation of shifts and emphases in meaning and significance grows into turning points. Practitioners with patience and resolve track the clients in their transformations of understanding as they are invited to revisit the dynamic elements that constitute that which they care about (or are careless of) and are committed to (or not committed to), because neither care nor things we commit ourselves to are fixed and permanent in time.

This study demonstrated that a hermeneutic phenomenological approach can guard against clinicians living out professional and institutional anxiety in the assessment and treatment of suicidal clients. It is an approach that gives informative priority to the client's story rather than to psychology's story, and this animating intersection of two subjectivities draws the therapist towards being more concerned and caring about the person present. In this way, the therapist and client enter a world far removed from the world of the profession and its institutions' concerns for itself.

This study has also demonstrated that therapists are there to attend to and contain the radical shift of consciousness for the client. However, the study also asks who is present to attend to and contain the radical shift in the therapist. In addition to attending to the technicalities of assessment and treatment during supervision, there is a need to attend to the radical shift in consciousness that belongs to the therapist. Supervision has a decisive and important contribution to make in this regard and requires a reconsideration of the issues 'admissible' for clinical discussion. Clinical supervision is challenged to 'disrupt' its interpretation of itself as existing for the sake of professional development in the form of technical training and supervising the competent application of technical skills. Supervision is challenged by the findings of this study to go "beyond the scope of mere *techne* [and open the] space that allows the *phronesis* [wisdom] of practice to be revealed [and to] trust the 'play' of relationship in the supervision encounter" (Smythe, MacCulloch, & Charmley, 2009, p. 17).

Additionally, this study influenced the lead author's own practice as a psychologist working in a District Health Board. What encourages the organisation in assessment and treatment is not necessarily what engages a client. As Szasz (1965) points out, institutionalised care is not necessarily the care that sets the client free to choose and live responsibly. The author remains unconvinced that a client approaches him for a diagnosis (even when they say they do) and 'coping skills' (i.e., standardized treatment) rather than about being vulnerable about no longer knowing what to do and how to live. The guiding question in assessment and treatment should be to ask what matters to the client. One seldom hears a client say that a symptom in itself is what matters to them. The course of therapy is circular, returning again and again to 'places' of doubt and confusion. In the repetitive telling, distinction is made between 'they' and 'me'. It is part of the therapeutic process that seems to bring people back to those 'moments of sense'. With each passing we begin to understand together. With each passing the individual is met by revelation and confirmation of 'who I have become'. In this confirmation, conscience invites, waiting to be made explicit, and that is the moment and place where therapy happens. There is no method that can tell you where that place is; the existence of each client unfolding in our presence reveals what matters to them and is in need of their care. Each client also decides how they choose to respond to the inviting call of conscience.

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