‘Liking’ working with suicidal patients: A mixed methods research investigation of clinicians’ positive inclination to patients at risk for suicide and the effect of this on the therapeutic encounter

Tess Soulié
À elle, puisque je n’en ai qu’une.
Abstract

**Background:** A strong therapeutic relationship is associated with better outcome in therapy/treatment, including with patients at risk for suicide (PRS). However, to build a strong therapeutic relationship with PRS, clinicians’ need to manage the emotional responses, also called countertransference (CT), that PRS tend to elicit in them. Conversely, evidence shows that positive CT, such as feeling of closeness and affiliation towards patients, are associated with better outcomes in therapy/treatment. However, such positive inclination from clinicians is rarely studied in relation to PRS, which represents an important knowledge gap.

**General aim:** To advance knowledge in clinical suicidology by studying the stance of clinicians who feel positively inclined towards, or “like working” with PRS.

**Methodology:** Sequential mixed methods design.

**Study 1 Nomothetic**

**Aims:** To explore systematically the nature of CT to PRS while estimating the prevalence of positive inclination to PRS among clinicians. To recruit positively inclined clinicians for the second study.

**Method:** National online survey using the Therapist Response Questionnaire (TRQ) (Betan, Heim, Conklin, & Westen, 2005) and a clinical questionnaire.

**Results:** Two hundred and sixty-seven clinicians took the survey online, 46 psychiatrists, 147 psychologists and 74 psychotherapists. Exploratory factor analysis (EFA) yielded a seven-dimension model of CT to PRS. However, clinicians endorsed CT dimensions only mildly on average, except for the positively connoted factor, expressing feelings of fulfilment and desire to engage with PRS (factor 2 - fulfilled/engaging). These patterns were interpreted as potentially reflecting a “CT montage”, where clinicians experience aspects of the suicidal state emotionally while preserving their willingness to engage despite the suicide risk. A minority of the clinicians surveyed (14.7%, \( n = 39 \)) reported liking working with PRS, of which 29 consented to be contacted about the subsequent study.

**Study 2 Idiographic**

**Aim:** To develop an in-depth understanding of clinicians’ positive inclination to
PRS.

**Method:** Constructivist approach to grounded theory method (GTM) applied to interview data.

**Results:** The study interviewed 12 clinicians, including two psychiatrists, five clinical psychologists and five psychotherapists. The analysis placed clinicians’ experience of forming a deep emotional connection with PRS at the core of the clinical encounter. This connection, named in this research an “aroha connection”, appeared to be satisfying for patients (i.e. soothing) and for clinicians simultaneously. It consisted of an interpersonal emotional regulation that could evolve into a therapeutic attachment. The findings suggested that suicidality decreases as connectedness grows.

**Conclusions:** Combining research methods provided a rich understanding of clinicians’ positive inclination to PRS, which inferred the development of a novel working model that formulates the interdependence of clinicians’ satisfaction and of PRS’ improvement in treatment. This project indicated the emotional nature of clinical suicidology, hereby providing new evidence for the importance of “CT literacy” in clinicians. Whilst reaffirming the pivotal role of relationship factors in treatment of PRS, this research highlighted the gaps in our understanding of how they operate. Further research is needed to fathom these processes. Ultimately, this project invites to reconcile the study of the mind and that of the brain by reaching across disciplines to move the field of clinical suicidology forward.

**Key words:** Suicide – Patients at risk for suicide - Clinical suicidology – Countertransference – Countertransference literacy - Mixed methods design
Outputs from this thesis

Publication arising from this thesis


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I feel profoundly lucky for this opportunity to have pursued a question that had been with me for years. A question, which, I understand now, might have been with me forever. Only when an answer consists of more questions can you know for sure that it is a wise one.

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Glossary

BPD: Borderline personality disorder

CBT: Cognitive behavioural therapy

CT: countertransference

CT montage: countertransference montage

DBT: Dialectical behavior therapy

DSM: Diagnostic and statistical manual

EFA: exploratory factor analysis

GTM: grounded theory method

PRS: patients at risk for suicide

TRQ: Therapist response questionnaire (Betan et al., 2005)
Part I
Background & methodology
Chapter 1
Introduction

I said that the world is absurd, but I was too hasty. This world in itself is not reasonable, that is all that can be said. But what is absurd is the confrontation of this irrational and the wild longing for clarity whose call echoes in the human heart. The absurd depends as much on man as on the world. For the moment it is all that links them together. It binds them one to the other as only hatred can weld two creatures together.¹

1.1 Impetus for the project

In the department of psychology where I studied for my master’s degree, students had to pick one “research seminar”, or topic area, from a list of over 30 from which to choose. As I was flipping through the leaflet’s pages, the title ‘clinique suicidaire’ (clinical suicidology) piqued my attention immediately.

From a philosophical standpoint, it did not seem to me that preventing people from killing themselves made much sense. At the time, I had been soaking in a cultural bath of atheism, existentialism and nihilism for already close to three decades. My French public education included the textual exegesis of The Myth of Sisyphus (Camus, 1955), and The Human Condition (Malraux, 1933) before I turned 18 years of age. I was therefore very open to the idea that suicide was a sensible alternative to sentient existence, and even maybe, at times, despite what Camus argued, the most reasonable one. As a neophyte, I originally attributed something of a Camusian “absurdity” to clinical endeavours seeking to prevent suicide. I sensed that my philosophical fascination for suicide would hinder my clinical intentions.

Naturally, as I graduated and started encountering the reality of suicidality in my own clinical practice, my views evolved. Nonetheless, the underlying existential layer there is to suicide is certainly what has chained me to the topic ever since.

**Suicide as a global phenomenon**

On a world scale, 788,000 people took their life in 2015, an annual global age-standardized suicide rate of 10.7 per 100,000 population (World Health Organization, 2018). This made suicide the 17th leading cause of death that year. Given the effect of suicide stigma on reporting, the number of equivocal causes of death, and the lack of a reliable recording system in most countries, experts deem these statistics to be an underestimation of the phenomenon. For the 15-29 age group, which is unaffected by both infantile diseases and conditions associated with aging, suicide is the second cause of death. Suicide has important and long lasting ripple effects among communities, with each death estimated to affect an average of 135 people (Cerel et al., 2018). For every adult who dies by suicide, research suggests that more than 20 attempt suicide (World Health Organization, 2014).

**Suicide in New Zealand**

In New Zealand (NZ), coronial services release provisional epidemiologic data on suicide each year. Subsequently, the Ministry of Health endorses official numbers within a two-year period, during which coroners investigate equivocal cases. In 2015, the most recent official statistics available, 527 people died by suicide in NZ, producing an age-standardised rate of 11.1 per 100,000. For every female dying by suicide, 2.7 males took their lives that year (NZ Ministry of Health, 2017). The rate is consistently higher among Māori communities, the indigenous people of NZ. In 2015, Māori males’ suicide rate was 25.3 per 100,000, 1.7 times that of non-Māori males. Māori females suicide rate was 11.5 per 100,000, which is 2.4 times higher than that of non-Māori females for the same period (NZ Ministry of Health, 2017).
In 2017, the Ministry of Health announced that numbers for the period 2006-2015, last official data, could indicate a slight decrease in annual rate (NZ Ministry of Health, 2017). However, coronial provisional data released since suggested that the suicide rate could have risen instead to 12.64 per 100,000 for the period 2016/2017, corresponding to a rate of 19.36 per 100,000 for males. Of note, Māori were still, by far, the ethnic group most affected in NZ, with an age-standardized rate of 21.73 per 100,000. In terms of methods, hanging, strangulation and suffocation represented 60% of all suicide deaths in the country (Coronial Services, 2018).

Prevention strategy plans


Akin to international organisations, NZ government deems suicide a public health issue (WHO, 2014, p. 69). Effectively, the first three of the seven general goals set by the current NZ suicide prevention pertain to mental health care. Goal 1 is to promote mental health and wellbeing, and prevent mental health problems. Goal 2 is to improve the care of people who are experiencing mental disorders associated with suicidal behaviours. Goal 3 is to improve the care of people who make non-fatal suicide attempts (NZ Ministry of Health, 2006, p. 1). The extant NZ suicide prevention plan hence regards guaranteeing accessibility and quality of health care services as fundamental to preventing suicide.

The gap between theory and practice
Internationally, the suicide prevention discourse is dominated by the idea that identifying people at risk upstream of a crisis would help prevent suicide (World Health Organization, 2014). Evidence such as the work of Ahmenadi et al. (2014) is used to argue this position. This study looked at a cohort of 5,894 people deceased by suicide between 2000 and 2010 in the US, to estimate that, although the majority (83%) had had contact with the health care system in the year preceding their death, only 24% had a mental health diagnosis in the month preceding their death. For the authors, these findings suggest that, in the majority of cases, health services had failed to assess people’s mental health state (Ahmedani et al., 2014). Consistent with this, in the American Psychiatric Association Textbook of Suicide Assessment and Management, Simon advocates that systematic assessment of suicide risk should become the standard of care (Simon, 2012).

However, limitations of risk assessment tools have been identified (Silverman & Berman, 2014). It has been argued that the validity of suicide risk assessment relies upon clinicians’ ability to establish a good rapport with patients (Large & Ryan, 2014; Rudd, 2012). In this sense, to be valuable, suicide risk assessment would require clinicians to be systematically willing and able to form a genuine rapport with patients. A closer look at the literature on clinicians’ reactions to suicidal patients is therefore required.

**The suicidal patient**

Practicing clinicians frequently report that treating suicidal patients comes with important challenges (Goldblatt & Maltsberger, 2009; Linehan, 1993; Rudd, Joiner, & Rajab, 2001). The literature backs this up through consistently finding that working with suicidal patients is often stressful for clinicians (Deutsch, 1984; T. E. Ellis, Schwartz, & Rufino, 2018; Farber, 1983; Menninger, 1990; Pope & Tabachnick, 1993).

Suicidal patients’ ambivalence toward life and death tends to be mirrored in an ambivalence toward the treatment and the person of the clinician (Linehan, 1993;
Wolk-Wasserman, 1987). Suicidal patients tend to display troubled interpersonal behaviours that prompt intense and often negative emotional responses within clinicians (Bodner, Cohen-Fridel, & Iancu, 2011; Goldblatt & Maltsberger, 2009; Samuelsson, Sunbring, Winell, & Asberg, 1997). Clinicians’ tendency to react to these emotional responses by being avoidant or rejecting of suicidal patients are counter-therapeutic and can have lethal consequences (Andriola, 1973; T. E. Ellis et al., 2018; Maltsberger & Buie, 1974; Modestin, 1987).

Clinicians’ emotional responses to patients, most commonly referred to as countertransference (CT) (Cartwright, 2011; Gelso & Hayes, 2007c), are therefore considered key elements of clinical suicidology. Clinicians need to be countertransference literate to treat patients with suicidal behaviours (American Psychiatric Association, 2003).

**Unexpected findings**

My master’s research project stemmed from a theoretical knowledge of CT to suicide patients. The literature indicated that, with suicidal patients, clinicians have to manage negative emotional responses to remain benevolent while maintaining professional boundaries. My study aimed to gain insight into the subjective experience of such practice. The research question asked how clinicians’ desire to help was sustained, subjectively, despite their experiences of negative countertransference. To answer this question, I undertook a case study of the head psychotherapist of a suicide prevention centre.

Contrary to my expectations, the key findings from this case study showed that according to the participant, working with suicidal patients was no more challenging than any other practice. Furthermore, Mme R, the clinician-participant, departed significantly from the neutral and benevolent attitude prescribed for clinical practice. Instead, she displayed an extremely warm and active therapeutic stance that seemed to go beyond the scope of psychotherapy practice, and sounded somewhat grandiose. She talked about “bringing people back to life”. I would
shamefully admit today that I attributed the strong maternal streak of her narrative to a lack of competence. Yet, Mme R asserted instead that, unlike her colleagues, she had not lost a single patient to suicide in over twenty years of practice. These unexpected findings stayed with me.

Over the following years, as I completed my clinical training and started practising, that case study prompted further reflections. I contemplated that a relationship could exist between Mme R’s positive inclination (she voluntarily specialised in clinical suicidology and declared “loving” her role), the lack of neutrality of her stance, and the consistent positive outcomes she claimed to achieve. Could Mme R be intuitively implementing a stance that met suicidal patients’ needs? I developed the idea that, perhaps, important clinical wisdom could be derived from exploring the stance of clinicians who feel positively inclined towards suicidal patients. I addressed this hunch by undertaking the present work some five years later, as one finally takes a bite from a fruit patiently left to ripen.

1.2 Overall research aims

The present project aimed to gain an understanding of clinicians’ positive inclination to suicidal patients. The anticipation was that examining clinicians’ positive inclination would provide clinical wisdom about an optimal therapeutic stance with suicidal patients. In addition, I hoped that novel insights into patients’ psychological needs in session could be gained from exploring the clinical encounter through the lens of positively inclined clinicians. This general research aim assumed that positive inclination to suicidal patients is uncommon for clinicians. To determine the validity of this assumption, the project started by reviewing the literature on clinicians’ emotional responses, conceptualised as countertransference, to suicidal patients.
1.3 Definition of terms

The terminology used in suicidology is subject to debate in the literature (O’Carroll et al., 1996; Silverman, Berman, Sanddal, O’carroll, & Joiner, 2007b, 2007a). The list below proposes the acceptance of the key terms used as a reference in this work.

Suicide

The “the human act of self-inflicted, self-intended cessation (i.e. the permanent stopping of consciousness)” (Shneidman, 1981). The term suicide comes from the modern Latin ‘suicidium’, which results from the combination of ‘sui’, self, and ‘caedere’, to slay. Etymologically, suicide means to kill oneself.

Suicidology

The scientific study of suicide and suicidal behaviours.

Clinical suicidology

Clinical endeavours, whether medical, psychiatric, or psychological, involving a person who might be at risk for suicide, including highly lethal people (defined with reference to Shneidman, 1981)

Clinician

I use the term “clinician” to refer to the professional who conducts treatment, which includes psychotherapy. Etymologically, “clinician” comes from the Greek terms for “bed” and “to lie”. The clinician is the one who is “at the bed of patients”, i.e. who is working face to face with patients.

Patient and client
The term “patient” refers to the people who receive treatment. From the Latin verb “pati”, to endure, “patient” conveys the notion of suffering over time. However, since this research builds on the narrative of clinicians who use the term “client” instead, “patient” and “client” are used interchangeably.

**Patients at risk for suicide (PRS)**

This project examines suicidality from the point of view of clinicians. The term “patients at risk for suicide” (Simon, 2012), abbreviated by the acronym “PRS”, is preferred to reflect the wide range of clinical presentations of suicidality. However, to improve readability, the terms “suicidal patients” and “suicidality” are also used.

**Countertransference (CT)**

“Countertransference”, abbreviated by the acronym “CT”, refers to clinicians' total emotional responses to patients, emerging from, and potentially affecting, the therapeutic relationship (Kernberg, 1965; Winnicott, 1960). Countertransference is a key concept of psychoanalysis that has clinical relevance across theoretical paradigms (Cartwright, 2011).

**Countertransference literacy (CT literacy)**

I call “countertransference literacy”, abbreviated by “CT literacy”, the aptitude to read one’s own countertransference responses and to manage them.

**1.4 Outlines of the thesis**

The thesis has four parts, including introductory material, study 1, study 2, and concluding material.

Part I is a background and methodology section. The present chapter sets the context of the thesis. Chapter 2 presents a narrative review of the literature on countertransference (CT) to patients at risk for suicide (PRS), and ends with the
project's research questions. The third chapter presents the overall methodology for the projects. A philosophical caveat argues that a realist approach to scientific knowledge can resolve the duality across clinical and research perspectives. This philosophical standpoint encourages an epistemic relativism which informed the methodology adopted. I briefly present the project’s mixed methods design, before ending the chapter with ethical considerations.

Part II presents the first study of the project. A cross-sectional survey study estimated the prevalence of positive inclination to PRS among NZ clinicians, while inviting them to undertake a second study. In addition, the study explored the nature of CT to PRS systematically using the Therapist Response Questionnaire (TRQ) (Betan et al., 2005). Chapter 4 presents the study method, followed by the findings in chapter 5. Chapter 6 discusses the findings, and reviews the state of the research questions upon entering the second study.

Part III presents the second study. Study 2 aimed to gain a qualitative understanding of clinicians’ positive inclination to PRS. The idiographic approach aimed to derive novel perspectives on an optimal therapeutic stance with PRS. Chapter 7 presents the study method, followed by the findings in chapter 8. Chapter 9 completes part III with a discussion of the findings.

Finally, part IV comprises a general discussion and a general conclusion. In chapter 10, I consider quantitative and qualitative findings together to reflect on the strengths and limitations of the mixed methods design in progressing the projects’ general aim. The general discussion finishes by considering implications of the research for clinical practice and for future research. I conclude the project in chapter 11.
PART 1
BACKGROUND & METHODOLOGY
• Chapter 1 - General Introduction
• Chapter 2 - Review Of The Literature
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Figure 1.1 Overview of the thesis
Chapter 2
Review of literature

Perhaps what makes all of this so complicated is the fact that unlike medicine, surgery, or dentistry, the mental health clinician is the instrument of care—there is no equipment failure, no pathogen, no virus to otherwise blame. We are the instrument of care; it does not get any more personal than that.2

The introduction chapter proposed that, given clinicians’ apprehension and reluctance to work with PRS, studying the minority of clinicians who feel positively inclined toward PRS could advance knowledge in clinical suicidology. To determine the validity of these assumptions, this chapter reviews the literature on clinicians’ emotional responses to patients, conceptualised as countertransference (CT), and examined the relevance of this to the treatment of patients at risk for suicide (PRS). This is neither an exhaustive nor a systematic review: rather, it narrates the genealogy of the concept of CT before drawing on psychotherapy research to argue its relevance to clinical practice in general, and to clinical suicidology in particular. Finally, before presenting the research questions, the chapter attempts to ground the notion of positive inclination to PRS in the literature despite the dearth of references on the topic.

2.1 Origin of the concept of countertransference

The concept of CT comes from psychoanalysis. Freud coined the term in 1909 in the private sphere of his correspondence with Jung, before introducing it publicly at the psychoanalytic congress of Nuremberg in 1910 (S. Freud, 1988). This section argues

that, contrary to widespread belief (Cartwright, 2011; Gabbard, 2001; Gelso & Hayes, 2007f; Kernberg, 1965; Mills, 2004; Norcross, 2001), Freud was aware of the clinical potential of CT (Holmes, 2014).

Since the concept of CT emerged in relation to that of transference (Balint & Balint, 1939), this chapter begins with an understanding of the concept of transference. Then, an overview of CT in Freud’s writings is provided, before Ferenczi’s significant contribution is reviewed. The section ends by recounting that CT gained momentum in the mid-20th century, which resulted in a series of influential publications associated with the “totalistic” view of the concept.

2.1.1 Transference

As a neurologist, Freud applied the medical model to mental health by aiming to develop a form of treatment that would cure neuroses. However, he noticed very early on that interpersonal patterns occurring in the relationship between his patients and him appeared to play a critical role in treatment. Although similar processes occur in all human relationships, Freud developed the concept of “transference” to refer to their occurrence in the clinical situation. Transference became quickly the cornerstone of his method of “psycho-analysis”.

The story of how Freud came to realise the importance of relationship factors in therapy is interesting. His patients, predominantly young females as he was originally treating hysteria, appeared to develop a tender attachment to him systematically. In fact, he first named the phenomenon observed ‘transference-love’. Upon the first few occasions, Freud deemed the emergence of such tender feelings a fortuitous disturbance. However, since the phenomenon repeated itself in every new case, and “under the most unfavourable conditions and where there [were] positively grotesque incongruities [...]”, Freud found himself forced to “abandon the idea of a chance disturbance [...]” (S. Freud, 1973, pp. 493–494). He hypothesised that his patients’ affection was an artefact of the treatment situation, which he conceptualised as ‘transference’. He urged doctors to consider
transference “a valuable piece of enlightenment”, and not mistakenly attribute such affection to “the charms of [their] own person” (S. Freud, 1915, p. 174).

Freud wrote about transference at length. In the Dora case, transference is defined as “new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician”. Transference phenomena consist of a “series of psychological experiences [that] are revived, not as belonging to the past, but as applying to the person of the physician at the present moment” (S. Freud, 1977, pp. 157–158). Put simply, transference refers to patients’ relational patterns inasmuch as they reflect pre-existing patterns developed in relation to significant others.

In Freud’s view (1958), transference is an ever-occurring phenomenon, whose management is the most difficult part of conducting psychotherapy. It is not created by psycho-analysis; rather, it “arises spontaneously in all human relationships” and is “the vehicle of success in psycho-analysis exactly as it is in other methods of treatment” (S. Freud, 1958, p. 106). Freud described transference as both “the greatest obstacle” to treatment and its “most powerful ally” (S. Freud, 1977, p. 159), and suggested that avoiding discussing relationship aspects in an attempt to preserve patients’ privacy, had held back the development of psycho-analysis during its first decade (S. Freud, 1915, p. 173).

Although transference has been considered relevant to other types of psychotherapy (Cartwright, 2011; Miranda & Andersen, 2007), only in psychoanalysis is its management the main therapeutic tool in treatment (S. Freud, 1973).

2.1.2 CT in Freud’s writings

Counter-transference, spelled hyphenated originally, referred simply to transference-love emerging from the clinician. However, within a few years, Freud
realised the complexity of the matter and referred to CT as “technically—among the most intricate in psychoanalysis” (S. Freud, 2001, p. 112).

1909-1910

Freud coined the term of countertransference to discuss the problematic involvement of Jung, his younger and close disciple, with his former patient and friend Sabina Spielrein. In a letter dated of June 7, 1909, Freud wrote:

Such experiences, though painful, are necessary and hard to avoid. Without them we cannot really know life and what we are dealing with. I myself have never been taken in quite so badly, but I have come very close to it a number of times and had a narrow escape. I believe that only grim necessities weighing on my work, and the fact that I was ten years older than yourself when I came to φα, have saved me from similar experiences. But no lasting harm is done. They help us to develop the thick skin we need and to dominate “counter-transference”, which is after all a permanent problem for us; they teach us to displace our own affects to best advantage. They are a “blessing in disguise”. (S. Freud & Jung, 1974, pp. 230–231)

By coining the term ‘counter-transference’, Freud implied that Jung’s feelings too were an artefact of the treatment, as well as a response to his patient’s transference. He warned his young colleagues that, to preserve treatment, these feelings should be worked through and dealt with (Martín Cabré, 1998). Freud described CT as “hard to avoid”, potentially “painful” but “necessary”, and a “blessing in disguise” (S. Freud & Jung, 1974, pp. 230–231).

Freud talked publicly about CT for the first time in his address to the Nuremberg psychoanalytic congress the following year, in 1910. Discussing recent innovations

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3 English in original
4 Abbreviation of ‘psycho-analysis’
5 English in original
around the analytic technique relating to physicians themselves, he explained that psychoanalysts had become aware of the countertransference:

We have begun to consider the ‘counter-transference’, which arises in the physician as a result of the patient’s influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this counter-transference in himself. (S. Freud, 1988, p. 19)

Noticing that analysts’ achievements are limited by their own “complexes and resistances”, Freud proposed that “self-analysis” became a prerequisite to practising psycho-analysis (S. Freud, 1988, p. 19).

1911-1913

Considering Freud’s comments on CT in his private correspondence between 1911 and 1913 sheds light further on the genealogy of the concept. First, in another missive to Jung written at the end of 1911 (S. Freud & Jung, 1974), Freud positioned himself firmly regarding CT. Reacting to having heard from a third party that Pfister, another fellow psychoanalyst, and Jung himself were still getting romantically involved with their patients, Freud qualified their behaviours as always “ill-advised”. He insisted that these two younger men should acquire a “necessary objectivity in their practice”, remain more emotionally reserved and not expect “the patient to give something in return” (S. Freud & Jung, 1974, pp. 475–476). Freud concluded with the well-known statement that an article on CT was “sorely needed” before adding, “of course we would not publish it, we should have to circulate copies among ourselves” (S. Freud & Jung, 1974, pp. 475–476).

Less than two years later, in a letter to Binswanger, Freud described CT as one of the most intricate problems in in psychoanalysis that is “much easier to solve” in theory (S. Freud, 2001, p. 112). In this correspondence, Freud attempted to formulate a realistic way to go about managing CT in practice:
What we give to the patient should, however, be a spontaneous affect, but measured out consciously at all times, to a greater or lesser extent according to need. In certain circumstances a great deal, but never from one's own unconscious. I would look upon that as the formula. One must, therefore, always recognise one's counter-transference and overcome it, for not till then is one free oneself. To give too little because one loves him too much is unfair to the patient and a technical error. This is all far from easy, and perhaps one has to be older for it, too. (S. Freud, 2001, p. 112)

In this excerpt, Freud appears acutely aware of the difficulties and subtleties attached to the management of CT in real time. Interestingly, the quote also shows that Freud deemed that, at times, repressing genuine positive CT responses would be a technical error too.

**Freud’s duality**

On one hand, a close look at his private correspondence indicates that Freud was mindful of the complexity and of the clinical value of CT (Holmes, 2014). On the other hand, Freud made firm declarations on the need to control CT to conduct treatment. For this reason, CT writers have qualified Freud’s legacy concerning CT as “ambivalent” (Gelso & Hayes, 2007e, p. 2).

However, considering Freud’s statements in context suggests that he might have used the term CT in two different ways. Sometimes, for example in the letter to Binswanger, CT refers to clinicians’ emotional responses to patients insofar as they affect the treatment. At other times however, CT appears to be a metonymy that refers to the transgression of the patient-doctor relationship. A metonymy is a figure of speech that substitutes a phrase or a word with another closely associated, and facilitates a rhetorical strategy of referring to something indirectly. In his firmest declarations, Freud seemed to have used the term CT to refer indirectly to the trespassing of the patient-doctor relationship by some of his close colleagues. In a similar vein, Barron & Hoffer (1994) have argued that Freud’s official reserve
about CT was due to an awareness of the dangers potentially associated with erotic countertransference, based on real events (Barron & Hoffer, 1994).

As noted, psychoanalysis aimed originally to cure neuroses, and especially hysteria, a condition that appeared resistant to treatments. As a consequence, the first generation of analysts were essentially treating young educated females, in 50 minutes sessions, daily, for weeks and sometimes months (Roudinesco, 2016). By its nature, the treatment wove a strong bond between analyst and patient, leading some psychoanalysts, Jung and Pfister in particular, to get involved with patients, generally after the treatment had ended. In his letter to Jung (S. Freud & Jung, 1974, pp. 230–231), Freud conceded having felt these urges himself. However, the need to protect his practice to support his family, as well as perhaps, the fact that he was older than Jung when he came to psychoanalysis, saved him from acting upon these desire. Freud was aware of the need to address this critical issue, however, he seemed to have been worried that a premature public disclosure would reflect badly on other analysts and on psychoanalysis as a whole. Given the controversies encountered by his new science (Roudinesco, 2016), he first intended to deal internally with these isolated incidents.

To avoid controversy, the concept of CT suffered an important publication bias in the early years of psychoanalysis. In addition, as a gifted clinician himself, Freud was certainly more interested in developing a meta-psychology than studying the technical aspects of the psychoanalytic technique (Holmes, 2014; Roudinesco, 2016). Yet, he encouraged others to study technical aspects of the treatment in more depth, a task which was taken up originally by Ferenczi and Rank (Martín Cabré, 1998). Ferenczi started presenting and publishing his work on the technical aspects of conducting psychoanalysis, that included the study of CT, from 1919 onward (Ferenczi, 1950).
2.1.3 Ferenczi’s contribution

Ferenczi was one of Freud’s closest collaborators. Freud praised Ferenczi’s intelligence and talent and wrote about their tumultuous father-son like relationship (Holmes, 2014; Martín Cabré, 1998). Ferenczi was probably one of the most creative but also most subversive of the first generation of psychoanalysts (Choder-Goldman, 2010; Hoffer, 1991). He laid the foundation for the relational perspective in psychoanalysis (Safran & Muran, 2000).

Ferenczi advanced Freud’s conceptualisation by exploring and experimenting with CT. He discussed delicate and often controversial topics such as the degree of active intervention from the analyst, trialled mutual analysis with one of his patient, and questioned the clinical impact on communicating CT to patients (Martín Cabré, 1998). By 1919, Ferenczi posited that, by virtue of their humanity, doctors will always be “liable to moods, sympathies and antipathies, as well as impulses” (Ferenczi, 2002, p. 96). According to him, clinicians’ task in therapy was therefore twofold: to observe and listen to the patient, while keeping in check and manage their own responses and attitudes at all time. For Ferenczi, conducting therapy consisted of having to alternate “continuously between empathy, self-observation, and making judgements” (Ferenczi, 2002, p. 96), a complex task that, in his view, required years to master (Ferenczi, 2002).

By 1927, Ferenczi suggested that advancing knowledge on CT could be a key to increasing the rate of positive outcomes in treatment. He wrote (Ferenczi, 1927, p. 86), “I am firmly convinced that, when we have learned sufficiently from our errors and mistakes, when we have gradually learned to take into account the weak points in our personality, the number of fully analysed cases will increase”. The following year, Ferenczi proposed the notion of “elasticity” in the interpersonal dialectic in psychoanalysis, stressing relational aspects of psychotherapy, ahead of his time. The notion of elasticity refers to the emotional push and pull present in the relationship with patients, that require from the clinician “(...) not only a firm control of his own narcissism, but also a sharp watch on his emotional reactions of
every kind” (Ferenczi, 2002, p. 95). Ferenczi pioneered the exploration of “antipathy” in the CT, suggesting that rather than a contraindication to treatment, antipathy should also be worked through. CT management skills should enable clinicians to regard “even the most unpleasant and repulsive” patient as a person in need of help (Ferenczi, 2002, p. 95).

With Ferenczi’s contribution, managing CT becomes an inherent part of analysts’ tasks. As noted, upon discovering the influence of CT phenomena on the therapeutic encounter, Freud made undergoing personal therapy a prerequisite to conducting analysis. Ferenczi took self-reflection in psychotherapy further by pioneering the idea of supervision in addition to personal analysis. In his view, CT is an ever occurring phenomenon that justifies on-going supervision (Ferenczi, 1950, p. 187).

However, Ferenczi’s work was disregarded for decades. Political and personal disagreements leading to tensions with Freud, the controversial nature of his work, and rumours associated with his own mental health, might all have contributed to the lack of exposure of his work (Choder-Goldman, 2010). Aron and Harris (2010) also proposed that his work might have suffered political censorship due to the rise of Nazism in Europe that culminated in Hitler’s election in Germany in 1933, also the year of Ferenczi’s death (Aron & Harris, 2010). Hence, complex contingencies have concealed Ferenczi’s tremendous contribution to the concept of CT until quite recently, including from psychoanalysts themselves (Choder-Goldman, 2010).

### 2.1.4 Golden age of CT in the psychoanalytic literature

In the early 50s, a new generation of emancipated analysts addressed CT in a series of influential papers (Heimann, 1950; Little, 1951; Racker, 1953; Winnicott, 1960). Their work propelled CT to a central place in psychoanalytic theories. According to Heimann, the rapid growth in publications on the topic indicated that the time was “ripe for a more thorough research into the nature and function of the counter-transference” (Heimann, 1950). While the overlooking of Ferenczi’s work inflated the novelty of these contributions, they have been seminal to the development of
CT nonetheless. These of Heimann and Winnicott stand out for having broadened the definition of CT (Heimann, 1950; Winnicott, 1949), thereby increasing its clinical relevance across theoretical frameworks.

**Paula Heimann**

Heimann is credited for having pioneered a shift in the conceptualisation of CT in a 1949 address to the 16th International Psycho-analytical Congress in Zürich (Heimann, 1950; Safran & Muran, 2000, p. 62).

In the short note published from the address, she appeared astonished that trainees merely considered CT as “a source of trouble”. She wrote, “many candidates are afraid and feel guilty when they become aware of feelings towards their patients and consequently aim at avoiding any emotional response and at becoming completely unfeeling and ‘detached’” (Heimann, 1950, p. 83). In her view, the widespread idea that an analyst should not feel anything more than a “mild benevolence” toward patients was a misconception, possibly originating from a misreading of Freud’s work. Referring to Freud’s surgeon analogy, she wrote:

> Freud’s demand that the analyst must ‘recognize and master’ his own counter-transference does not lead to the conclusion that the counter-transference is a disturbing factor and that the analyst should become unfeeling and detached, but that he must use his emotional response as a key to the patient’s unconscious. (Heimann, 1950, p. 83)

Heimann acknowledged that both patients and clinicians have feelings, thereby emphasising the relational nature of therapy. However, the clinician, unlike patients, need to “sustain the feelings which are stirred in him, as opposed to discharging them [...]” (Heimann, 1950, p. 82). She viewed violent emotions such as love, hate, anger, and helplessness as potential impediments to therapy due to their tendency to “impel towards action rather than towards contemplation” (Heimann, 1950, p. 83). By decrypting their emotional responses before acting on them,
clinicians can preserve therapy while deepening their understanding of the patient's unconscious processes (Heimann, 1950). Heimann's perspective aligned with Freud's contention that doctors need to manage their own responses to avoid imposing a "censorship of [their] own" on patients' material (S. Freud, 1957, p. 115). In Heimann’s view, the analyst's unconscious understands that of the patient (Heimann, 1950), which calls to mind Freud’s statement that the analyst “must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient” (S. Freud, 1957, p. 115).

Heimann’s contribution was therefore threefold. First, she stressed the relational nature of analysis. Second, she proposed to regard all of clinicians’ emotional responses to patients as CT, thus initiating the shift towards a more inclusive definition of the concept. Third, she viewed CT as an “instrument of research into the patient’s unconscious”, thus turning CT into analysts’ most important clinical tool (Heimann, 1950).

**Donald W. Winnicott**

Winnicott made a further major contribution to psychoanalysis around “hate” in the CT (Winnicott, 1949). Although Ferenczi did write about “antipathy” in the CT some twenty years prior (Ferenczi, 2002, p. 95), Winnicott reached beyond circles of psychoanalysts by addressing the medical profession.

Winnicott pointed out that, like transference, CT responses are present in every human relationships, including therapeutic ones, and that overlooking them can have anti-therapeutic consequences. Alluding specifically to practices such as leucotomy commonly practised in psychiatry at the time, Winnicott wrote that, “However much [the psychiatrist] loves his patients he cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patients” (Winnicott, 1949, p. 350). In line with Heimann, Winnicott contended that unmanaged CT could affect the clinical encounter unknowingly.
Furthermore, Winnicott (1949) introduced a novel distinction between “subjective” and “objective” aspects of CT. He proposed to label “subjective CT”, emotional responses arising from clinicians’ repression of their own set of relational patterns, and “objective CT”, those arising in reaction to patients’ actual personality and behaviour (Winnicott, 1949). In fact, Winnicott assigned transference patterns emanating from clinicians to the subjective aspects of CT. Put simply, subjective CT thus provides information about the clinician her/himself, while objective CT are emotional responses manifesting in clinicians that provide information about the patient. In line with Freud, Winnicott argued that interferences arising from subjective CT require personal therapy, while adding that this was less an issue among psychoanalysts, who traditionally undergo analysis, than for other clinicians (Winnicott, 1949, p. 350). Finally, he noted that some aspects of subjective CT are enabling, such as when a personal desire to help nurtures positive emotional responses to patients. In contrast, Winnicott distinguished a “truly objective countertransference”, defined as “the analyst’s love and hate in reaction to the actual personality and behaviour of the patient, based on objective observation” (Winnicott, 1949, p. 350). Differentiating objective aspects of CT put forward the idea that some clinical presentations will necessarily evoke intense emotional responses in clinicians, regardless of how well analysed clinicians are. With such “psychotic or anti-social” patients (p. 350), treatment outcomes will depend on clinicians’ ability to handle feelings of hate occurring objectively in the CT. Only by managing their own emotional responses, can clinicians deliver a treatment that is adapted to the needs of their patients rather than to their own (Winnicott, 1949).

Winnicott’s contribution was ground breaking for bringing the controversial notion of clinicians’ ambivalence towards patients to a broad audience of clinicians (Gabbard, 1994). The distinction introduced by Winnicott between subjective and objective aspects of CT formalised the idea that some emotional responses reflect patients’ interpersonal behavioural patterns objectively, and constitute therefore valuable clinical tools (Betan, Heim, Conklin, & Westen, 2005; Winnicott, 1949).
2.1.5 Different perspectives on the concept of CT

Kernberg coined the term “totalistic” to describe the shift supposedly brought to the “classical” conception of CT by these contributions in the mid-20th century (Kernberg, 1965). After Heimann’s original proposition (Heimann, 1950), the totalistic view defines CT as “the total emotional reaction of the psychoanalyst [or clinician] to the patient in the treatment situation” (Kernberg, 1965, p. 38). The totalistic view is seen as having broadened the scope of CT (Gabbard, 2001), thereby increasing its clinical potential as a conceptual tool to think and manage the impact of clinicians’ emotional responses to patients in all types of treatment/psychotherapy. According to Gelso and Hayes who reviewed the concept of CT, a complementary and a relational perspective can also be distinguished, to which they added an integrative one that draws on the strengths and limitations on the other four (Gelso & Hayes, 2007b; See Hayes, Gelso, & Hummel, 2011 for review).

2.2 Transtheoretical potential of countertransference

This section argues that CT, especially considered within the totalistic perspective, can be used as a conceptual tool to describe relationship factors pertaining to the clinical situation in both dynamic and insight based treatments. The term CT is not used as such in humanistic and systemic traditions of psychotherapy (Gelso & Hayes, 2007a). However, it has emerged as a conceptual tool in cognitive-behavioral therapies (CBT), or learning based psychosocial treatments, which include CBT but also DBT and ACT for instance.

This section presents theories and research which support CT having clinical relevance in the CBT paradigm. I subsequently argue that, for the time being, CT is the conceptual tool with the most potential to foster collegial discussions on clinicians’ emotional responses to patients within and across paradigms. Before this however, the section takes a historical approach in reviewing the two major developments that contributed to approaches within the CBT paradigm also
needing to conceptualise therapists’ influence on the clinical encounter, including their emotional responses to patients.

2.2.1 Relationship factors in the CBT paradigm

In contrast to pure behavioural therapy approaches (Kahn & Baker, 1968; Linehan, 1988), the quality of the relationship between therapist and client was always deemed important in CBT. However, the relationship was viewed as a necessary condition to promote effectiveness rather than a therapeutic agent itself (Gilbert & Leahy, 2007; Linehan, 1988; Moorey, 2014; Wilson & Evans, 1977). Yet, as they started treating personality disorder patients, CBT clinicians felt the need to start considering the relationship as an important element of treatment. Later, as evidence on common factors in psychotherapy (Lambert & Barley, 2001) started compounding, CBT authors too began considering that therapy was essentially a relational act (Gilbert & Leahy, 2007; Leahy, 2008; Norcross & Lambert, 2011; Safran & Muran, 2000).

In the 1960s, proponents of the cognitive behavioural paradigm aimed to differentiate themselves from traditional forms of therapies dominant at the time, by applying the hypothetic-deductive method of scientific enquiry to the study of psychotherapy (Moorey, 2014). From the onset, CBT clinicians provided evidence that seemed to support their efficiency at treating anxiety, depression and anxiety disorders (See for instance A. T. Beck, 1964; Marks, Hodgson, & Rachman, 1975). However, when the focus of CBT treatment extended to personality disordered patients, CBT therapists began to consider relationship factors, initially left out of their models for lacking empirical potential (Moorey, 2014). Indeed, until the late 1980s and early 1990s, the clinical literature on personality disorder was almost exclusively psychoanalytic (A. T. Beck, Freeman, Davis, & Associates, 2004b).

Around that same time, a fierce debate sparked between Eysenck and Strupp after the first claimed hastily, based on a dearth of quantitative evidence at the time, that psychodynamic therapies were not efficient at improving patients’ conditions.
(Eysenck, 1952; Strupp, 1963). Notwithstanding the Manichean divide it reinforced between insight and learning based treatments, the on-going debate has led to tremendous advances in identifying evidence of factors accounting for therapy effectiveness (Wampold, 2013). In this regard, the field is in debt to the CBT movement for having applied the hypothetic-deductive method to the study of psychotherapy, thereby supporting empirically the comparable effectiveness of insight and learning based treatments (Lambert & Bergin, 1994; Wampold & Imel, 2015a).

Two major findings have emerged for psychotherapy research. First, that psychotherapy, in general, is effective at improving patients’ conditions. Smith and Glass performed a meta-analysis of close to 400 outcomes studies to estimate that 75% of treated patients are better off than matched patients in untreated control groups (Smith & Glass, 1977). Second, that therapy factors most strongly associated with positive outcomes are common to all types of therapies (Smith, Glass, & Miller, 1980), which has been referred to in the literature as the “dodo effect” (Rosenzweig, 1936; Wampold & Imel, 2015b). In an influential body of work (Asay & Lambert, 1999; Lambert & Barley, 2001), Lambert and colleagues reviewed the literature to propose a rough estimate of the weight of different contributors to psychotherapy outcomes. They sorted the variables generally involved in psychotherapy outcomes into four categories, including extra-therapeutic factors, expectancy, specific therapy techniques, and common factors. Examining over 100 studies, they estimated that about 40% of positive outcomes were due to extra therapeutic factors such as spontaneous remission or life events, 15% to expectancy (placebo effect), 15% to specific therapy technique, and 30% to common factors. Hence, excluding external factors (40%), common factors accounted for half of the therapeutic influence of psychotherapy (Lambert & Barley, 2001). These active ingredients common to all forms of psychotherapy include the relationship between therapist and patient, therapist and researcher allegiance to the treatment, and therapists’ characteristics (Messer & Wampold, 2002). However, relationship factors have been associated most dramatically with positive patients’ outcomes (Duncan, Miller, Wampold, & Hubble, 2010; Gelso, Palma, & Bhatia, 2013; Horvath,

The common factor approach thus signifies the limited applicability of the medical model to psychotherapy, i.e. where the treatment is curative independently of the person administrating it (Wampold, 2015), while opening a path towards a contextual approach to psychotherapy (Messer & Wampold, 2002; Norcross & Lambert, 2011). In line with this, other work has provided evidence that strict adherence to CBT principles without attention to relationship factors is negatively correlated to positive outcomes (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Goldfried & Wolfe, 1998). Norcross and Lambert have voiced their hope that the compelling association of relationship factors, specifically the quality of the therapeutic alliance, with positive outcomes, would reconcile divergent traditions of psychotherapy for the benefits of clinicians and patients alike (Norcross & Lambert, 2011).

2.2.2 Conceptualising clinicians’ influence on the therapeutic relationship

Regarding psychotherapy as a relational practice has placed a new emphasis on clinicians’ potential influence on the clinical encounter (Norcross & Lambert, 2011; Norcross & Wampold, 2011; Wampold & Imel, 2015d). As CBT theorists started reflecting more specifically on the part played by clinicians in the clinical encounter, they have gradually emphasised the need for therapists to manage their emotional responses to preserve and foster the therapeutic alliance (Gelso & Hayes, 2007b; Safran & Muran, 2000). With relational factors having received tremendous attention in the psychoanalytic literature for over century, some CBT theorists have naturally turned to the psychoanalytic corpus to borrow existing concepts from it when relevant (Cartwright, 2011).

For example, although originally a psychoanalytic concept, the therapeutic relationship, or therapeutic alliance, is now commonly discussed transtheoretically
(A. T. Beck, Freeman, Davis, & Associates, 2004a; J. S. Beck, 1995). Similarly, the conceptual dichotomy of transference/countertransference has been viewed by non-psychoanalytic schools of therapy as a useful tool to describe what clients and clinicians each bring to the therapeutic encounter (Cartwright, 2011; T. E. Ellis et al., 2018; Prasko et al., 2010; Vyskocilova, Prasko, Slepecky, & Kotianova, 2015). Reviewing evidenced-based therapy relationships, the American Psychological Association interdivisional task force found that, despite requiring further research, managing CT was a promising areas of study to advance the field of psychotherapy, along with congruence/genuineness and repairing alliance ruptures (Norcross & Wampold, 2011).

2.2.3 CT in CBT

Some CBT and psychoanalytic writers argue that fundamental conceptual differences between paradigms make transference and countertransference essentially inadequate for CBT (Ivey, 2013; Rudd & Joiner, 1997). Rudd and colleagues have proposed an alternative CBT conceptualisation called the “therapeutic belief system (TBS)” (Rudd & Joiner, 1997). However, other CBT authors view this model as failing to reflect the complexity and ambivalence of human emotional responses (Cureton & Clemens, 2015). Others continue to see transference and countertransference as useful conceptual tools to think relationship factors in CBT (Cartwright, 2011; Moorey, 2014; Prasko et al., 2010).

Jan Prasko

Prasko and collaborators (2010) argued that transference and countertransference represent a valuable source of information about both clinician and patient’s inner worlds. Referring to the work of Beck (J. S. Beck, 1995) and Gluhoski (Gluhoski, 1994), Prasko and colleagues contended that believing that no attention is paid to transference phenomena in CBT is a major misconception. That is, while interpreting transference is not a central therapeutic tool like it is in psychoanalysis, examining therapists’ automatic thoughts and feelings is very much within the
scope of CBT (Prasko et al., 2010). Furthermore, these authors asserted that CT occurs regardless of the type of therapy implemented. In their view, “no therapist is free of countertransference” (Prasko et al., 2010, p. 193):

Rather than having no feelings, or being an expert at repression, the cognitive therapist is attuned to personal emotions that might affect the therapy environment. Just as the therapist would encourage a client to do, cognitive behavioural therapists use awareness to their own physical sensations and subtle mood shifts as cues, suggesting the presence of automatic thoughts. Any changes in the therapist’s typical behavior might signal an emotional reaction and associated automatic thoughts, such as talking in a commanding (or hesitating) tone of voice, increased frequency of thoughts about a client outside sessions, or perhaps avoidance of returning a client’s phone call or tardiness in starting or ending a session. (Prasko et al., 2010, p. 193)

Just like in psychoanalysis and psychodynamic therapies in general, Prasko and collaborators contended that in CBT a lack of CT awareness could potentially lead to counter-therapeutic behaviours from therapists, that CT literacy could help prevent (Prasko et al., 2010; Vyskocilova et al., 2015).

Stirling Moorey

Moorey leant on empirical evidence on transference (Berk & Andersen, 2000; Gelso & Bhatia, 2012) to argue that transference and countertransference occur everywhere in everyday life, including in CBT, whether or not these are paid attention to (See Moorey for history of the concept in (Moorey, 2014)). In his view, these concepts are relevant to CBT, provided one accepts the premise of a “cognitive unconscious” consisting of implicit cognitions (Moorey, 2014, p. 143). However, to propose a terminology that has greater appeal to CBT therapists, he suggested to label the transference/countertransference dialectic “interpersonal schema” instead, which comprises “cognitive, affective, memory, behavioural and somatic elements” (Moorey, 2014, p. 137).
Cartwright observed that while transference and CT are less widely endorsed in the CBT literature than the concept of therapeutic alliance, all three constructs are eminently welded to one another (Cartwright, 2011). That is, transference and CT too allow discussing the complex reality of the interpersonal dialectics occurring in therapy. Cartwright (2011) argued that these conceptual tools could inform and facilitate reflective practice and self-supervision in CBT. An interesting study surveyed 55 clinical psychology trainees across four campuses in Australia and New Zealand, to demonstrate that, despite lacking confidence in managing their emotional responses to clients, the majority of students showed interest in learning about CT (Cartwright, Rhodes, King, & Shires, 2014). In New Zealand, Cartwright and colleagues have developed a five-step method to train CT literacy (Cartwright & Read, 2011). An intervention study piloted the method in a 2-day training, with pre- and post-intervention self-administrated questionnaires, in a group of 63 postgraduate clinical psychology trainees in Australia and New Zealand (Cartwright, Rhodes, King, & Shires, 2015). The study showed that the majority of CBT trained psychology post-graduate students found learning about CT literacy relevant to their practice and useful, and that they benefited from the brief training intervention (Cartwright et al., 2015).

In summary, the transtheoretical potential of CT is manifest. Specifically, although critiqued by some authors for being too inclusive (Gelso & Hayes, 2007a), the totalistic view of CT constitutes a flexible hence clinically useful conceptual tool to reflect on clinicians’ influence on the clinical encounter across theoretical paradigms (Gelso & Hayes, 2007e; Kernberg, 1965). In fact, despite arguing that alternative terminology would fit the CBT paradigm better, most CBT authors in this area use the term CT in the totalistic sense (Cartwright et al., 2015; A. Ellis, 2001; T. E. Ellis et al., 2018; Vyskocilova et al., 2015). Clinicians’ variables have been identified as critical elements of the therapeutic transaction that deserve scientific scrutiny. CT is probably the most sophisticated and widely accepted concept to describe the potential influence of clinicians’ emotional responses on the therapeutic situation.
As such, it has received a renewed attention from scholars over the past two decades.

### 2.3 Empirical evidence on countertransference

By nature, CT reflects complex interpersonal dialectics that are difficult to study empirically. It has been described as a “clinically important but empirically elusive phenomenon” (Rosenberger & Hayes, 2002, p. 264). For some authors, attempting to study CT systematically, or test it, risks robbing the phenomenon of ecological and clinical validity (Kächele, Erhardt, Seybert, & Buchholz, 2015). However, bringing scientific objectivity to the area has obvious advantages. Empirical evidence informs practice guidelines, which benefits both clinicians and patients. In recent years, researchers have developed new ways of operationalising CT and started building a compelling empirical literature. Several reviews of the research evidence on CT have been completed (Gelso & Hayes, 2007d; Machado et al., 2014; Rosenberger & Hayes, 2002; Singer & Luborsky, 1977).

The following section provides a rapid overview of the type of research conducted on CT, sorting it in research on the nature of CT and on its relationship to therapy outcomes.

#### 2.3.1 Measuring CT

Machado et al. reviewed 25 studies on CT phenomena in adult psychotherapy (Machado et al., 2014), and noticed that CT is assessed generally by rating on a Likert-scale a list of statements describing emotional responses to patients, either by an observer or by clinicians themselves.

However, Hayes, Gelso and Hummel distinguished two types of research on CT: research investigating internal states of CT from that exploring its behavioural manifestations (J. A. Hayes, Gelso, & Hummel, 2011). Studies looking at behavioural manifestations of CT tend to be examined via an external appraisal of sessions. Trained raters, often the clinician’s supervisor, use standardised tools to analyse
transcripts or recordings of sessions. Studies have used the CT index (CT Index) (1-item) (J. A. Hayes, Riker, & Ingram, 1997), the Index of CT Behavior (IBC) (21-item) (Friedman & Gelso, 2000) or the CT Behavior Measure (CBM) (10-item) (Mohr, Gelso, & Hill, 2005), and all investigated the effect of CT behaviours on the therapy. Studies looking at internal states of CT, i.e. clinicians’ perception of CT, tend to use self-report measures. These measures include for example the CT Factors Inventory (CFI) (Gelso, Latts, Gomez, & Fassinger, 2002), the Feeling Word Checklist (FWC-58) (Dahl, Røssberg, Bøgwald, Gabbard, & Høglend, 2012; Holmqvist & Armelius, 1996; Lindqvist et al., 2017), and the Therapist Response Questionnaire (TRQ) (Betan et al., 2005; Tanzilli, Colli, Del Corno, & LINGIARDI, 2015). These studies have examined the nature of CT in relation to patients’ personality pathology, hence investigating the potential of CT as a diagnostic tool. Others have investigated the relationship between CT literacy and treatment outcomes.

2.3.2 CT response and patient personality

For example, Betan et al. developed the Therapist Response Questionnaire (TRQ) to derive dimensional models of CT phenomena empirically (Betan et al., 2005). Replication of this original study led to the refinement of the TRQ factor structure, from eight to nine factors or CT dimensions (Tanzilli et al., 2015). The table below presents these nine factors using the description offered by the authors in their publication (Tanzilli et al., 2015).
### Table 2.1 Description of the TRQ nine factors by (Tanzilli et al., 2015)

<table>
<thead>
<tr>
<th>FACTOR NAME</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HELPLESS/INADEQUATE</td>
<td>Indicated “feelings of inadequacy, incompetence, hopelessness, and a strong sense of inefficacy”</td>
</tr>
<tr>
<td>OVERWHELMED/DISORGANIZED</td>
<td>Indicated “an intense feeling of being overwhelmed by the patient’s emotions and needs, as well as confusion, anxiety, dread or repulsion”</td>
</tr>
<tr>
<td>POSITIVE/SATISFYING</td>
<td>Indicated “an experience of close connection, trust, and collaboration with the patient resulting from a good therapeutic alliance”</td>
</tr>
<tr>
<td>HOSTILE/ANGRY</td>
<td>Indicated “feelings of anger, hostility, and irritation toward the patient”</td>
</tr>
<tr>
<td>CRITICIZED/DEVALUED</td>
<td>Indicated “a sense of being criticized, unappreciated, dismissed, or devalued by the patient”</td>
</tr>
<tr>
<td>SPECIAL/OVERINVOLVED</td>
<td>Indicated “that the patient is very special, so much so that the clinician may show some difficulties in maintaining the boundaries of the therapeutic setting (e.g., s/he self-discloses his or her feelings or more about his or her personal life with the patient than with other patients, or ends sessions late)”</td>
</tr>
<tr>
<td>PARENTAL/PROTECTIVE</td>
<td>Indicated “a wish to protect and nurture the patient in a parental way, above and beyond normal positive feelings toward him/her”</td>
</tr>
<tr>
<td>SEXUALIZED</td>
<td>Indicated “the presence of sexual attraction or feelings toward the patient”</td>
</tr>
<tr>
<td>DISENGAGED</td>
<td>Indicated “feelings of annoyance, boredom, withdrawal, or distraction in sessions”</td>
</tr>
</tbody>
</table>

Additionally, the TRQ was used to investigate the relationship between specific dimensions of CT and patients’ personality. Both the original study and its replication found specific patterns of associations between certain dimensions of CT and patients’ personality pathology that have high clinical face validity (Betan et al., 2005; Tanzilli et al., 2015). For instance, a significant association was found between borderline personality pathology and clinicians’ feelings of being
overwhelmed, disorganised, helplessness and apprehensive (See Tanzilli et al., 2015 for comprehensive description of results). This type of work supports the potential value of CT as a clinical tool to assist the assessment of patients’ personality.

Of note, both these studies have suggested that clinicians’ theoretical orientation did not affect their ability to rate statements pertaining to their emotional responses to patients (Betan et al., 2005; Tanzilli et al., 2015), which is consistent with the view that CT does occur in all types of psychotherapy (Cartwright, 2011; Prasko et al., 2010).

2.3.3 CT literacy and therapy outcomes

Hayes et al. (2011) conducted a meta-analysis of 10 quantitative studies which supported the hypothesis that CT was inversely related to psychotherapy positive outcomes, although modestly. Moreover, this review of evidence suggested that effective management of CT was associated with better therapy outcomes (J. A. Hayes et al., 2011). A more recent systematic review of the literature (Machado et al., 2014) confirmed that the empirical evidence on the effect of CT in adult psychotherapy suggested that both successful CT management and positive CT, such as feelings of closeness, affiliation and respect, were associated with better therapy outcome (Machado et al., 2014).

For example, in a study examining interview data from eight clinicians, four male and four female, collected immediately after observing their therapy sessions, Hayes et al. (1998) found a high occurrence of CT in therapists deemed experts by their peers (J. A. Hayes et al., 1998). The study analysed 12 to 20 sessions per clinician for a total number of 127 sessions and found that these expert clinicians were aware of experiencing CT reactions in 80% of their sessions. For the authors, these findings indicated without ambiguity that reputed therapists do experience CT responses, thereby undermining the “professional myth that good therapists do not experience” CT (J. A. Hayes et al., 1998, p. 477). On the contrary, these findings
aligned with a previous study suggesting that reputedly excellent therapists demonstrated more qualities theoretically associated with CT literacy (Van Wagoner, Gelso, Hayes, & Diemer, 1991).

In a similar vein, Hayes and colleagues randomly assigned 18 clinicians, ten men and eight women, either a case of successful or unsuccessful psychotherapy to discuss (J. A. Hayes, Nelson, & Fauth, 2015). Comparing the two conditions showed that clinicians articulated more unpleasant feelings when they discussed successful cases of psychotherapy. This is consistent with CT literacy having positive association with therapy outcome. Alternatively, the authors considered that this could indicate instead that clinicians felt more comfortable disclosing CT responses when discussing cases that they deemed successful (J. A. Hayes et al., 2015).

Another study investigated the benefit of CT literacy applied to preventing clinical errors in the context of a clinical trial for the psychodynamic-interpersonal group treatment of depression (Tasca, Mcquaid, & Balfour, 2016). Reviewing systematically cases of clinical errors and negative outcomes suggested that group therapists were more likely to avoid clinical errors if CT was addressed in reflective practice, as well as work conditions and latent\(^6\) organisational pressures (Tasca et al., 2016).

### 2.4 Countertransference in the treatment of patients at risk for suicide

The aim of this section is to demonstrate that CT literacy and management are critical to clinical suicidology.

The section starts by arguing that a collaborative approach is needed to treat PRS. Following this, it argues that PRS are prone to elicit intense emotional responses within clinicians that make a collaboration often difficult to achieve. The counter-therapeutic potential of these emotional responses from clinicians has been

\(^6\)“(of a quality or state) existing but not yet developed or manifest; hidden or concealed” definition retrieved from (Oxford Dictionary, 2018)
examined in the literature in terms of CT. After presenting Maltsberger and Buie's psychodynamic formulations of CT hate in the treatment of suicidal patients, the section reviews the clinical and empirical literature on CT to PRS.

### 2.4.1 The need for a collaborative approach

A strong evidence base supports that establishing a genuine therapeutic alliance in clinical practice with PRS is central to both risk assessment and therapy/treatment alike (Bedics, Atkins, Harned, & Linehan, 2015; Dunster-Page, Haddock, Wainwright, & Berry, 2017; Jobes, 2011; Joiner, Van Orden, Witte, & Rudd, 2009). Rudd (2012) asserted that clinicians cannot assess the risk of suicide accurately without building a genuine rapport with the patient (Rudd, 2012). Indeed, efforts to develop risk assessment tools that have a predictive value have failed. In 1991, Goldstein and colleagues attempted to develop a statistical model that would predict suicide attempts (Goldstein, Black, Nasrallah, & Winokur, 1991). They concluded that, based on the knowledge of their time, “it was not possible to predict suicide, even among a high-risk group of inpatients” (Goldstein et al., 1991, p. 418). In the same vein, Large et al. (2016) conducted a meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients to conclude that a “statistically strong and reliable method to usefully distinguish patients with high-risk of suicide remains elusive” (Large et al., 2016, p. 2). Large and Ryan argued that basing treatment decisions on the “basis of notions of risk of future suicide are ill-founded”, due to the lack of sensitivity and specificity of suicide risk assessment tools (Large & Ryan, 2014, p. 681). Large and Ryan maintained that, “[...] instead of treating people according to statistical notions of risk, we should comprehensively and compassionately assess all of our patients and tailor our management according to their needs and wishes” (Large & Ryan, 2014, p. 681). As the confidence in predicting suicide accurately through risk assessment instruments faded, the emphasis put on collaborative and narrative approaches to clinical suicidology have increased.
Many evidence-based specialised treatments of suicidal behaviours have a strong relational component, including interpersonal (Joiner, Van Orden, Witte, & Rudd, 2009a), dialectical (Linehan, 1993), and collaborative (D. Jobes, Lento, & Brazaitis, 2012) approaches. These treatments reflect their authors’ opinion on, and experience of, clinical practice with PRS as a relational practice in nature. For the authors of the interpersonal theory of suicide, the importance of the relationship in treating PRS “cannot be overstated” (Rudd, Joiner, & Rajab, 2001, p. 12). For Linehan, in DBT “a strong, positive relationship with a suicidal patient is absolutely essential” (Linehan, 1993, p. 514). For the group of international experts known as the Aeschi Working Group who developed the collaborative approach, “without a robust therapeutic alliance, psychotherapists cannot expect to be successful in [their] interventions with suicidal patients” (Konrad, 2011, p. 13). Expert writers stress unequivocally that establishing a strong and positive therapeutic relationship is critical to achieving positive outcomes in the treatment of PRS in all types of treatment (Joiner, Van Orden, Witte, & Rudd, 2009b; Michel & Jobes, 2011; Schechter & Goldblatt, 2011).

Reviewing the literature on the relationship between therapeutic alliance and patients’ suicidality, Dunster-Page at al. (2017) identified 12 studies meeting the following inclusion criteria: a) participants were 18-years-old or over; b) use of a validated measure of therapeutic alliance between patients and staff; and c) studies reported associations between therapeutic alliance and patient’s suicidality. The 12 studies differed in their design, population, measure of alliance (i.e. nine patient-rated, two therapist-rated, and one observer-rated), and measure of suicidality (i.e. five explored thoughts, five self-harm, eight suicide attempt, and three used a composite measure of suicidality). Despite this heterogeneity, the review showed that a therapeutic alliance with a therapist, a care-coordinator or a mental health team, tended to have a positive impact on patient’s suicidality across studies. Moreover, no studies found evidence that a strong alliance could be associated with an increase in suicidality (Dunster-Page, Haddock, Wainwright, & Berry, 2017).
Naturally, psychodynamically oriented authors have stressed the critical role of the therapeutic relationship in treatment too (Maltsberger, 2001; Schechter, Goldblatt, & Maltsberger, 2013; Shneidman, 1981). However, authors from these orientations have also emphasised the challenges associated with building a relationship with the suicidal patient (Goldblatt & Maltsberger, 2009; Wasserman, 2001; Weinberg, Ronningstam, Goldblatt, & Maltsberger, 2011). Clinicians and suicidal patients are not always inclined to collaborate with one another. In other words, the relationship between wanting to help a suicidal person in principle and being inclined and able to build a rapport with them is often far from transparent.

2.4.2 The ‘difficult’ patient

Suicide can trigger latent emotions in clinicians that can generate a reluctance to work with PRS. At the same time, PRS’ ambivalence towards life and death can manifest in their behaviour towards the clinician. For these reasons, treating PRS is commonly acknowledged as one of the most difficult clinical endeavours (See for instance the preface of Rudd et al., 2001a).

**Symbolic impact of suicide**

By its very nature, patients’ suicidality can activate clinician’s beliefs and latent emotions (e.g. angst/wish) around death and suicide. There is something profoundly human and yet fundamentally puzzling, or anxiety provoking, even fascinating, about suicide. There is a gravity inherent to it. For some, the term also resonates with painful memories.

The psychological impact of suicide likely explains that stigma is attached to it, and that numerous myths surround it (Domino, 1990; Leenaars & Lester, 1992; McIntosh, Hubbard, & Santos, 1985; Segal, 2000). These myths include for example the notion that people who talk about suicide do not attempt suicide, that most suicides happen without warning signs, that suicidal people are determined to die, etc. (World Health Organization, 2014). These misconceptions seem to be spread also among clinicians (Joiner, 2010):
Joiner argued that the level of stigmatisation of suicide reflected people’s great level of fear, as well as their ignorance about it (Joiner, 2010). Research shows that negative attitudes toward suicidal patients are common (Saunders, Hawton, Fortune, & Farrell, 2012; Swain & Domino, 1985).

**Suicidal patients in practice**

Suicidal patients represent the subgroup of suicidal people who get professional help. From a clinical standpoint, it has been argued that a majority of suicidal people who invest in treatment present features commonly associated with the diagnosis of borderline personality disorder (BPD) (Linehan, 1993; Maltsberger, 2001).

Suicidal patients tend to demonstrate troubled interpersonal dialectics, or transferential dynamics, often of hostile or of dependent nature, along with negative reaction to treatment (Bloom, 1967; Perry, Bond, & Presniak, 2013; Wolk-Wasserman, 1987). Moreover, PRS’ behaviour is often characterised by ambivalence, which is reflected in treatment (Leenaars, 2011). According to Weinberg and colleagues, those dynamics include dissociation of ideation and intent, impulsivity, lack of ability for self-disclosure, and potential denial of suicidality. Moreover, in borderline and narcissistic organisations of personality, suicidality can be associated with manipulative and destructive tendencies directed towards the clinician (Weinberg et al., 2011). As a result, suicidal patients tend to evoke intense feelings within the therapist, in regard of which the Kleinien concept of projective identification appears particularly relevant (Kernberg, 1987; Klein, 1986).

**Losing a patient to suicide**

Psychiatrist and psychologists—highly trained, doctoral level mental health professionals—sometimes whisper about or panic about or skirt around the issue of suicide, an aversion that has always puzzled me, and one that strikes me as similar to a surgeon afraid of blood. (Joiner, 2010, p. 4)
It has been estimated that approximately one in two psychiatrists and one in five psychologists lose at least one patient to suicide in their career (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Séguin, Bordeleau, Drouin, Castelli-Dransart, & Giasson, 2014). This led Chemtob and colleagues to propose the now famous adage that suicide should be considered an occupational hazard for psychiatrists and psychologists (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988).

Losing patients to suicide is understandably distressing for clinicians (Gaffney et al., 2009; Landers, O’Brien, & Phelan, 2010; Wurst et al., 2013). It has both professional and personal impacts (Alexander, Klein, Gray, Dewar, & Eagles, 2000; Landers et al., 2010), including long lasting ones (Linke, Wojciak, & Day, 2002), for all clinicians (Chemtob, Hamada, Bauer, Kinney, et al., 1988; Chemtob, Hamada, Bauer, Torigoe, et al., 1988; Collins, 2003). In a national survey of psychologists, Chemtob et al. found that half of the clinicians who lost a patient to suicide had intrusive thoughts about suicide, and displayed stress levels similar to those observed in people after the loss of a parent, for which they sought treatment (Chemtob, Hamada, Bauer, Torigoe, et al., 1988). These effects are stronger for junior clinicians or clinicians in training (Kozlowska, Nunn, & Cousens, 1997; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004).

Studies show that a patient’s suicide elicits intense anxiety, shock, shame, anger but also guilt, helplessness, feeling of failure and doubts about professional competence that can lead to burn out (Gaffney et al., 2009; Menninger, 1990, 1991). The sense of responsibility, whether actual or perceived, can be burdening for clinicians, and many fear liability issues following the suicide of a patient while under their care (APA, 2003; Goldblatt & Maltsberger, 2009; Gutin, McGann, & Jordan, 2011). The feeling of not being properly trained to care for PRS is also common among health professionals, including psychiatrists (Betz et al., 2013; Hendin, Haas, Maltsberger, Koestner, & Szanto, 2006). Alexander and colleagues found that 15% of a sample of psychiatrists had considered retiring early following the suicide of a patient (Alexander et al., 2000).
Working with PRS is therefore inherently challenging, and clinicians may not necessarily be inclined or able to build a rapport with the suicidal patient. In 2003, along similar lines from the American Psychiatric Association (APA, 2003), NZ best practice guidelines acknowledged this by declaring that “all clinicians who work with people who self-harm or are suicidal should be in regular clinical supervision to mitigate the negative impact that this work can have, both on them and on the quality of their work with suicidal people” (NZ Ministry of Health, 2003).

2.4.3 The iatrogenesis of suicide

In the 1960s, authors began discussing CT responses specific to suicidal patients. They suggested that the tendency to cope with negative CT by being avoidant or rejecting of PRS could have lethal consequences. This has been referred to as the potential iatrogenesis of suicide (Andriola, 1973).

Based on case studies, Tabachnick (1961) argued that suicidal patients demonstrate a great need for treatments that emphasise a warm accepting care of “motherly qualities”, which seems often unrecognised and unmet by clinicians whose common response was often cruel and rejecting (Tabachnick, 1961, pp. 64–65). Questioning the reasons why that would be, he hypothesised that these negative attitudes could reflect a “countertransference crisis” in which patients’ hostility, manifested through suicidal behaviours, conflicted with clinicians’ conscious desire to help while triggering their latent hostile and sadistic impulses otherwise defended against. When unmanaged, these hostile CT responses would likely spark anti-therapeutic reactions. To break out of this “countertransference crisis”, Tabachnick recommended that clinicians explored their latent emotions and seek consultation with a peer to avoid retaliating (Tabachnick, 1961).

A few years later, Havens (1965), a clinical professor of psychiatry at Harvard Medical School, published the case of a patient treated within his service in which CT enactments (i.e. behaviours caused by suppressed or denied CT) likely played a role in the lethal outcome. He found himself wondering if, as a team, they had
reacted to the patient’s “unspoken anger” by becoming angry themselves (Havens, 1965, p. 405). Similarly, Bloom (1967) conducted a retrospective analysis of 32 cases of suicide that occurred in a training centre by reviewing case reports, and by interviewing the professionals involved in the case when possible. For the 11 cases that happened while the patient was in treatment, the findings suggested that therapists’ rejecting behaviours, in response to patients’ hostile and dependent transference, had preceded the suicide (Bloom, 1967). Along the same lines, Andriola (1973) argued that clinicians’ negative reactions to communications about suicide intentions could precipitate the act. He reported that psychiatrists commonly misread suicidal intention as an attention seeking behaviour and a strategy to manipulate others, and make inappropriate observations about it. Drawing on the psychodynamic interpretation of six case vignettes, he contended that such observations, either overt or conveyed non-verbally, play a part in “encouraging patients to kill themselves” (Andriola, 1973, p. 213). He concluded:

No matter how we try to rationalize or otherwise explain attitudes which appear to be flippant, disparaging, objectively neutral, or denial of what should be obvious suicidal danger, they are counterproductive. Furthermore, I am inclined to believe that in a substantial number of cases, such attitudes and the messages they convey strip the patient of any remaining shred of hope and provide him with a license for attempted self-murder. In such circumstances they contribute to one of the most pernicious and frequently irreversible iatrogenic malfunctions. (Andriola, 1973, p. 218)

It might be worth noting that these contributions followed the creation of The Los Angeles Suicide Prevention Center (LASPC) in 1958, first suicide prevention center in the US. The LASPC implemented the first scientifically and clinically based programme for the study and prevention of suicide. The first generation of suicidologists have developed the psychological autopsy method to investigate equivocal death, and examined suicide notes held by the coroner (Litman, Curphey, Shneidman, Farberow, & Tabachnick, 1963). Their endeavours attracted popular attention after they investigated the case of Norma Jeane Mortenson (aka Marilyn
Monroe) in 1962. Shneidman started using the term “suicidology” to refer to the scientific study of suicide, and created the American Association of Suicidology in 1968. By the mid-70s, the time was ripe to theorise the possible iatrogenesis of suicide as a special feature of clinical suicidology.

2.4.4 CT hate in the treatment of suicidal patients

In 1974, Maltsberger and Buie published detailed psychoanalytic formulations of CT to PRS (Maltsberger & Buie, 1974). Drawing on Winnicott’s seminal contribution (Winnicott, 1949), they proposed that suicidal patients arouse “countertransference hate” (CT hate), a mixture of malice and aversion, that represents a tremendous obstacle to treatment. To this day, experts from all orientations regard their work as a ground-breaking contribution to the field of clinical suicidology (T. E. Ellis et al., 2018; Rudd et al., 2001b; Yaseen et al., 2013).

The paper proposed that borderline and psychotic patients, who are prone to suicide, stir up CT hate in their therapists. More specifically, Maltsberger and Buie contended that, given their self-representation of being caring and benevolent, therapists would find experiencing hate a distressing experience, and tend to adopt defensive attitudes to cope with the anxiety evoked. The table below, reproduced from the original publication, provides a review of the defensive postures likely to be implemented, along with the conscious fantasy associated, affect experimented, and type of potential acting out. Defensive postures refer to postures betraying the use of defence mechanisms, i.e. unconscious psychological mechanisms that reduce anxiety arising from unacceptable or potentially harmful stimuli (Schacter, Gilbert, & Wegner, 2009, pp. 482–483).
Table 2.2 ‘Economy of countertransference hate’, reproduced from (Maltsberger & Buie, 1974)

<table>
<thead>
<tr>
<th>DEFENSE</th>
<th>THERAPIST’S CONSCIOUS FANTASY</th>
<th>AFFECT EXPERIENCED</th>
<th>POTENTIAL FOR ACTING OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, exercise of caring, restraint</td>
<td>Murder, torture and rejection</td>
<td>Hate</td>
<td>Little</td>
</tr>
<tr>
<td>Repression of hate</td>
<td>Wish to be elsewhere, difficulty in concentrating on what patient says</td>
<td>Restlessness, anxiety, drowsiness; little affect experienced toward patient; empathically not in touch</td>
<td>Tendency to watch the clock, be impatient, to convey indirectly a mild rejection</td>
</tr>
<tr>
<td>Turn hate against self</td>
<td>Impulse to give up; fantasies of self-devaluation, degradation, possibly of suicide</td>
<td>Sense of worthlessness and hopelessness; active sense of inadequacy</td>
<td>Refer patient elsewhere; accept devaluation from patient masochistically and without investigation</td>
</tr>
<tr>
<td>Turn hate into its opposite (reaction formation)</td>
<td>Wish to rescue the patient from his plight</td>
<td>Sense of anxious solicitude, an urgency to help and cure</td>
<td>Meddlesome intervention in the patient’s affairs: too frequent enquiry into patient’s suicidal impulses, plans</td>
</tr>
<tr>
<td>Projection of hate</td>
<td>The patient is about to kill himself, the patient will kill me</td>
<td>Fear, some hatred</td>
<td>Rejection of the patient; attempts to control suicidal behavior by imposing controls</td>
</tr>
<tr>
<td>Distortion and denial</td>
<td>The patient is beyond help</td>
<td>Indifference, pity, resignation to failure</td>
<td>Rejection of the patient</td>
</tr>
<tr>
<td>Sudden breakdown of defense</td>
<td>Death of patient and therapist, utter disaster</td>
<td>Intense fear, rage, and helplessness</td>
<td>Flight, immobilization</td>
</tr>
</tbody>
</table>
Maltsberger and Buie argued that, when unmanaged, these defensive postures can be harmful to therapy and that it is incumbent upon therapists to become aware and manage CT hate to avoid displaying antitherapeutic behaviours (i.e. acting out). They wrote, “We conceive ourselves to be compassionate, caring, and nonjudgmental, and often predicate our professional self-respect on not being rejecting, punitive, sadistic, murderous, and disgusted with patients. An able therapist cannot permit himself to behave according to such feelings, but neither can he afford the illusion that he differs from other human beings and has no id. [...]” (Maltsberger & Buie, 1974, p. 628). Conversely, Maltsberger and Buie also contended that, provided therapists could reflect upon and manage their responses, CT hate too could constitute a precious clinical tool. This contribution established CT literacy as a key element of suicidal patients’ treatment (Maltsberger & Buie, 1974).

2.4.5 Experts’ opinion and qualitative evidence on CT to PRS

The critical role of CT hate and negative CT responses to PRS have featured in the literature ever since Maltsberger and Buie’s classic paper, in book chapters (Goldblatt & Maltsberger, 2009; Maltsberger, 1999; Weinberg et al., 2011), opinion papers (Birchnell, 1983; Marcinko et al., 2008; Orbach, 2001; Roose, 2001; Schechter et al., 2013; Shneidman, 1981), clinical case studies (Leenaars, 1994; Modestin, 1987), and qualitative research (Richards, 2000; Rossouw, Smythe, & Greener, 2011; Wolk-Wasserman, 1987).

For instance, Shneidman (1981) argued in an opinion paper that treating the suicidal patient was as different from ordinary therapy, than ordinary therapy was from ordinary talk. In particular, while acknowledging therapists’ feelings of frustration and helplessness, Shneidman warned that, “in the treatment of the suicidal person there is almost never any place for the therapist’s hostility, anger, sardonic attitudes, daring the patient or pseudo-democratic indifference” (Shneidman, 1981, p. 342 [150]).
Leenaars (1994) proposed a model of crisis intervention with highly lethal people, which he illustrated with a case study. He reiterated the danger associated with unmanaged CT responses, and described a range of counter-therapeutic behaviours likely to stem from clinicians’ feelings of guilt, incompetence, anxiety, fear, or anger. These include the tendency to underestimate patients’ suicidality, reluctance to discuss suicide thoughts or attempts, or hasty endorsement of a non-harm contract. Moreover, he argued that clinicians could sometimes ignore the cry for help that suicide behaviours constitute, while focussing on manipulative, regressive and aggressive tendencies in patients. Leenaars proposed that denying the importance one has for the patient and failing to establish a fruitful and genuine therapeutic relationship were also products of clinicians’ negative CT (Leenaars, 1994).

In a systematic observational study on institutional suicide, Modestin (1987) attempted to estimate the contribution of CT to patients’ death by examining the clinical record of 149 patients died by suicide between 1960 and 1981 in two Swiss psychiatric institutions. Of these 149 clinical records, only 9 provided sufficient indications that uncontrolled CT reactions had contributed to the patients’ suicide, which Modestin argued was an underestimation due to a lack of record of CT. A content analysis of these 9 cases led him to propose a four-dimension “therapeutic constellation” of CT responses that, leading to therapeutic impasses, had resulted in the patient’s suicide. These dimensions, each illustrated by at least one case vignette in the paper, included failure of the therapist to cope with the issue of aggressiveness, failure of the therapist to tolerate the patient’s dependency, inadequate handling of erotic transference, and disturbed loyalty towards the patient (Modestin, 1987).

In a study investigating cases of outpatients’ suicide attempts in three intensive care units (ICU) in Sweden, Wolk-wasserman (1987) interviewed 40 patients, as well as their relatives, friends, and the people involved in their treatment, for a total of 300 interviews, of which 149 were tape-recorded. In addition, patients’ clinical record was also analysed (Wolk-Wasserman, 1987). Wolk-wasserman applied a psychodynamic framework to her analysis by describing the defence processes
manifest in the interview data, as well as behavioural manifestations such as nuances in intonation, emotional reactions, speech emphasis, and occurrences of pauses (Wolk-Wasserman, 1985, p. 585). Regarding CT, the study findings suggested that therapists’ initial commitment decreased rapidly due to patients’ aggressive, provocative and demanding attitudes, and due to the therapists’ disappointment associated with the realisation that patients would have needed longer contact than the context of the ICU allowed for (Wolk-Wasserman, 1987). Analysis of the interviews indicated that clinicians experienced feelings of guilt, incompetence, anxiety, fear, and anger, and that the following anti-therapeutic behaviours could arise when these CT responses were not worked through:
Table 2.3 Possible therapists’ anti-therapeutic behaviours emerging from unmanaged CT to suicide attempters - Reproduced from Wolk-wasserman (1987, p. 77)

<table>
<thead>
<tr>
<th>Possible anti-therapeutic behaviours arising from unmanaged CT to suicide attempter (Wolk-wasserman, 1987, p. 77)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Underestimation of the seriousness of the suicidal action</td>
</tr>
<tr>
<td>• Absence of discussion of the suicide attempt in therapy</td>
</tr>
<tr>
<td>• Allowing oneself to be lulled into a false sense of security by the patient’s promise not to repeat the suicide attempt. Some therapists received the news of a new suicide attempt with amazement and the comment that they had not expected it</td>
</tr>
<tr>
<td>• Disregard of the “cry for help” aspect of the suicide attempt and exclusive concentration on its manipulative character</td>
</tr>
<tr>
<td>• Exaggeration of the patient’s provocative, infantile and aggressive sides</td>
</tr>
<tr>
<td>• Denial of the therapist’s own importance to the patient</td>
</tr>
<tr>
<td>• Failure to persuade the patient to undergo further treatment</td>
</tr>
<tr>
<td>• Feeling of lacking the therapeutic resources required by a particular patient</td>
</tr>
<tr>
<td>• Exaggerated sense of hopelessness in response to the patient’s troubled social situation and abuse of drugs or alcohol</td>
</tr>
<tr>
<td>• Being “pleased” when the patient claimed to be better after only a few sessions, without reflecting closely on the plausibility of this statement</td>
</tr>
<tr>
<td>• Feeling “upset” when the patient showed insufficient progress after a brief course of treatment, despite the therapist’s initially profound commitment</td>
</tr>
</tbody>
</table>

Finally, the study findings suggested that interruptions in the contact with the clinician, including due to unprepared referrals and therapists' absence (holiday), frequently appeared as a factor precipitating suicidal behaviours (Wolk-Wasserman, 1987).

In the same vein, Richards (2000) investigated qualitatively the experience of therapists working with suicidal patients by analysing the content of 35 questionnaires completed by psychodynamic psychotherapists and five follow-up
interviews. The study findings indicated that working with suicidal patients had affected the participants both personally and professionally, resulting in feelings of hopelessness, helplessness and a sense of failure. The study suggested that management of these CT responses was required to avoid displaying counter-therapeutic behaviours. Richards concluded by noting that the pressure experienced within the therapeutic relationship by psychotherapists could be further alleviated by setting firm boundaries and making use of professional support such as supervision and peer-vision (Richards, 2000).

Finally, Rossouw et al. (2009) used a hermeneutic-phenomenological approach to explore the experience of working with suicidal patients in 13 therapists, including one psychiatrist, five psychologists and seven psychiatric nurses. The analysis resulted in the identification of three themes common to all clinicians: reaction of shock and surprise upon learning of the suicide of their client, experience of assessing suicidal clients as a burden, professional and personal crisis as a result of their experiences, and struggling to come to terms with events. Rossouw et al. drew from these findings to argue that, by disregarding the phenomenological aspects of working clinically with suicidal patients, supervision practices failed to promote therapists’ wellbeing (Rossouw et al., 2011).

Experts have warned repeatedly about the suicidogenic potential of unmanaged CT responses to PRS (Maltsberger, Hendin, Haas, & Lipschitz, 2003; Modestin, 1987; Yaseen et al., 2013), and drawn on case studies, surveys, and qualitative research to argue that CT literacy is critical to achieving positive outcomes in clinical suicidology. Effectively, the last official American Psychiatric Association (APA) clinical guidelines deemed CT literacy necessary to treat patients with suicidal behaviors, “regardless of the theoretical approach used for psychotherapy and regardless of whether these issues are directly addressed in treatment” (APA, 2003, p. 51). For indeed, as Joiner and collaborators have put it, “ultimately, clinicians can control only their own actions, not those of their clients” (Joiner et al., 2009b, p. 160). To promote CT management, experts recommend that clinicians treat PRS in institutional settings rather than in isolation (i.e. private practice), make use of
supervision regularly and consult with colleagues when necessary, manage their caseload if they can to avoid treating several highly suicidal individuals at one given time, and learn to self-care (APA, 2003, p. 51; Goldblatt & Maltsberger, 2009; Leenaars, 1994; Linehan, 1993; Modestin, 1987; Richards, 2000; Shneidman, 1981; Wolk-Wasserman, 1987).

2.4.6 Quantitative evidence on CT to PRS

Given the indicated importance of CT in the treatment of suicidal patients, the paucity of empirical research seeking to produce hard evidence of these phenomena is striking. In the 1970’s, Maltsberger and Buie suggested that the lack of research on the topic could be another product of our own negative CT to PRS. They wrote, “[...] Perhaps the intolerance for hating patients accounts in part for the paucity of countertransference literature relating to treatment of suicidal patients” (Maltsberger & Buie, 1974, p. 628). In fact, the psychoanalytic origin of the term CT has likely contributed to the paucity of empirical research on the topic. Traditionally, psychoanalytically oriented clinicians have privileged case studies, and been sometimes reluctant to apply the hypothetic-deductive method to testing their clinical formulations. On the other hand, CBT theorists who do assess the empirical validity of their clinical formulations have not taken interest into the concept of CT until recently. Thomas Ellis recently reviewed the literature and argued that the lack of research on CT to suicidal patients represented an important gap also in the CBT literature (T. E. Ellis et al., 2018).

The general evidence on CT and other aspects of therapy may have relevance to PRS. For instance, findings that CT literacy is associated with better outcomes in therapy is consistent with the clinical literature on CT to PRS. There is also evidence of significant associations between specific patterns of CT arising in work with BPD patients for instance, that is likely to be of relevance to PRS (See section 2.3.2). Nonetheless, studies looking specifically at CT to PRS in a systematic and replicable way are surprisingly rare (T. E. Ellis et al., 2018; Yaseen et al., 2013).
Searching the literature for quantitative evidence on CT to PRS

A computerised literature search conducted in PsycINFO in November 2018, intertwining the terms of CT and suicide, as subject headings and key words, limited to English language, led to 151 results (see search strategy and results in Table 2.4 and Figure 2.1).

Table 2.4 Search conducted on PsycINFO on Nov 14th 2018

<table>
<thead>
<tr>
<th></th>
<th>Subject headings</th>
<th></th>
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</tr>
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<tbody>
<tr>
<td>1</td>
<td>countertransference/</td>
<td></td>
<td>6563</td>
</tr>
<tr>
<td>2</td>
<td>(countertransfer* or &quot;counter-transfer*&quot; or &quot;counter transfer*&quot;),tw.</td>
<td>Keywords in title, abstract and key concepts</td>
<td>12263</td>
</tr>
<tr>
<td>3</td>
<td>1 or 2</td>
<td></td>
<td>12507</td>
</tr>
<tr>
<td>4</td>
<td>suicide/ or attempted suicide/ or suicidal ideation/ or suicidology/</td>
<td>Subject headings</td>
<td>35906</td>
</tr>
<tr>
<td>5</td>
<td>suicid*.ti, or suicid*.ab. /freq=2</td>
<td>Keywords in title, abstract and key concepts, at least present twice</td>
<td>38999</td>
</tr>
<tr>
<td>6</td>
<td>4 or 5</td>
<td></td>
<td>42972</td>
</tr>
<tr>
<td>7</td>
<td>3 and 6</td>
<td></td>
<td>185</td>
</tr>
<tr>
<td>8</td>
<td>limit 7 to English language</td>
<td></td>
<td>151</td>
</tr>
</tbody>
</table>

I screened the 151 titles and abstracts against the following inclusion criteria: (1) be published in a peer-reviewed journal; (2) involve participants; (3) investigate CT responses to PRS as a variable of the study; (4) attempt to measure or describe CT in a systematic fashion. According to criterion (4), case studies, opinion papers and qualitative studies were excluded.
Screening the 151 search results against these criteria led to selecting 20 references. From this total pool of 20 studies, an additional 17 were excluded after further examination for failing to meet the selection criteria: eight unpublished dissertation abstracts, one book chapter and four qualitative studies. Note, three of these four qualitative studies are described in the section above dedicated to experts' opinion and qualitative evidence (Modestin, 1987; Richards, 2000; Wolk-Wasserman, 1987), and one in the section on the iatrogenesis of suicide (Bloom, 1967). Only three studies were found to provide quantitative evidence on CT to PRS, including two emerging from the same team of researchers (Perry et al., 2013; Yaseen et al., 2013; Yaseen, Galynker, Cohen, & Briggs, 2017). I report below on these two different bodies of work picked up by this search.
Firstly, Perry et al. studied treatment factors associated with subsequent decrease in suicidality in a naturalistic study of 53 cases of long-term psychodynamic therapy, divided into non-suicidal (n=22) and suicidal groups (n=31). In term of psychotherapy process, the study explored the potential impact of therapists’ negativity and errors as a proxy for negative CT and potential enactments, using the Therapeutic Alliance Analogue Scale (TAAS) (Perry, Fowler, & Howe, 2008), on the quality of the therapeutic alliance and outcome of suicidality assessed with the LIFE-ASP (Perry et al., 2009), at 1 and 6 months. Based on psychodynamic formulations (Kernberg, 1993), the authors postulated that PRS' negative reactions to treatment at onset would provide an alternative to turning hostility inward, thus be associated with subsequent faster improvement of symptoms. They further hypothesised that the quality of the therapeutic alliance would mediate this relationship, so that therapists’ negativity would be negatively associated with patients’ improvement. The findings indicated that therapists’ negativity at 1 month, in the absence of observable technical errors on their part (including indications of CT enactments), was associated with better quality of the alliance and greater decrease in suicidality, including suicidal ideation, suicide attempt and self-mutilation, at 6 months. According to the authors, this suggested that, negative CT in response to patients’ hostility occurred commonly at the beginning of the therapy. However, with appropriate management, these early negative CT responses did not seem to affect the alliance, and could rather signal therapists’ engagement in therapy.

This study demonstrated that psychotherapeutic process in relation to PRS’ improvement in treatment, including measures of CT responses, could be examined empirically using validated instruments. From a statistical standpoint, replication is granted to validate the effect size (medium to large) found in the study. Yet, the study benefits from important clinical validity for having applied an effectiveness design regarding symptoms of suicidality including long-term follow up (median of 5 years or over), in long-term treatment (median duration of 3 years) of a naturalistic cohort of patients. However, as pointed out by the authors themselves, the study measured CT responses using two subscales of the TAAS, which, despite
being reasonable proxies for CT responses, are far from capturing the complexity of CT phenomena. Although examining the possible impact of CT responses on patients’ treatment outcome was not the principal aim of this work, the study would have benefited from a more thorough assessment of CT. Finally, the study did not explore possible difference in nature of CT responses between suicidal and non-suicidal patients.

The second group of researchers investigated the potential for measured CT to be used as a suicidal risk assessment indicator. A preliminary study aimed to identify and quantify a potential association between specific CT patterns and risk of imminent suicide. Clinicians \((n=40)\) used the Therapist Response Questionnaire (TRQ) (Betan et al., 2005), to report retrospectively their emotional responses to patients \((n=82)\) in the last encounter before they either, attempted suicide, killed themselves, or died of an unexpected non-suicidal death. The study findings indicated that a paradoxical CT combination of “distress/avoidance” and “hopefulness” in treatment discriminated patients who died by suicide from those who died of a sudden non-suicidal death (Yaseen et al., 2013). The authors argued that their quantitative data were congruent with Maltsberger and Buie’s formulations of CT hate to PRS (Maltsberger & Buie, 1974). A subsequent study by the same group of researchers examined the potential of measured CT, using the Therapist Response Questionnaire – Suicide Form (TRQ-SF) a shorter measure developed by the authors, to discriminate between suicide attempters and non-attempters, assessed with the Columbia Suicide Severity Rating Scale (C-SSRS) (Madan et al., 2016). The study findings suggested that clinicians’ conflicting reports of distress and hopefulness in treatment could discriminate between suicide attempters and non-attempters, and predict short-term (1-2 months) post-discharge suicidal behaviours, beyond other risk factors.

Despite its limitation, such as the nature (i.e. risk concentrated) and size of the sample of patients, and the focus on short-term outcomes, this study provided promising preliminary evidence of the potential of measured CT for assessing the risk of suicide (Yaseen et al., 2017). By assessing CT based on dimensions of
emotional responses found in sample of personality-disordered patients, this work is limited in its ability to reflect the nature of CT to suicidal patients. Of note, however, the TRQ-SF, which consists of CT responses found to have the most potential in terms of suicide risk assessment, has been further validated (Barzilay et al., 2018), and constitutes a subscale of a novel multimodal assessment of suicide risk designed by this team of researchers (Hawes, Yaseen, Briggs, & Galynker, 2017).

**Summary of evidence of CT to PRS**

Reviewing the literature indicated that working clinically with patients at risk for suicide can be challenging at best and sometimes daunting. The literature is replete with experts’ opinion papers warning against the dangers associated with overlooking CT responses elicited by suicidal patients (Andriola, 1973; Birtchnell, 1983; Leenaars, 2009; Maltsberger & Buie, 1974; Shneidman, 1981; Wolk-Wasserman, 1987). Case studies have illustrated that the breaching of the therapeutic alliance due to therapists’ enactment of unmanaged CT could result in fatal outcomes for patients (Bloom, 1967; Modestin, 1987). The clinical literature contends that therapists need to be CT literate to treat the suicidal patient, which psychiatric clinical guidelines have endorsed (APA, 2003; NZ Ministry of Health, 2003). Finally, although scarce (T. E. Ellis et al., 2018), recent quantitative evidence on CT to PRS supports the clinical literature in promising ways.

In light of the unambiguous message conveyed by the literature, the findings of my primordial study appeared surprising. Remember that a case study found a strong positive inclination to work with PRS in a head psychotherapist of a suicide prevention centre, and suggested that this stance could be associated with achieving positive outcomes in treatment (Soulié, 2008). Later on, I found a very similar association between a positive inclination and positive outcomes in statements emanating from some of the most prominent experts in the field. This suggested that an opportunity to derive important clinical wisdom could be missed
by overlooking the case of clinicians who feel positively inclined towards, or like working with PRS.

### 2.5 Positive inclination to patients at risk for suicide

There is currently no literature on positive inclination to PRS. As discussed previously however, there is evidence that clinicians’ positive feelings of closeness, respect and affiliation are associated with better outcomes in therapy in general (Machado et al., 2014). Given evidence for the critical role played by the therapeutic alliance in treatment, especially with PRS (Dunster-Page et al., 2017), it would make sense that clinicians’ positive disposition toward PRS could increase positive outcomes in therapy. To my knowledge, no empirical work so far has explored specifically clinicians’ positive inclination to PRS or investigated its possible effect on the clinical encounter. However, a close look at the literature shows that a link exists between an active and warm stance and positive treatment outcomes with PRS in some expert authors’ clinical publications.

After reviewing these expert authors’ statements, the section emphasises the similarities they bear with the case study I conducted in 2007 (Soulié, 2008), before drawing on the self-determination theory to argue that we can reasonably postulate an association between clinicians’ positive inclination and their ability to achieve positive outcome in treatment of PRS. The section ends by reporting on a survey study in which the presence of positive inclination among clinicians might have affected their CT responses to PRS (Jacoby, 2004).

#### 2.5.1 Expert authors’ statements

Looking closely at the literature showed that a special compassion and even an affection for PRS filtrate through experts’ writings from all orientations (Joiner, 2010; Shneidman, 1993a). For example, Linehan (1993) explained that she developed Dialectical Behavior Therapy (DBT) to provide a theory of BPD that is “both scientifically sound and nonjudgmental and nonpejorative in tone”, and fosters a compassionate attitude from clinicians (Linehan, 1993, p. 18). Some
authors from the first generation of suicidologists, all oriented by the psychodynamic paradigm, described the compassionate attitude needed with PRS, as well as their own clinical stance with very eloquent and bold statements. These authors being among the most prominent experts in the field, including Shneidman, Maltsberger and Farberow, these isolated statement sparked my curiosity.

**Edwin S. Shneidman**

Edwin S. Shneidman was a clinical psychologist and a professor of thanatology (Leenaars, 2010). Along with Farberow and Litman, Shneidman founded the first suicide prevention centre in the US in 1958 (Shneidman & Farberow, 1965). Recall that Shneidman (1981) argued that psychotherapy with PRS is different from ordinary psychotherapy. He explained:

> Specifically, the transference (from the patient to the therapist) and the countertransference (from the therapist to the patient)—especially those positive feelings of affection and concern—can legitimately be much more intense and deep than would be seemly or appropriate (or even ethical) in ordinary psychotherapy where time is assumed to be endless and where it is taken for granted that the patient will continue functioning in life. (Shneidman, 1981, p. 344 [152])

The addition of “or even ethical” into brackets called to mind the case of Mme R immediately. He developed further (Shneidman, 1981):

> As in almost no other situation and at almost no other time, the successful treatment of a highly suicidal person depends heavily on the transference. The therapist can be active, show his personal concern, increase the frequency of the sessions, invoke the “magic” of the unique therapist-patient relationship, be less of a tabula rasa, give “transfusion” of (realistic) hope and succorance. In a figurative sense, I believe that Eros can work wonders against Thanatos. (p. 348 [156])

58
Shneidman (1981) contended that working clinically with the highly suicidal person requires a different type of involvement that goes beyond that needed in ordinary psychotherapy. Specifically, he described the stance needed as active, warm and providing anything necessary to keep the person alive, beyond what could seem appropriate or even ethical. He proposed metaphorically that “Eros”, i.e. love, could overcome “Thanatos”, i.e. death.

**J. Terry Maltsberger**

J. Terry Maltsberger, a psychiatrist, psychoanalyst and researcher, was also a major figure in clinical suicidology internationally (Goldblatt, Schechter, Ronningstam, & Herbstman, 2016; Ronningstam, Goldblatt, Schechter, & Herbstman, 2016).

Along similar lines, Maltsberger (2001) maintained that with PRS, the emphasis should be on the real relationship rather than on the transference relationship proper. He explained that “the principal characteristics of the real relationship must be that the therapist will love the patient and not conceal this fact”. This love, he added, should be an “essential love”, and obviously not an erotic one (Maltsberger, 2001, pp. 160–161).

For Maltsberger too, treating successfully the suicidal patient requires an emotional engagement from the therapist and an active stance that goes beyond the standard professional stance, which he described as an “essential love”.

**Edwin S. Shneidman and Norman Farberow**

Shneidman (2004) published a book about the psychological analysis of a case of suicide he undertook upon the request of a grieving mother who needed to make sense of the death of her son, Arthur (Shneidman, 2004). To do so, Shneidman interviewed Arthur’s family, and close friends, psychotherapist, psychiatrist, as well as solicited the professional assessment of eight experts who reviewed the case independently. Norman Farberow, psychologist, founding father of suicidology, co-
founder of the LASPC, was one of them. To each interviewee and consultant, Shneidman asked if according to them “Arthur could have been saved”. Arthur’s psychotherapist thought that she did all that could have been done. His psychiatrist declared that he was sure upon very first encounter that Arthur would kill himself one day. In contrast, Norman Farberow, declared that saving Arthur would have required a therapist “who firmly believed that he was worth saving […]

(Shneidman, 2004, p. 66) Shneidman conveyed a similar sense of confidence or affirmation in his final response to the mother of the deceased:

Shneidman statement’s conveys a combination of humility and acceptance of death as a possible outcome, as well as a strong affirmation of both his desire and ability to help. Just like in Farberow's statement before, the need to believe that the person can be helped appears to underlie his clinical endeavours.

These expert authors’ statements invite to consider that a positive inclination and strong motivation or drive to work with PRS may be necessary to achieve positive outcomes. In many ways, the strong positive, warm and active clinical stance found Shneidman, Farberow, Maltsberger, but also Joiner and Linehan’ writings was also found in Mme R's case, the case study I conducted in 2007.
2.5.2 Possible association between ‘positive inclination’ & outcomes

As noted in the introduction, in 2007 I conducted a case study of a therapist who worked in a suicide prevention centre that led to unexpected results (Soulié, 2008). The study explored the subjective ways in which the therapist managed negative CT and coped with the stress associated with the risk of suicide, using thematic analysis underpinned by the psychoanalytic meta-psychology on open-ended interview data. However, the participant, Mme R, found her practice profoundly satisfying instead, and no more challenging than any other clinical work. In short, Mme R’s narrative refuted the postulate upon which the entire study rested.

Moreover, Mme R departed from the standard professional stance, which promotes clear professional boundaries, in that her narrative had a strong maternal tone. She talked about “carrying in her the desire for life”, and liking cultivating it in others. She compared her satisfaction to that of an obstetrician or a midwife assisting childbirth. Finally, Mme R claimed that, unlike her colleagues, she had not lost a single patient to suicide in over 20 years of experience.

As noted in the introduction, these findings invited me to consider that a causal relationship could exist between Mme R strong positive inclination, her active stance and her reports of achieving positive outcomes consistently. Intuitively, it could seem reasonable to assume that a positive association could exist between clinicians’ positive inclination to PRS and their ability to achieve positive outcomes in treatment. The self-determination theory (SDT) provides a framework to articulate this association theoretically.

Self-determination theory

SDT conceptualises motivation on a continuum going from amotivation, through extrinsic motivation, to intrinsic motivation, which represents the strongest level of self-determined motivation. Intrinsic motivation reflects a positive inclination toward “assimilation, mastery, spontaneous interest, and exploration” that has been found essential to psychological wellbeing and satisfaction (Ryan & Deci, 2000, p.
70). Furthermore, SDT postulates that the need to satisfy three basic psychological needs lies at the root of a positive motivation, including the need for autonomy, competence, and relatedness (Baumeister & Leary, 1995; Gagné & Deci, 2005; Ryan & Deci, 2000). In this light, the case of Mme R conveyed the sense of coherence among goals, values and regulation which characterises an inherent autonomous motivation, and is associated with an interest in, and an enjoyment of the task (Ryan & Deci, 2017). Theoretically, intrinsic motivation thus implies that the fundamental needs for autonomy, competence, and relatedness are fulfilled. Leaning on the SDT provided further ground to postulate that we could learn from examining specifically the stance of clinicians who feel positively inclined toward PRS. With this in mind, I searched the literature looking for research on clinicians’ positive inclination to PRS.

### 2.5.3 Positive CT to PRS & better outcomes

As mentioned, no research regarding clinicians’ positive CT to PRS or positive inclination to PRS was found in the peer-reviewed literature. However, an unpublished study was identified that contradicted the evidence on CT to PRS.

In a doctoral project submitted in 2004, a researcher designed the Negative Countertransference Scale (NCS) to test the validity of Maltsberger and Buie’s formulations of CT hate. Quite unexpectedly, the 101 clinicians who completed the survey did not report CT of boredom, fear, helplessness or the desire to abandon or reject their patients as hypothesised. Only an “urgency to intervene” corroborated Maltsberger and Buie’s theory. Instead, participants in the study expressed interest, a sense of affiliation, a lack of fear, as well as confidence in their abilities to help their suicidal patients. Although anxiety was reported by participants in the additional open-ended questions, the overall findings largely contradicted the author’s hypotheses (Jacoby, 2004). In fact, these results contradicted most of the clinical literature on the topic. However, it appeared that the participants were all members of the American Association of Suicidology (AAS), so they might not have been representative of all clinicians, as they likely had a particular interest in
suicidal issues. This study indicates that there may be a sub-group of positively inclined clinicians who could be somehow immune to the challenges that working with PRS typically entails. Just like Mme R seemed to be.

The potentially suicidogenic effect of negative CT justifies that it receives more attention from researchers. Yet, the opinions of several prominent experts in the field, along with a couple of example from the grey literature, invite consideration that an association could exist between positive inclination to PRS and positive treatment outcomes, thereby suggesting that advancing knowledge in the field may be facilitated by studying the stance of clinicians who feel positively inclined toward PRS.

### 2.6 General research questions

The present project aimed to advance knowledge in clinical suicidology by studying clinicians’ positive inclination to PRS.

First, I aimed to understand clinician’s positive inclination to PRS and its consequence on the therapeutic relationship. I suspected that positively inclined clinicians adopt a specific therapeutic stance, instinctively, that lead them to achieve positive outcomes.

Incidentally, I anticipated that observing the therapeutic encounter through positively inclined clinicians’ lens might provide insights pertaining to both clinicians and PRS in the clinical situation.

The research questions were:

- Why do some clinicians, a minority of them, like working with PRS?
- Can we derive clinical wisdom from understanding the therapeutic stance of positively inclined clinicians?
- Does examining the therapeutic encounter through the lens of positively inclined clinicians provide novel insight into PRS' psychological needs in session?

This aim relied on the assumption, drawn from the international literature on the challenges associated with working with PRS that, positive inclination to PRS is rare, including among NZ clinicians. Before I could look into positive inclination to PRS, assessing the validity of this assumption was in order.

The research therefore aimed to answer the following preliminary questions:

- Do the majority of clinicians experience predominantly negative CT responses to PRS?
- Do only a minority of clinicians feel positively inclined towards PRS?

2.7 Summary

This chapter presented the concept of CT, across theoretical paradigms, before arguing its relevance to the treatment of PRS. After discussing the literature on CT to PRS, it developed the rationale for postulating that clinical wisdom may be derived from studying the stance of clinicians who feel positively inclined towards PRS. The chapter ended by providing an overview of the research questions. The following chapter presents the general methodology for this project.
Chapter 3
Methodology

The previous chapter showed that there is scant literature on the topic of clinicians’ positive inclination to PRS. Rather than force an existing theoretical framework onto the question, I resolved to approach it from a stance of theoretical agnosticism, which was enabled by adopting an epistemological stance of critical realism. This chapter begins by providing my rationale for adopting a posture of critical realism, and shows how this meta-theory informed the methodology for this research. The chapter ends with an overview of the mixed methods design adopted for this research.

3.1 Reflecting on my approaches to knowledge

David Scott proposed that “ontological and epistemological beliefs underpin the adoption of strategies and methods by empirical researchers” (Scott, 2010b, p. 57). This means that our conceptions of reality and scientific knowledge affect the way we conduct research. In my view, these underlying beliefs drive our scientific endeavours whether or not we are aware of it. Originally, I perceived an incompatibility between my perspectives on clinical practice, focussing on the particular, and research, aiming at the general, which led me to reflect on the nature

\[\text{Science is an essentially anarchistic enterprise: theoretical anarchism is more humanitarian and more likely to encourage progress than its law-in-order alternatives.}^7\]

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of scientific knowledge. To dissipate my confusion in order to design this research, identifying my beliefs appeared indeed like a necessary place to start.

### 3.1.1 Epistemological considerations

Epistemology, from the Greek *epistēmē*, knowledge, and *logos*, logical discourse, is the branch of philosophy concerned with the nature of rational knowledge (Hamlyn, 1995). It involves the critical examination of the processes entailed to generate rational knowledge in general, and of scientific knowledge in particular, since the emergence of science in the XVII century as a discipline that attempted to understand the world objectively (i.e. considered as an entity independent of God and of humankind) (Juignet, 2018). What is, after all, scientific knowledge? This question, which seems deceptively evident, is in fact extremely complex.

Referring to an overarching dichotomy between positivism and interpretivism paradigms can help make sense of this complexity (Wainwright & Forbes, 2000). Positivism is the scientific paradigm associated with forms of objectivism. Positivism proposes that phenomena occur independently of a potential observer. Scientists strive therefore to understand, or discover, a truth about phenomena that exist, and make sense, independently of their research endeavours. Interpretivism instead is the scientific paradigm associated with forms of subjectivism. Interpretivism proposes that scientific knowledge is merely the product of the mind who generates it in the first place (Williams, 2003). Phenomena have no intrinsic meaning besides that constructed by humankind about them. Knowledge is therefore eminently subjective. Effectively, most theoretical frameworks lie on a continuum between these two epistemological poles.

### 3.1.2 Duality across clinician & researcher perspectives

**The clinician’s perspective**

As a clinical psychologist and psychopathologist trained in France within a Lacanian psychoanalytic theoretical framework, subjectivism dominates my practice of
psychology. My clinical practice tends towards an epistemological stance of interpretivism.

Jacques Lacan offered a post-structuralist interpretation of the Freudian meta-psychology, in which he proposed that the unconscious is structured like a language (Lacan & Wilden, 1968). Clinicians of this orientation train to prioritise the singularity of the patient, referred to as “subject of the discourse” or “analysand”. The Lacanian perspective invites the therapist to resist the urge to impose predetermined theoretical formulations onto the patient’s discourse. What is true in general, including scientific evidence, is regarded as being of limited value to the individual case. The general excludes, by definition, the “singular”. Instead, the therapy room provides a safe environment where the person can attempt to make sense of their own story, in their own words. The clinician strives to perceive what is specific to this individual, rather than focussing on the similarities between cases (symptoms, diagnoses). Ultimately, therapy prioritises the person’s subjective reality (Fink, 2005), arguing that the patient’s discourse, that of the neurotic and of the psychotic alike, should be valued as “the truth” for it is this particular person’s truth.

The researcher’s perspective

As a researcher however, my views align with the notion that scientific enquiry should assist human progress, including in health sciences and psychology (Cruickshank, 2012), by aiming to develop objective knowledge. My research endeavour has tended towards an epistemological stance of positivism.

In positivist paradigms, scientific knowledge relies on observed phenomena. Originally, positivism relied on empiricism, which consists of developing theories by inductivist inference before verifying them by gathering observations that corroborate them. Inductive inference goes from the singular to the general, that is, from observation to theory. Until Karl Popper challenged the concept of induction, science was therefore primarily a matter of ‘discovery’. However, Popper (1934)
demonstrated that inductivist inferences are not justifiable from a logical point of view, which he illustrated with the swan example. No matter how many white swans one might observe, the general statement that “all swans are white” might still be false (Popper, 1934). Popper proposed therefore to replace verification by falsification. Arguing that falsification and refutability constitute the demarcation between science and pseudo-science, Popper proposed to substitute empiricism with the hypothetic-deductive method (Popper, 1963). Contrary to empiricism, the hypothetic-deductive method makes theoretical guesses by formulating hypotheses before striving to prove them wrong (Crotty, 1998b). Indeed, observing only one black swan is sufficient to assert that, “Not all swans are white”. A hypothesis is credited as long as the evidence does not contradict it.

In line with positivist paradigms, this project aimed to explore phenomena assumed to occur in clinical practice independently of any scientific endeavour. This research sought to generate theoretical formulations that could inform practices beyond the individual case, while minimising the sacrifice of clinical relevance to increase scientific validity. The project called for a methodology that allowed articulating these two demands.

### 3.1.3 Resolving the epistemological duality at the ontological level

Reality is often more complex, messier even, than needed to make a good case with the hypothetic-deductive method. By controlling variables to increase scientific validity, researchers sometimes compromise their account of reality in general and of clinical practice in particular. In the case of suicidal patients, the price can be high (Maltsberger, 2001). Goldblatt and colleagues have argued that the evidence produced in suicidology is often of very limited benefit to clinical practitioners (Goldblatt, Schechter, Maltsberger, & Ronningstam, 2012; Kral, Links, & Bergmans, 2012). This project endeavoured to advance knowledge while embracing the complexity inherent in human psychology. Despite its limitation, this knowledge would need to be both scientifically robust and clinically relevant.
Yet, as Shneidman argued, “a discipline can be no more rigorous than its essential subject matter will permit” (Shneidman, 1993b). When human psychology is the object of science, the divide between what phenomena are (ontology) and what we know of them (epistemology) is particularly blatant. This divide fosters the gap between scientific endeavours and clinical practice. For example, what we know of suicide as a phenomenon, in terms of its aetiology and epidemiology for instance, is of limited value in real time of the clinical encounter. Conversely, the subjective reality of suicidality for a given individual is of limited value to understand the phenomenon suicide, for what is true for one person might not apply to the next one.

Distinguishing theoretically ontology from epistemology can help conceptualising this discrepancy. Ontology addresses the reality or nature of phenomena (Crotty, 1998c). Taking the suicidal crisis as an example, ontology concerns what a suicidal crisis is. Epistemology concerns the scientific knowledge about phenomena (Crotty, 1998c). For instance, it concerns what we know or wish to know about the suicidal crisis. Pertaining to epistemology, methodology concerns the strategies we design to develop this knowledge. For instance, a qualitative study can be designed to gain insight into the subjective experience of a suicidal crisis. Finally, methods are the actual tools used to implement a given methodology. For instance, choosing interview versus focus groups in the qualitative study imagined above.

There is therefore a natural alignment between epistemology, methodology and methods (Crotty, 1998c). Put simply, what one wants to know influences how one goes about finding out about it. The nature of the research questions affects the methodology designed to answer them. However, the methodology chosen, let alone the methods, whether quantitative or qualitative, have nothing to do with the nature of phenomena under investigation. Hence, the divide between interpretivism and positivism occurs merely at an epistemological level (Hanly & Fitzpatrick Hanly, 2001). At the ontological level, there is no divide.
The view that assigns the divide between objectivism and interpretivism to the epistemological level corresponds to the meta-theory of critical realism. It has been argued that realism is a “third way” between positivism and interpretivism (Wainwright & Forbes, 2000).

3.2 Critical realism and methodology

In the 60s, the debate in philosophy of science questioning the relationship between ontology and epistemology culminated in the meta-theory of critical realism (Brown, 2007; Scott, 2010a). This section will briefly introduce critical realism to discuss a core notion raised by Bhaskar— the “epistemic fallacy” (Bhaskar, 1975). Consideration of the potential damage that can be caused by the epistemic fallacy informed the methodology adopted for this project.

3.2.1 Critical realism

Critical realism proposes a “[...] a reorientation of philosophy towards a non-anthropomorphic conception of the place of humanity in nature “(Bhaskar & Lawson, 1998, p. 3). According to Bhaskar and colleagues, critical realism offers an alternative to positivism and interpretivism by providing a “realist” philosophy of science (Archer, Bhaskar, Collier, Lawson, & Norrie, 1998).

Critical realism arose from the postulate that a difference exists between a real world and a conceptual one, which constitutes a critique of positivism (Denermark, Ekstrom, Jakobson, & Karlsson, 2002). Our conceptions of the world are different from, yet embedded in, what the world actually is. Critical realism argues that ontology is stratified in three domains: the real, the actual and the empirical. The domain of the real consists of the fundamental structures which cause phenomena to occur. The domain of the actual covers the occurrence of all phenomena, whether they are observed or not. The domain of the empirical consists of observed phenomena.
Critical realism points out that positivism remains mainly at the empirical level by relying solely on observed phenomena, rather than striving to access the domain of the real. In contrast to positivism, critical realism encourages moving beyond the empirical domain to fathom the processes that cause observed phenomena (Raduescu & Vessey, 2009; Scott, 2010a).

3.2.2 The ‘epistemic fallacy’

The concept of “epistemic fallacy” expresses the view that a conflation of ontology and epistemology prevails in the classical philosophy of science (Scott, 2010a). Bhaskar (1975) wrote, “this consists in the view that statements about being can be reduced to or analysed in terms of statements about knowledge; i.e. that ontological questions can always be transposed into epistemological terms” (Bhaskar, 1975, p. 36).

Bhaskar (1975) argued that identifying the epistemic fallacy was germane to an epistemological paradigm shift from transcendental idealism to transcendental realism. In transcendental idealism, scientific knowledge consists solely of the theoretical models that can be corroborated by observed phenomena. If there is no tangible evidence of a given phenomenon, then, as far as positivism goes, there is no ground to confirm its existence. Transcendental realism instead posits that the structures and processes that generate phenomena exist independently of our ability to discern them. The knowledge we have of these phenomena is what we have constructed of them. Scientific knowledge is therefore, in essence, a representation of reality:

[Critical realism] regards the object of knowledge as the structures and mechanisms that generate phenomena; and the knowledge as produced in the social activity of science. These objects are neither phenomena (empiricism) nor human constructs imposed upon the phenomena (idealism), but the real structures which endure and operate independently of our knowledge, our experience and the conditions which allow us access them. (Bhaskar, 1975, p. 25)
There is a gap between transient concepts and the intransient world. Concepts and theories change when the world does not. They are flawed in their ability to capture the reality of the world. However, according to the critical realist concept of “judgement of rationality”, it is possible to compare between different theories and judge their validity. Although never fully “touching” reality, the validity of concepts and theories should be based on how close they come to it, rather than on the consistency with which they agree with a set of selected facts.

3.2.3 Implication for methodology

Critical realism proposes that ontology transcends epistemology, which results in epistemic relativism (Raduescu & Vessey, 2009). Scientific knowledge can only represent parts of the reality without actually touching its truth (Scott, 2010a). Nomothetic approaches, looking at the general, and idiographic approaches, looking at the singular, are different methods to probe into the depth of the same reality (Crotty, 1998a). Researchers henceforth design and use any tool they can, conceptual or otherwise, to try fathoming a reality that exists independently of their endeavours. The knowledge created depends on the technical ability to observe or measure phenomena. Conversely, an inability to observe a given phenomenon, for example an emotion, does not mean that it does not exist, or that it cannot be the object of science.

Clarifying my conceptions of scientific knowledge informed the methodology for this research in two ways. First, adopting a realistic stance resorbed the apparent antinomy between my approaches to science and to clinical practice, by assigning the divide to the epistemological level. This was of heightened relevance since clinical practice is also the object of this research. Adopting a research stance of theoretical agnosticism overcomes this epistemological divide. Philosophically, there is no contraindication to adopting a transtheoretical approach to clinical practice for they are merely different perspectives describing the same reality. Second, since critical realism leads to epistemic relativism, the project can combine
3.3 Designing a general methodology

This section presents the rationale for designing two studies. I outline each study in the context of the project’s general methodology—an explanatory mixed methods design.

3.3.1 Rationale for conducting two studies

As indicated in the previous chapter, this project had three general aims, corresponding each to a research question (see Table 3.1):

<table>
<thead>
<tr>
<th>General aim</th>
<th>General research question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - <strong>To understand clinicians positive inclination to PRS</strong></td>
<td>Why do some clinicians, a minority of them, like working with PRS?</td>
</tr>
<tr>
<td>2 - Investigate whether understanding positive inclination to PRS can advance knowledge in clinical suicidology</td>
<td>Can we derive clinical wisdom from understanding the therapeutic stance of positively inclined clinicians?</td>
</tr>
<tr>
<td>3 - Gain insights into PRS’ psychological needs in session by examining the clinical encounter through the lens of positively inclined clinicians</td>
<td>Does examining the therapeutic encounter through the lens of positively inclined clinicians provide novel insight into PRS’ psychological needs in session?</td>
</tr>
</tbody>
</table>

My research questions relied on a set of assumptions. First, they assumed that NZ clinicians tend to experience intense and often negative CT responses to PRS, which would mean that the knowledge acquired internationally applies to NZ. Of note, NZ clinical guidelines for working with PRS are largely in line with international ones (APA, 2003; NZ Ministry of Health, 2003), which could indicate that international
evidence on CT to PRS do apply to clinicians in NZ. However, these guidelines are somehow dated. In the meantime, a national suicide prevention strategy was implemented in NZ that could have affected clinicians’ knowledge and attitudes toward PRS in more recent years (NZ Ministry of Health, 2006). Second, my research questions assumed that the paucity of the literature on positive inclination to PRS is due to it being uncommon for clinicians, including in NZ.

To avoid compromising the scientific validity of the project by relying on multiple unknown variables, a first study was designed to assess the legitimacy of these premises. This first study used a nomothetic approach to investigate the nature of CT to PRS in the NZ context, while gauging the prevalence of positive inclination to PRS among NZ clinicians. A second study would aim to understand clinicians’ positive inclination to PRS, provided study 1 confirmed that it was an uncommon phenomenon. Given the important knowledge gap on the topic, an idiographic exploratory method would probably be required.

### 3.3.2 Study 1 – Nomothetic approach

Study 1 consisted of a cross-sectional online survey, including the Therapist Response Questionnaire (TRQ) (Betan et al., 2005; Tanzilli et al., 2015) and a clinical questionnaire.

The study served a triple purpose: to explore the nature of CT to PRS systematically using the TRQ; to estimate the prevalence of NZ clinicians who feel positively inclined towards PRS; to act as a recruitment tool for study 2, by identifying and inviting positively inclined clinicians to undertake a second study.

Chapter 4, Part II, details the method for the study.

### 3.3.3 Study 2 – Idiographic approach

Study 2 consisted of a grounded theory study (Bryant, 2017c; Charmaz, 2006b) applied to interview data.
The study aimed to explore qualitatively the nature of clinicians’ positive inclination to PRS. It was undertaken more than a year after the first one, and involved predominantly participants from study 1.

Chapter 7, Part III, details the method for the study.

3.3.4 Sequential mixed methods design

The research questions were addressed by using nomothetic and idiographic approaches for studies one and two respectively. This general strategy resembles an explanatory sequential mixed methods design (Creswell & Creswell, 2018b). However, according to Creswell and Creswell, the explanatory sequential design has a strong quantitative base, which is not the case in this project.

In this project, the quantitative study was used to assess the validity of the project’s theoretical premises, and to support empirically the rationale underpinning study 2. As proposed by the model above, study 2 effectively probed into one aspect of study 1. Yet, considering the project as a whole shows that study 1 was more a prerequisite to study 2 rather than the main component of the project as would be the case in a pure explanatory mixed methods design according to Creswell & Creswell (2018). Ultimately, both phases were equally important in addressing the research questions as illustrated by the diagram below (see Figure 3.1), adapted from the diagram found in (Creswell & Creswell, 2018a, p. 218).
Figure 3.1 Mixed methods design for this project

A realist approach to these research questions resulted in an explanatory sequential mixed methods design, in which the quantitative phase sets the scene for the subsequent qualitative phase. The general discussion combines findings from both approaches to reflect on the strengths and limitations of the mixed methods design in addressing the research aims.

3.4 Ethical & cultural considerations

This section discusses the processes undertaken to obtain ethical and cultural approval. In New Zealand, researchers are required to seek Māori consultation about their projects. This applies to all areas of research. This process ensures the cultural safety of research endeavours while assessing the extent to which they support Māori communities. Undertaking Māori consultation is only one of the requirements for researchers. Other aspects relating to ethics are the prerogatives of other ethics committees.

For each study in this project, Ngāi Tahu Research Consultation Committee provided Māori consultation, and the University of Otago Human Ethics Committee (UOHEC) granted ethical approval.

This section presents the Māori consultation process, followed by ethical considerations for each study and finishes with a summary of the decisions issued by the UOHEC.
3.4.1 Māori consultation

To seek Māori consultation, a researcher has to complete and submit a “Research Consultation with Māori Form” online. Subsequently, the committee issues a formal letter about their views on the proposed research and assesses the relevance of the research to Māori. The committee does not have power of veto on the research project. Rather, it provides a mandated response making suggestions pertaining to cultural safety (see appendix I).

Ngāi Tahu Research Consultation Committee considered both studies to be of importance to Māori, requested that ethnicity data were collected, and findings disseminated to Māori health organisations (See official letters in appendices II and I).

Additionally, for study 1, the committee suggested that a researcher with expertise in analysing and interpreting data in relation to ethnicity was added to the team. Effectively, although not mentioned in the submission to the committee, the biostatistician involved in study 1 had expertise in this area.

For the second study, given that suicide affects Māori youth disproportionately, the committee suggested considering programmes such as Waka Hourua. Waka Hourua is the NZ National Māori and Pacifika suicide prevention programme. However, study 2 did not target any organisation in particular. Instead, study 1 screened for clinicians’ positive inclination in anticipation of study 2. This design sought to access a representative sample of clinicians by distributing the study equally to all psychiatrists, psychologists, and psychotherapists via NZ national professional associations. I did not alter the study design to implement the committee’s suggestion.

3.4.2 Other ethical considerations

Ethical approval for each study was granted by the University of Otago Human Ethics Committee (UOHEC).
Informal peer-review preliminary consultations

The research protocol of each study underwent informal peer-review consultations.

The protocol for Study 1 was discussed with a research group of affiliation of one of the supervisors for this project. The research group consisted of psychiatrists, psychologists, and occupational therapists who provided feedback on the study design in relation to ethical issues.

The protocol for study 2 was discussed with an adviser with expertise in grounded theory.

Participants’ vulnerability

Both studies involved mental health clinicians, including psychiatrists, psychologists, and psychotherapists, fully registered and currently practising. Participants were not involved in any capacity as patients, therefore were not considered a particularly vulnerable population. Each study was designed to ensure participants’ safety nonetheless.

In the first study, participants reported their CT responses to PRS in an online anonymous survey. Given that they were practising clinicians, we did not anticipate that there should be any hindrance to their understanding, judgment and ability to consent to participate. Furthermore, we anticipated that clinicians would find reporting CT to PRS essentially similar to engaging in self-reflective practice. We did not anticipate that taking the questionnaire would cause any particular kind of psychological stress to them.

To increase the study safety further, the survey did not include open-ended questions. Participants could not disclose personal material, which could exacerbate their sense of vulnerability. Finally, a message of support followed a set of questions considered sensitive (e.g., whether they lost patients to suicide):
If you currently feel distressed or vulnerable, please ensure that you make use of your own supervision and of the professional help that is available to you.

If you are thinking about suicide yourself, you can call 0508 TAUTOKO (0508 82 88 65) for support.

TAUTOKO helpline operates 24 hours, 7 days, and is a service of Lifeline New Zealand.

Study 2 consisted of in depth interviews around the topic of suicide. Although the study involved mental health professionals too, suicide remains a sensitive topic. However, the sequential design should have increased participants’ safety by demonstrating their willingness and determination to participate. Furthermore, I, the interviewer, relied on my clinical skills to assess participants’ emotional state in interview. Upon concluding interviews, I offered a verbal version of the support message displayed in the survey when deemed necessary.

Finally, I decided upon a pathway that ensured that the ethics committee assessed both applications in meetings. This means that, despite involving mental health professionals, I chose to consider that both studies had the potential to incur some “form of psychological stress” to participants. Given that both studies were categorised as “non-health” research, I could have simply sought approval at school level instead.

**Deception**

Study 1 included a form of deception for participants. Participants knew that the study aimed to explore their emotional responses to PRS. However, clinicians were not aware that the survey was also screening for positive inclination to PRS. I concealed this information to avoid influencing participants’ answers (social desirability bias). Only positively inclined clinicians received this information by the end of the questionnaire, along with an invitation for study 2.
I also concealed that the study screened for positive inclination to avoid conveying the idea indirectly that CT responses are undesirable. As discussed, conducting treatment with PRS can be particularly challenging. In this context, experiencing negative CT is natural and expected. Becoming aware and managing these responses is part of clinicians’ responsibilities. Conversely, denying these CT reactions can lead to antitherapeutic behaviours.

**Precautionary measures**

Precautionary measures ensured that participants would not feel coerced to participate. First, participants were educated and experienced professionals who were free to exercise their judgement in deciding to participate. Second, study 1 was distributed to clinicians through professional associations. This means that clinicians did not hear about the study from their workplace hierarchy. However, professional associations communicated about the study in different ways, which might have caused the observed underrepresentation of psychiatrists in the sample (i.e. psychologists were emailed personally while psychiatrists received information about the study in a long newsletter attached to an email). In an attempt to recruit more psychiatrists, approval was granted to email directors of mental health services directly, inviting them to distribute the study to their clinical team. For the second study, participants came from study 1, where they consented anonymously to be contacted about the subsequent study, and provided their contact details online directly.

Each study reminded participants of their right to withdraw from the research at any time. Study 1 information stipulated that data would not be collected unless participants clicked the “SUBMIT” button, located in a corner of the last screen of the online survey. For study 2, I, the interviewer, reiterated this information verbally in introduction.

Participants had access to the primary researcher’s details as well as those of the three supervisors, for any inquiry, concerns or support. Note that two supervisors
of this research are practicing clinicians. The information sheets of each study also invited participants to contact the ethics committee directly, should they have concerns about the research.

**Guaranteeing privacy of participants**

Each study was designed in compliance with The Privacy Act 1993 and the Health Information Privacy Code 1994, with respect to collection, use and disclosure of personal information (NZ Ministry of Justice, 1993, 1994).

The national survey was entirely anonymous. The design excluded the possibility for disclosure of illegal activity. Only participants meeting selection criteria for study 2 provided an email address. In study 2, interview data were stripped from identifiable information upon transcription.

**Data storage**

The contact details provided by participants are stored on the university server, protected by personal login details. The contact details of study 1 participants who did not take part in study 2 were destroyed upon study 2 completion. The contact details of participants for study 2 will be destroyed after I have sent them a summary of findings.

For possible future scrutiny, all anonymized original data and material will be retained for as long as possible and for at least 5 years after completion of this work.

**Conflict of interest**

In this project, conflict of interest was avoided in two ways. First, by deciding that supervisors would not take part in any studies, including the survey, despite meeting the inclusion criteria. Second, by having the Associate Dean Research acting as Head of Department (HoD) signing off ethics applications, for the actual HoD was a supervisor of the project.
Procedures

I drafted and amended both ethics applications iteratively upon receiving feedback from my supervisory team. I submitted them personally to the UOHEC after they were approved by the supervisor acting as the applicant (a student cannot be the applicant), and signed off by the Associate Dean Research acting as HoD.

The UOHEC meets monthly and released an official written decision within three to four working days following the meeting. The possible decisions are, approved, approved with comments, conditional approval, deferred or declined.

Decisions from UOHEC

Study 1

The initial proposal for study 1 was approved by the UOHEC in first instance (see decision letter in appendix III).

However, during the course of the study I filed three successive requests for amendments. The first request concerned small amendments required by refining the study design, and before data collection started. They included the designation of the instrument used, the addition of a prize draw as an incentive, the change of tool to design the survey, as well as amendments to the survey content. The second and third requests addressed issues with recruitment. I sought approval to recruit additional participants by communicating about the study at a NZ Psychological Society annual conference held in the city. Finally, I asked for approval to email Directors of Area Mental Health Board directly in an attempt to recruit more psychiatrists.

The UOHEC accepted and approved all three requests for amendments (see appendices IV, V and VI).

Study 2
The initial application for study 2 received a conditional approval (see appendix VII). The committee was concerned and asked clarification about three points:

- They wanted to be reassured that I would strip data of any identifiable information pertaining to the patients that participants might be mentioning in interview.
- They asked us to confirm that the supervisors would be able to access to the data, and not just me as the student.
- They required that I expanded the aim of the research and its potential benefit in the information sheet.

All three comments were addressed in an email, to which the committee answered by granting full approval (see approval in appendix VIII).

After I conducted seven interviews, I filed a request for amendments to use a snowball sampling method to recruit additional participants. In line with the Grounded Theory Method, I also took this opportunity to inform the committee about changes made to the interview schedule.

### 3.5 Summary

This chapter showed that the duality across clinical and research perspectives encouraged me to question the nature of scientific knowledge. A philosophical caveat clarified my rationale for adopting a position of critical realism, which resulted in an epistemic relativism. In turn, this realist approach informed the methodology selected for the project, which consists of a sequential mixed methods design. After presenting the overall methodology, the chapter finished by reviewing ethical considerations for the project. The following chapter will introduce and present the method for study 1.
Part II
Nomothetic approach
National survey

Acknowledgement: This part of the thesis, including chapters 4, 5 and 6, is derived from an article published in *Archives of Suicide Research*, received 20 Dec 2017, accepted Jul 2018, accepted author version posted online: 17 Aug 2018, published by Taylor & Francis, http://www.tandfonline.com:

Chapter 4
Study 1 Method

As previously stated, this project assumed that international evidence on the nature of CT to PRS applied to NZ clinicians therefore the research questions are based on the assumption that positive inclination to PRS is uncommon, including in a sample of clinicians in NZ. The previous chapter showed that holding a critical realist approach to knowledge led to the design of an initial study to provide empirical foundation for the project. The first study aimed to gather evidence to assess the validity of these premises around CT to PRS in NZ clinicians, before proceeding further.

This chapter introduces the study and outlines the research questions and their operationalisation, followed by a detailed account of the methods and procedures.

4.1 Introduction

As indicated in the literature review chapter, relationship factors are a significant predictor of therapy outcomes (Wampold, 2015), and clinicians’ positive feelings of closeness and affiliation to patients are associated with better outcomes in therapy.

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(Machado et al., 2014). The quality of the alliance mediates the relation between clinicians’ positive feelings and therapy outcomes.

As explained earlier, this is of particular relevance to clinical suicidology where establishing a strong therapeutic alliance is critical to achieving positive outcomes (Joiner et al., 2009b; Linehan, 1993; Michel & Jobes, 2011; Schechter et al., 2013). Yet, there is scant research on clinicians’ positive inclination to PRS. As discussed in chapter 2, experts’ opinion within the field of suicidology conveys the idea that a positive inclination to PRS could increase treatment effectiveness (see Chapter 2, section 2.5.3). No research data on the prevalence of clinicians who feel positively inclined toward PRS was identified in the literature review.

In contrast, the literature is replete with evidence that PRS tend to evoke intense and often negative CT responses in clinicians. Yet, despite being a critical aspect of clinical suicidology, CT to PRS is rarely studied empirically (T. E. Ellis et al., 2018; Maltsberger & Buie, 1974; Yaseen et al., 2013). The characteristics of CT to PRS are addressed in book chapters (Goldblatt & Maltsberger, 2009; Maltsberger, 1999; Weinberg et al., 2011), opinion papers (Birnchnell, 1983; Marcinko et al., 2008; Roose, 2001; Schechter et al., 2013; Shneidman, 1981), clinical cases studies (Leenaars, 1994; Modestin, 1987), observational studies and qualitative studies (Richards, 2000; Wolk-Wasserman, 1987). However, attempts to produce quantitative evidence on CT to PRS remain rare (Yaseen et al., 2013).

Empirically derived descriptive models of CT phenomena have been developed (See Fauth, 2006; Hayes et al., 2011a; and Kächele et al., 2015 for review of empirical studies on CT). This is the case for Betan and colleagues who designed a clinician self-report measure originally named the Countertransference Questionnaire (CTQ) (Betan, Heim, Conklin, & Westen, 2005). The tool, now referred to as the Therapist Response Questionnaire (TRQ), consists of 79 items designed by experienced clinicians and based on the literature, to describe a broad range of CT phenomena, including emotional, cognitive and behavioural responses to patients in an atheoretical fashion. A psychometric validation study of the questionnaire
provided evidence of a nine-factor structure of the TRQ, including helpless/inadequate, overwhelmed/disorganised, positive/satisfying, hostile/angry, criticised/devalued, special/overinvolved, parental/protective, sexualized, and disengaged. Together, the nine factors represented 58% of the total variance explained (TVE), ranging each from 8.6% to 3.7% of the TVE. All subscales showed good internal consistency (with Cronbach’s alpha coefficients all above 0.78). The intercorrelations among the nine factors ranged from -0.23 to 0.48 with a median of 0.28 (Tanzilli, Colli, Del Corno, & Lingiardi, 2015). Hence, the TRQ showed excellent validity and reliability in describing a broad spectrum of CT phenomena, and in providing evidence of specific patterns of associations between CT dimensions and clusters of personality disorder. However, these studies did not investigate about the nature of CT to PRS specifically.

The research that comes closest to examining the nature of CT to PRS is that carried out by Yaseen et al., described in chapter two (see section 2.4.6). However, rather than the nature of CT to PRS per se, this research used the TRQ to investigate the potential of CT responses to assist suicide risk assessment. Two successive studies (Yaseen et al., 2013, 2017) provided preliminary evidence that a specific combination of distress/avoidance and hopefulness CT responses could be discriminant of suicidal versus non-suicidal deaths, and predict short-term post discharge suicidal behaviours (see Yaseen et al., 2013, 2017 respectively). This research led to develop a shorter version of the TRQ for PRS—the Therapist Response Questionnaire-Suicide Form (TRQ-SF)—which constitutes a subscale of a multi-informant tool for evaluating short-term suicide risk—the Modular Assessment of Risk for Imminent Suicide (MARIS) (Barzilay et al., 2018; Hawes et al., 2017).

### 4.2 Research questions

Study 1 aimed to answer two questions. The first research question aimed to identify the nature of CT to PRS in a NZ sample. The second research question
focused on identifying the proportion of clinicians holding a positive inclination to PRS. Primary and secondary hypotheses were derived for each of these questions.

**4.2.1 First research question**

The first research question was as follows:

1) What is the nature of CT to PRS?

**4.2.1.1 Operationalisation of the first research question**

Question 1 was operationalised by asking clinicians to rate the TRQ items referring to a PRS.

**4.2.1.2 Primary hypotheses**

Given the large descriptive spectrum and structure stability of the TRQ across all types of patients’ personality pathology (Tanzilli et al., 2015), I hypothesised that it would provide a statistically robust description of the factor structure of CT in a sample of PRS:

*H1: Applied to a sample of PRS, the factor structure of the TRQ is similar to that found across groups of personality pathology patients.*

**4.2.1.3 Alternative primary hypothesis**

Alternatively, in the case where the current TRQ factor structure would not constitute a robust description of this data, I would present the preliminary findings of the TRQ factor structure with PRS.

*H1bis) Applied to a sample of PRS, the factor structure of the TRQ is different from that found across groups of personality pathology patients.*
4.2.1.4 Secondary hypotheses

The secondary hypotheses are applicable to both variants of the primary hypothesis. First, I anticipated that the challenges associated with working with PRS described in the literature would translate in high levels of endorsement of negatively connoted CT dimensions by clinicians.

\textit{H1b: On average, clinicians report higher levels of negatively connoted CT dimensions of the TRQ, than positively connoted ones.}

Considering that experts have been discussing the critical importance of CT literacy in clinical suicidology since the 60s (see Chapter 2, section 2.4.3), I expected the majority of clinicians to be CT literate. I expected this to translate into high levels of endorsement of a broad range of CT dimensions, with an emphasis on those negatively connoted, regardless of clinicians’ primary theoretical orientation.

Second, the study aimed to investigate further the nature of CT to PRS by investigating specific associations between TRQ CT patterns to PRS (dependent/outcome variable) and demographic (e.g. gender) and clinical data (e.g. theoretical orientation, level of experience, patient personality pathology) (independent/predictor variables). For example, I expected that experienced clinicians would be more skilled in managing CT responses. I hypothesised that this would translate into higher levels of positive CT compared to junior clinicians. In fact, the statements presented in chapter 2, which described an exceptionally warm and engaging stance, were all attributed to seasoned clinicians.

\textit{H1c: Experienced clinicians endorse higher level of positive CT, than junior ones.}

Consistently with other studies looking at the effect of therapists’ orientation on reporting of CT responses, I expected to find that CT patterns were not affected by clinicians' theoretical orientation (Betan et al., 2005; Tanzilli et al., 2015).
H1d: There are no significant differences in CT factor mean scores by clinicians’ theoretical orientation.

4.2.2 Second research question

Second, the study aimed to answer the following question:

2) How prevalent is positive inclination to PRS among clinicians?

4.2.2.1 Operationalisation of the second research question

To reflect the specific inclination found in the case of Mme R and in statements from expert authors in the field, which reflects an intrinsic motivation according to the SDT (see Chapter 2, section 2.5), I operationalised the notion of a positive inclination with the terms “to like”. In so doing, I hoped to discriminate a strong and instinctual positive inclination to PRS that goes beyond a sense of competence and comfort in the practice.

The study screened for positive inclination to PRS by requiring clinicians to rate the statement “overall, it would be true to say that you like working with suicidal patients”, also referred to as the “like-statement”, on a five-point Likert scale ranging from very true to not true at all. Positively inclined clinicians, those rating the statement in the true range of the scale, would be invited to take part in a second study.

4.2.2.2 Primary hypothesis

Based on expert opinion, case studies and qualitative research reporting on the challenges associated with working clinically with the suicidal person, the main hypothesis for the second research question stated the following:

H2: Only a minority of clinicians report liking working with PRS.
4.2.2.3 Secondary hypothesis

A secondary hypothesis speculated on the relationship between TRQ CT patterns and clinicians' self-report of positive inclination to PRS. Again, in the absence of an empirical literature to refer to, I speculated about the possible translation of clinicians' positive inclination into CT patterns on the bases of expert opinion, case studies and qualitative research.

One could expect that a positive inclination, or intrinsic motivation to work with PRS, would translate into higher levels of positively connoted CT responses. However, expert authors have stressed that working comfortably and efficiently with PRS does not mean not experiencing negatively connoted CT responses but rather, being able to manage them. For example, the findings from Hayes et al. study (1998), presented in chapter 2, indicated that therapists deemed experts by their peers reported experiencing CT reactions in 80% of their sessions (J. A. Hayes et al., 1998). Another study found that clinicians reported more negative CT responses when discussing cases of successful therapy than cases of unsuccessful ones (J. A. Hayes et al., 2015). Therefore, assuming that positive inclination is associated with the ability to achieve positive outcomes (which is itself associated with greater CT literacy), we should expect positively inclined clinicians to endorse a broader range of CT responses, including negatively connoted ones, at higher levels than non-positively inclined clinicians. However, given their overall positive disposition towards PRS, we could also expect higher endorsement of positive CT responses compared to non-positively inclined clinicians. To summarise, I hypothesised that positively inclined clinicians would endorse higher levels of both, negative CT and positive CT, than non-positively inclined clinicians would.

H2b: Self-reported positive inclination is associated with higher levels of endorsement of both negatively and positively connoted CT on the TRQ factors.
4.3 Methods & Procedures

4.3.1 Participants

The population for the study consisted of clinicians most likely to conduct treatment/therapy with PRS, whose practice is regulated by a national board in NZ. This included psychiatrists, psychologists (all scopes of practice) and psychotherapists.

4.3.1.1 Sampling frame

The sampling frame for the study consisted therefore of psychiatrists, psychologists and psychotherapists registered in NZ (see Table 4.1).

Table 4.1 Numerical estimation of sampling frame for study 1 in 2016

<table>
<thead>
<tr>
<th>Source</th>
<th>Number of registrants</th>
<th>Sampling frame (total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL COUNCIL OF NZ (PSYCHIATRISTS)</td>
<td>554</td>
<td>2513</td>
</tr>
<tr>
<td>NZ PSYCHOLOGISTS BOARD</td>
<td>1444</td>
<td></td>
</tr>
<tr>
<td>PSYCHOTHERAPISTS BOARD OF AOTEAROA NZ</td>
<td>515</td>
<td></td>
</tr>
</tbody>
</table>

4.3.1.2 Convenience sampling

Clinicians were invited to participate through their professional associations: the Royal Australian and NZ College of Psychiatrists (RANZCP); the NZ College of Clinical Psychologists (NZCCP); the NZ Psychological Society (NZPsS); and the NZ Association of Psychotherapists (NZAP). This resulted in a non-probability sample of clinicians who accessed the survey online.

4.3.1.3 Inclusion and exclusion criteria

To be eligible for the study, clinicians needed to be a NZ registered psychiatrist, psychologist or a psychotherapist, currently holding a practising certificate. Furthermore, to be included in the study, clinicians needed to have worked with at least one suicidal patient, for at least three sessions, in the past 6 months.
4.3.2 Measures

The survey included demographic information about clinicians, the TRQ (Betan et al., 2005), and clinical information relating to clinicians, to patients, and to the therapy/treatment. I presented the questions in this order to prioritise the TRQ completion.

A group of eight mental health clinicians also involved in research pre-tested the survey, which led to minor alterations to the content.

The survey is presented in Appendix IX. Alternatively, it can be previewed online by copying and pasting the following URL it in an internet browser: https://otago.au1.qualtrics.com/jfe/preview/SV_6X0cN3oSUarhl0V?Q_SurveyVersionID=current&Q_CHL=preview

4.3.2.1 Demographic information

The survey collected demographic information relevant to the study. These included professional occupation, gender, ethnicity, primary theoretical orientation, years of experience, average hours of work face to face with patients per week, and type of work setting (public or private).

4.3.2.2 TRQ

The TRQ is a self-report measure consisting of 79 items describing a broad range of CT responses that clinicians might experience toward their patient while conducting therapy/treatment. Respondents rated each item on a 5-point Likert scale (ranging from 1 - very true to 5 - not true at all), referring their responses to a patient at risk for suicide (PRS).

To randomise patient selection and minimise recall bias, clinicians were required to refer only to the PRS with whom they met most recently, and who they had met at least 3 times in the previous 6 months. To collect data reflecting the dropout rate
among PRS, the minimum number of sessions selection criterion was reduced from eight used in other studies (See Tanzilli et al, 2015), to three.

4.3.2.3 Clinical information

The survey collected clinical information pertaining to clinicians (such as perceived competence, and number of patients lost to suicide), to patients (such as age range, presence of personality disorder, type of suicidality), and to the therapy/treatment (such as whether therapy had been regular or erratic, its duration and quality according to the clinician).

4.3.2.4 Positive inclination and recruitment for study 2

The study screened for positive inclination to PRS by asking clinicians to rate a “like-statement” on the 5-point Likert scale shown in the Figure 4.1.

![Figure 4.1 Screenshot of question 10 about positive inclination](image)

The like-statement question was purposefully placed at the end of the questionnaire. The rationale for this was that by the end of the survey, participants might be more weary from taking the survey, therefore less inclined to be affected by a social desirability bias.

The like-statement also acted as a screening tool to recruit participants for study 2. Survey participants who rated the like-statement as either very true or true were consider to meet selection criteria for study 2. Positively inclined clinicians were redirected to a screen displaying a message inviting them to consent to be contacted
about study 2, and to provide their email address. At this stage, participants were reassured that they were not consenting to participate in study 2 but merely to be sent information about it (see Figure 4.2).

![Recruitment message for study 2](image)

**Figure 4.2 Recruitment message for study 2**

### 4.3.2.5 Subjective appraisal of clinical characteristics

Because I aimed to explore clinicians’ subjective experience of the clinical encounter with PRS, I based all data collection on participants’ clinical judgment. For instance, I operationalised patients’ suicidality as the risk for suicide perceived by clinicians themselves. This led me to define ‘suicidal patient’, for the purpose of the study, as:
A ‘person who shows or has shown suicidal behaviours (including suicidal ideation) or who has attempted suicide before **AND** who seems [to the clinician] to be at risk of suicide.

Similarly, the survey inquired about patients’ personality pathology in a series of three questions. First, we inquired about participants’ clinical sense of whether the patient suffered from a personality disorder. Then, we invited them to describe the personality disorder with their usual clinical language, before asking them to refer to the DSM-V nomenclature if applicable. By encouraging participants to refer to their clinical judgement, we ensured that all clinicians who conducted therapy/treatment with PRS could be included in the study, regardless of whether they referred to the DSM nomenclature and used standardized assessment tools in their practice.

**4.3.3 Procedures**

**4.3.3.1 Recruitment**

Participants received information about the study in an email or e-newsletters sent by their professional associations, including a reminder sent two to three weeks later.

To increase the participation rate, I sought and obtained ethical approval to add two other methods of recruitment at later stages. First, I advertised the study in a 3-day conference held in Wellington by the NZ Psychological Society (NZPsS). Second, I emailed directors of Area Mental Health Services (publicly funded services), all around NZ. Of the twenty services contacted, five directors agreed to send the study to their team of clinicians directly, as well as a reminder a few weeks later.

**4.3.3.2 Survey distribution**

The survey was created and delivered online using Qualtrics® survey software. Participants accessed the survey through a link provided in an email. They
consented online directly (see survey Appendix IX). The survey was anonymous and took 10 to 15 minutes to complete. As an incentive, participants could enter a draw to win an electronic tablet device.

### 4.3.4 Statistical analyses

Exploratory factor analysis (EFA) was run in first instance to determine which items of the TRQ correlated strongly enough in the data to group into latent variables. These preliminary findings were compared with the TRQ current factor structure (Tanzilli et al., 2015). Subsequent to this, EFA results were examined further to provide a description of the TRQ factor structure in a sample of PRS.

#### 4.3.4.1 EFA

*Extraction:* we used the scree plot and a visual inspection of the factor analysis results (requesting several predetermined numbers of factors across rotation methods) to determine the number of factors to retain. Exploratory data analysis (z-scores of skewness and kurtosis for each factor, Shapiro-Wilk test, histograms, normal Q-Q plots and box plots) strongly suggested that the normality assumption did not hold for five of the seven factors. We therefore used Principal Axis Factoring as a factor extraction method (Fabrigar, Wegener, MacCallum, & Strahan, 1999). *Rotation:* Since we were dealing with emotional reactions, we used oblique rotation (Direct Oblimin) to allow latent variables to become correlated, however without requiring this (Fabrigar et al., 1999). *Parallel analysis:* Monte Carlo simulation indicated that seven factors had eigenvalues larger than the corresponding eigenvalues in a randomly generated sample of n=1000 using the 95th percentile, which legitimated the solution reached manually. *Factor refinement:* Each factor was refined with respect to measures of reliability (Cronbach’s Alpha), and by comparison with alternative results from a principal component analysis (PCA) with oblique rotation (Direct Oblimin). Items loading <.4 were retained when they increased internal consistency, loaded >.4 in PCA, and added clinical coherence to the factor.
4.3.4.2 Group comparison

From these factors, we calculated scales that consisted of the mean item score of the items selected for each “latent variable”. We compared gender, levels of experience, profession and orientation groups using t-test, or one-way ANOVA and Tukey post-hoc tests as applicable. As clinicians’ profession and primary theoretical orientation appeared related in our sample, we used 2-way ANOVA and the Tukey post hoc test to examine which variable was a better predictor of factors’ scores. IBM SPSS 24 was used to perform all statistical analyses.

4.4 Summary

This chapter presented the methods and procedures for study 1. After an introduction, I reviewed the research questions and associated hypotheses. The method section describes the measures used as well as the procedures for recruiting participants and distributing the survey. The chapters finished by detailing the statistical analyses conducted. The following chapter presents the study findings.
This chapter presents the findings for study 1. The chapter starts by a description of the demographic characteristics of the sample, followed by clinical information pertaining to clinicians, patients and therapy/treatment. I then introduce the results from EFA, which constitute preliminary findings of the factor structure of the TRQ with PRS. After examining the differences in factor mean scores between different groups, the chapter ends by considering the findings concerning positive inclination to PRS.

*Note: all percentages presented in the text are rounded*

### 5.1 Sample characteristics

Three hundred and fifty-one people (n = 351) accessed information about the study online, with 83% completing the survey. Of these, 268 had a patient meeting the inclusion criteria for completion of the TRQ. One case with missing data was excluded, so the analysis was conducted on 267 complete cases.

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Figure 5.1 Flowchart of participant recruitment for study 1

In the final sample ($n = 267$), the majority of respondents identified as female. New Zealand European and non-NZ European together represented 91% of the sample. Māori (NZ indigenous) clinicians accounted for just under 3% of the sample, akin to their representation (2.7%) in NZ health workforce (NZ Ministry of Health, 2016).
In terms of profession, the majority of respondents were psychologists (55%), followed by psychotherapists (28%) and psychiatrists (17%). Close to 40% of respondents referred to an eclectic range of theoretical frameworks (ECL), a similar proportion referred to the cognitive-behavioural framework (CBT), and the remaining 24% had a psychodynamic orientation (PDY) (see Table 5.1).

Table 5.1 Sample characteristics \( (n = 267) \)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>( n )</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>194</td>
<td>72.6</td>
</tr>
<tr>
<td>Male</td>
<td>71</td>
<td>26.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maori</td>
<td>7</td>
<td>2.6</td>
</tr>
<tr>
<td>Pacific People</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Asian</td>
<td>10</td>
<td>3.7</td>
</tr>
<tr>
<td>MELAA (Middle Eastern / Latin American / African)</td>
<td>5</td>
<td>1.8</td>
</tr>
<tr>
<td>Other European</td>
<td>43</td>
<td>16.1</td>
</tr>
<tr>
<td>New Zealand European</td>
<td>199</td>
<td>74.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Profession</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>46</td>
<td>17.2</td>
</tr>
<tr>
<td>Psychologist</td>
<td>147</td>
<td>55.0</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>74</td>
<td>27.7</td>
</tr>
<tr>
<td><strong>Primary Theoretical Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>100</td>
<td>37.4</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>63</td>
<td>23.5</td>
</tr>
<tr>
<td>Eclectic</td>
<td>102</td>
<td>38.2</td>
</tr>
</tbody>
</table>

### 5.2 Clinical Information

#### 5.2.1 Participants’ practice characteristics

Table 5.2, displayed below, lists characteristics pertaining to respondent clinicians and their practice. Results indicated that the sample consisted predominantly of experienced clinicians, who worked over 11 hours a week face to face with patients.
and felt competent in their ability to treat PRS. The majority reported having attended training on the topic of clinical suicidology in the past five years. Roughly half of respondents had lost one or more patients to suicide. Finally, approximately half of them considered having encountered issues related to suicide in their personal life, concerning either themselves or someone close to them.

Table 5.2 Participants’ practice characteristics (n = 267)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5</td>
<td>36</td>
<td>13.5</td>
</tr>
<tr>
<td>Between 5 and 10</td>
<td>43</td>
<td>16.1</td>
</tr>
<tr>
<td>11 and over</td>
<td>188</td>
<td>70.4</td>
</tr>
<tr>
<td>Average time of face to face work with patients per week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 hours</td>
<td>9</td>
<td>3.4</td>
</tr>
<tr>
<td>Between 5 and 10 hours</td>
<td>33</td>
<td>12.4</td>
</tr>
<tr>
<td>Between 11 and 15 hours</td>
<td>79</td>
<td>29.6</td>
</tr>
<tr>
<td>Over 15 hours</td>
<td>146</td>
<td>54.7</td>
</tr>
<tr>
<td>Type of work setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>109</td>
<td>40.8</td>
</tr>
<tr>
<td>Private</td>
<td>100</td>
<td>37.5</td>
</tr>
<tr>
<td>Both</td>
<td>58</td>
<td>21.7</td>
</tr>
<tr>
<td>Attendance of course/training for the assessment and/or treatment of PRS in past 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>191</td>
<td>71.5</td>
</tr>
<tr>
<td>NO</td>
<td>74</td>
<td>27.7</td>
</tr>
<tr>
<td>Not specified</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td>Current level of competence enables to care for PRS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>True range</td>
<td>209</td>
<td>78.2</td>
</tr>
<tr>
<td>Middle range</td>
<td>53</td>
<td>19.9</td>
</tr>
<tr>
<td>Not true range</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td>Not specified</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td>Further training would be needed to help PRS appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>True range</td>
<td>73</td>
<td>27.3</td>
</tr>
<tr>
<td>Middle range</td>
<td>113</td>
<td>42.3</td>
</tr>
<tr>
<td>Not true range</td>
<td>79</td>
<td>29.5</td>
</tr>
<tr>
<td>Not specified</td>
<td>2</td>
<td>0.7</td>
</tr>
</tbody>
</table>
Patients lost to suicide

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>141</td>
<td>52.8</td>
</tr>
<tr>
<td>YES</td>
<td>124</td>
<td>46.4</td>
</tr>
</tbody>
</table>

How many (in % of the Yes answer)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70</td>
<td>56.5</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
<td>14.5</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>13.7</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>4.8</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>4.8</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>3.2</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>10 or over</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Consider having encountered suicidal issues personally, either affecting them directly or a person close to them?

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>148</td>
<td>55.4</td>
</tr>
<tr>
<td>NO</td>
<td>117</td>
<td>43.8</td>
</tr>
<tr>
<td>Not specified</td>
<td>2</td>
<td>0.7</td>
</tr>
</tbody>
</table>

5.2.2 Patients characteristics

Respondents reported their CT responses in reference to one PRS. Table 5.3 displays the clinical characteristics of the 267 patients to which clinicians referred their responses in the survey. The sample of patients was predominantly composed of adult patients (83%), with chronic suicidality that could include acute phases. Just under half of patients presented with a personality disorder (PD) according to their clinician. The vast majority of PD patients belonged to Cluster B personality disorder (the dramatic, emotional, and erratic cluster), of which the majority showed Borderline personality disorder (BPD) features (American Psychiatric Association, 2013).

5.2.3 Therapy/treatment characteristics

Treatment had exceeded 6 months in the majority of cases, with the patient attending sessions/appointments regularly (see Figure 5.2). In most cases, the
treatment/therapy was ongoing at time of study. In terms of quality, the vast majority of clinicians estimated that the therapy/treatment was going well or had relatively positive outcomes. Seven percent of the sample reported that the patient had dropped out (see Table 5.3).

Table 5.3 Patients & treatment/therapy characteristics (N = 267)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of suicidality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic (can include acute phases)</td>
<td>194</td>
<td>72.7</td>
</tr>
<tr>
<td>Acute</td>
<td>54</td>
<td>20.2</td>
</tr>
<tr>
<td>Cyclical (intermittent) – with periods of time where the patient is not suicidal</td>
<td>17</td>
<td>6.4</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Presence of personality pathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES, with as a dominant cluster of personality (see below in % of the Yes answer)</td>
<td>127</td>
<td>47.6</td>
</tr>
<tr>
<td>Cluster A</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Cluster B</td>
<td>107</td>
<td>86.3</td>
</tr>
<tr>
<td>Of which BPD traits were dominant</td>
<td>81</td>
<td>65.3</td>
</tr>
<tr>
<td>Cluster C</td>
<td>15</td>
<td>12.1</td>
</tr>
<tr>
<td>NO</td>
<td>139</td>
<td>52.1</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Length of treatment/therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>85</td>
<td>31.8</td>
</tr>
<tr>
<td>Between 6 months and 1 year</td>
<td>80</td>
<td>30.0</td>
</tr>
<tr>
<td>Between 1 and 2 years</td>
<td>42</td>
<td>15.7</td>
</tr>
<tr>
<td>More than 2 years</td>
<td>59</td>
<td>22.1</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Quality of treatment/therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular (constant)</td>
<td>205</td>
<td>76.8</td>
</tr>
<tr>
<td>Erratic (on and off)</td>
<td>61</td>
<td>22.8</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Treatment/therapy status and quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ON-GOING, of which participants declared that:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The therapy is going well</td>
<td>172</td>
<td>80.4</td>
</tr>
<tr>
<td>The therapy is not going very well</td>
<td>42</td>
<td>19.6</td>
</tr>
<tr>
<td>TERMINATED, of which participants declared that:</td>
<td>52</td>
<td>19.5</td>
</tr>
</tbody>
</table>
The therapy had relatively positive outcomes 31 59.6
The therapy had relatively negative outcomes 2 3.8
The therapy was interrupted or the patient dropped out 19 36.5
Not specified 1 0.4

Overall quality of treatment/therapy
Positive (is going well or had relatively positive outcomes) 203 76.0
Negative (is not going very well or had relatively negative outcomes) 44 16.5
Drop outs 19 7.1

Figure 5.2 Cross tabulation of treatment/therapy length in months by overall session regularity (N = 267)

5.3 Factor analysis

5.3.1 Sample adequacy

Exploratory factor analysis (EFA) was run on the entire sample (N = 267). The Kaiser-Meyer-Olkin index was in the highest range (KMO = .907) indicating excellent sample adequacy (Hutcheson, 1999). Bartlett's test of Sphericity was significant at $p < .01$ ($X^2 (3081) = 11764.82, p \leq .0005$), indicating that variables were sufficiently correlated to conduct EFA efficiently.
5.3.2 EFA preliminary findings

EFA yielded a different factor structure of the TRQ from that obtained by Tanzilli et al., (2015). This means that the assumption that the TRQ would provide an accurate description of the factor structure in this data did not hold. Instead, different sets of items described the underlying structure of this data more accurately than the TRQ factors, which suggests that the risk for suicide, perceived by the clinician her/himself, elicits specific patterns of CT. I therefore decided to present the seven new factors that emerged in the analysis across extraction and rotation methods, as a more accurate description of the factor structure of the TRQ in this data.

5.3.3 Factor structure of the TRQ with patients at risk for suicide

The factor structure of the TRQ with PRS is presented in a table in Appendix X.

The study offers a seven-factor solution as the most statistically sound and clinically relevant description of CT to PRS in this data. We named each factor, or CT dimension, using both the most representative affective/emotional and cognitive/behavioural components of clinicians’ experiences and motivations. The seven factors account for 49.87% of the dispersion in the data, or total variance explained (TVE). For each subscale, reliability was measured by calculating a Cronbach’s Alpha score ($\alpha$). The internal consistency was acceptable for six factors, ranging from $\alpha \geq .90$ for factor 1 and 7, to $\alpha > .80$ for factor 2, 3 and 5, and $\alpha > .70$ for factor 4 (Tavakol & Dennick, 2011). I maintained factor 6 in spite of a poor internal consistency ($\alpha > .50$) for it appeared consistently across extractions and rotations method as well as in the PCA alternative analysis (see Chapter 6, section 6.2). Intercorrelations among the seven factors ranged from -0.43 to 0.33 with a median of -0.40. Table 5.4 displays the description of these seven factors is:
### Table 5.4 Description of the seven factors of the TRQ with PRS

<table>
<thead>
<tr>
<th>Factor</th>
<th>TVE</th>
<th>α</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1 (13 items): <strong>ENTRAPPED/REJECTING</strong></td>
<td>25.2%</td>
<td>.908</td>
<td>conveys the feeling of being trapped in an impossible situation, where low perceived self-efficacy (inadequacy) associated with hopelessness and apprehension elicit desires to reject the patient</td>
</tr>
<tr>
<td>Factor 2 (9 items): <strong>FULFILLED/ENGAGING</strong></td>
<td>8.6%</td>
<td>.820</td>
<td>expresses professional and personal satisfaction, associated with hopefulness and eagerness to engage with the patient</td>
</tr>
<tr>
<td>Factor 3 (6 items): <strong>ARoused/REACTING</strong></td>
<td>5.7%</td>
<td>.809</td>
<td>evokes an instinctual distortion of rapport, mainly sexualised, but also in a sense of competition, envy or hostility, potentially linked to heightened reactivity in the clinician</td>
</tr>
<tr>
<td>Factor 4 (9 items): <strong>INFORMAL/BOUNDARY CROSSING</strong></td>
<td>3.1%</td>
<td>.758</td>
<td>illustrates the tendency to slip from a professional stance into familiarity, resulting in a porous therapeutic frame that fosters boundary crossing</td>
</tr>
<tr>
<td>Factor 5 (9 items): <strong>PROTECTIVE/OVERINVOLVEMENT</strong></td>
<td>2.8%</td>
<td>.828</td>
<td>evokes protection and nurturance associated with a sense of felt responsibility, which, together with the emotional intensity described, indicates possible overinvolvement from the clinician</td>
</tr>
<tr>
<td>Factor 6 (5 items): <strong>AMBIVALENT/INCONSISTENT</strong></td>
<td>2.3%</td>
<td>.534*</td>
<td>describes an ambivalent state of preoccupation with the patient, however combined with a decrease in attention, and a tendency to disengage from the therapeutic relationship</td>
</tr>
<tr>
<td>Factor 7 (11 items): <strong>MISTREATED/CONTROLLING</strong></td>
<td>2.2%</td>
<td>.900</td>
<td>conveys feelings of being criticised, denigrated and manipulated, which elicit resentfulness and a propensity to increase rigidity and control over the therapeutic frame</td>
</tr>
</tbody>
</table>

Note. TVE = total variance explained; α = internal consistency measure Cronbach’s Alpha. *Refer to the strengths and limitations section (Chapter 6) for rationale behind maintaining factor 6 despite a poor reliability score.

### 5.3.4 Examination of factor scores

Table 5.5 and Figure 5.2 describe the distribution of factor scores. All factors but factor 2 (fulfilled/engaging) had a mean score higher than the somewhat true response, with 78.3% to 100% of the ratings leaning towards the negative (not true/not true at all) part of the scale. This means that overall, clinicians tended not to endorse CT dimensions, except for factor 2 (fulfilled/engaging). As expected, the
positively connoted factor (factor 2 – fulfilled/engaging) was not significantly correlated to four of the other six factors, and only mildly negatively correlated to two (factor 1 – entrapped/rejecting and factor 7 - mistreated/controlling, Spearman’s rho, r = -0.240 and r = -0.175 respectively). Factor 2 – fulfilled/engaging was the most readily endorsed by clinicians.

Table 5.5 Factors distribution

<table>
<thead>
<tr>
<th>Factors</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
<th>% &gt; 3 - somewhat true</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entrapped/Rejecting</td>
<td>1.57 – 5.00</td>
<td>3.82</td>
<td>0.63</td>
<td>89.9%</td>
</tr>
<tr>
<td>Fulfilled/Engaging</td>
<td>1.10 – 4.50</td>
<td>2.92</td>
<td>0.54</td>
<td>39.7%</td>
</tr>
<tr>
<td>Aroused/Reacting</td>
<td>3.25 – 5.00</td>
<td>4.60</td>
<td>0.39</td>
<td>100%</td>
</tr>
<tr>
<td>Informal/Boundary Crossing</td>
<td>2.67 – 5.00</td>
<td>4.27</td>
<td>0.48</td>
<td>98.5%</td>
</tr>
<tr>
<td>Protective/Overinvolvement</td>
<td>1.33 – 4.93</td>
<td>3.46</td>
<td>0.62</td>
<td>78.3%</td>
</tr>
<tr>
<td>Ambivalent/Inconsistent</td>
<td>2.13 – 5.00</td>
<td>3.81</td>
<td>0.46</td>
<td>95.5%</td>
</tr>
<tr>
<td>Mistreated/Controlling</td>
<td>2.00 – 5.00</td>
<td>3.97</td>
<td>0.58</td>
<td>92.9%</td>
</tr>
</tbody>
</table>
5.4 Group comparison

The study investigated the effect of independent variables on clinicians’ endorsement of CT dimensions by comparing factors’ mean scores. Note the study attributed the following scores to each rating: 1 - very true; 2 - true; 3 - somewhat true; 4 - not true; 5 - not true at all. For this reason, a low score on a CT dimension corresponds to a high endorsement from the clinician and vice versa.

5.4.1 Gender

Clinician gender was available for all but two of the respondents. Because factors were not always normally distributed, both Wilcoxon and t-tests were used to compare means between groups. There was no statistically significant difference.
between female and male respondents’ mean scores with respect to the main CT dimension - factor 1 (entrapped/rejecting) - as determined by two-tailed t-test (t (263) = .219, p = .826, Wilcoxon p = 0.765), nor with respect to factors 4, 5, 6 and 7. However, the independent-samples two-tailed t-test indicated that there was a statistically significant difference between gender groups with respect to factor 2 (fulfilled/engaging) and factor 3 (aroused/reacting).

Female clinicians scored statistically significantly lower on factor 2 (fulfilled/engaging) than male clinicians, which means that they reported more fulfilled/engaging CT responses than their male counterparts (t (263) = -2.239, p = .026, Wilcoxon p = 0.055). Conversely, female clinicians scored statistically significantly higher on factor 3 (aroused/reacting), which means that they reported significantly less aroused/reacting CT responses than male clinicians (t (263) = 2.591, p = .010, Wilcoxon p = 0.002).

5.4.2 Level of experience

Clinicians’ level of experience was determined by whether they had worked in their occupation for less than 5 years (13.5%, n = 36), between 5 and 10 years (16.1%, n = 43), or over 11 years (70.4%, n = 188) (see Table 5.2). I refer to these three groups as junior, senior and experienced clinicians respectively.

Contrary to expectations, a one-way ANOVA indicated that there was no significant difference in level of endorsement of positive CT (factor 2 – fulfilled/engaging) between junior and experienced clinicians in this data (F (2,264) = 1.341, p = .263).

5.4.3 Professional & primary theoretical orientation

Profession and primary theoretical orientation were related in this sample. Seventy-eight percent of psychiatrists had an eclectic orientation (ECL); 73% of psychotherapists were psychodynamically oriented (PDY); and psychologists were 62% CBT, and 35% ECL. However, after taking out the interaction term, two-way ANOVA and Tukey post-hoc test indicated that theoretical orientation was in fact
the best predictor for five of the seven factors. The difference between orientation
groups’ mean scores with respect to factor 1 (entrapped/rejecting) was borderline
significant (F (2,260) = 2.699, p = .069, η2 = .020), but reached significance in post
hoc pairwise analysis, with PDY clinicians (M = 3.61, SD = .55) scoring significantly
lower than ECL clinicians (M = 3.93, SD = .59, p = .005). There was also statistical
significant differences between orientation groups’ mean scores with respect to
factor 3 (aroused/reacting) (F (2,260) = 5.184, p = .006, η2 = .038) with PDY
clinicians scoring lower (M = 4.33, SD = .44) than both ECL (M = 4.66, SD = .35, p = .000) and CBT clinicians (M = 4.71, SD = .33, p = .000); factor 4 (informal/boundary
crossing) (F (2,260) = 3.052, p = .049, η2 = .023) with PDY clinicians scoring lower
(M = 4.03, SD = .50) than both ECL (M = 4.34, SD = .44, p = .000) and CBT clinicians
(M = 4.36, SD = .47, p = .000); factor 5 (protective/overinvolvement) (F (2,260) =
3.798, p = .024, η2 = .028) with ECL clinicians scoring higher (M = 3.64, SD = .56)
than both CBT (M = 3.38, SD = .68, p = .008) and PDY clinicians (M = 3.32, SD = .57,
p = .003); and factor 7 (mistreated/controlling) (F (2,260) = 4.629, p = .011, η2 = .034), with PDY clinicians scoring lower (M = 3.68, SD = .61) than both CBT (M = 4.03, SD = .57, p = .000) and ECL clinicians (M = 4.09, SD = .51, p = .000). No
significant difference was found for factor 6 (ambivalent/inconsistent).

To summarise, PDY clinicians reported significantly more entrapped/rejecting CT
responses to PRS than ECL clinicians, and significantly more aroused/reacting,
informal/boundary crossing and mistreated/controlling CT responses to suicidal
patients than both CBT and ECL clinicians. ECL clinicians reported significantly less
protective/overinvolvement CT responses to patients than both CBT and PDY
clinicians.

Conversely, professional group was the best predictor for factor 2
(fulfilled/engaging) (F (2,260) = 13.409, p = .000, η2 = .094), with psychiatrists
scoring significantly higher (M = 3.28, SD = .58), than both psychologists (M = 2.88,
SD = .51, p = .000) and psychotherapists (M = 2.78, SD = .49, p = .000). This means
that psychiatrists reported significantly less fulfilled/engaging CT responses to PRS
than did psychologists and psychotherapists, regardless of theoretical orientation.
5.4.4 Personality disorder (PD)

The study found significant differences in mean scores between personality disorder patients (PD) (48% of the sample; of which 86% belonged to Cluster B) and non-PD patients, with respect to six of the seven factors. Mean scores of factor 1 – entrapped/rejecting (t (264) = -4.227, p = 0.000), factor 3 - aroused/reacting (t (251) = -2.493, p = 0.013), factor 4 - informal/boundary crossing (t (264) = -2.708, p = 0.007), factor 6 – ambivalent/inconsistent (t (242) = -4.348, p = 0.000), and factor 7 – mistreated/controlling (t (242) = -8.150, p = 0.000), were significantly lower when clinicians referred to Personality Disorder (PD) patients than non-PD patients. Conversely, factor 2 – fulfilled/engaging mean score was significantly higher with PD patients than with non-PD patients (t (264) = 2.440, p = 0.015) (see Table 5.6).

This means that clinicians reported significantly more entrapped/rejecting, aroused/reacting, informal/boundary crossing, ambivalent/inconsistent and mistreated/controlling CT responses, and significantly less fulfilled/engaging CT responses, when referring to PD patients than to non-PD patients. There was no significant difference in mean scores between PD and non-PD patients with respect to factor 5 – protective/overinvolvement. Non-parametric analysis (Wilcoxon) gave the same results as the t-tests.

Table 5.6 Comparison of factor mean scores between PD and non-PD patients

<table>
<thead>
<tr>
<th>Factors means</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1 – Entrapped/Rejecting</td>
<td>-4.227</td>
<td>264</td>
<td>.000</td>
</tr>
<tr>
<td>Factor 2 – Fulfilled/Engaging</td>
<td>2.440</td>
<td>264</td>
<td>.015</td>
</tr>
<tr>
<td>Factor 3 – Aroused/Reacting</td>
<td>-2.493</td>
<td>251.293</td>
<td>.013</td>
</tr>
<tr>
<td>Factor 4 – Informal/Boundary Crossing</td>
<td>-2.708</td>
<td>264</td>
<td>.007</td>
</tr>
<tr>
<td>Factor 5 – Protective/Overinvolvement</td>
<td>-5.77</td>
<td>264</td>
<td>.564</td>
</tr>
<tr>
<td>Factor 6 – Ambivalent/Inconsistent</td>
<td>-4.348</td>
<td>264</td>
<td>.000</td>
</tr>
<tr>
<td>Factor 7 – Mistreated/Controlling</td>
<td>-8.150</td>
<td>242.055</td>
<td>.000</td>
</tr>
</tbody>
</table>
5.5 Positive inclination

The survey estimated the prevalence of positive inclination to PRS by recording respondent ratings on the like-statement (i.e. “overall, you would you say that you like working with suicidal patients”), on a 5-point Likert scale ranging from very true to not true at all.

The study found that 14.7% \((n = 39)\) of clinicians rated the like-statement in the true range of the scale (true or very true), 40.1% \((n = 107)\) in the middle range (somewhat true), and 44.5% \((n = 119)\) in the not true range (not true or not true at all).

![Figure 5.4 Prevalence of positive inclination to PRS (N = 267)](image)

*Percentage are rounded

5.5.1 Inclination group

To investigate the potential effect of clinicians’ inclination to PRS on CT patterns, I compared factor mean score between inclinations groups. In order to do so, I constituted inclination groups by pairing together the true and very true ratings to obtain a “true” range of answer \((n = 39)\) group, and the not true and not true at all ratings to obtain a “not true” range of answer \((n = 119)\) group. I considered the
somewhat true rating as a “neither true nor false” group (n = 107). The differences in factor mean scores between these groups were examined.

A one-way ANOVA indicated a significant difference in mean score between inclination groups only in relation to the positive factor (Factor 2 – fulfilled/engaging) (F (2, 262) = 7.277, p = 0.001). The not true group scored significantly higher (M = 3.06, SD = .54), than the true (M = 2.77, SD = .54, p = .009) and the neither true nor false group (M = 2.83, SD = .51, p = .004). This means that clinicians who rated the like-statement as not true, endorsed less positive CT responses to PRS than clinicians who rated it either true or neither true nor false (see Table 5.7). A t-test showed that there was no significant difference in mean score between the true and the neither true nor false group except for factor 4 – informal/boundary crossing (t (144) = 2.160, p = 0.03). The true group endorsed significantly higher scores for informal/boundary crossing CT (M = 4.43, SD = .48), than the neither true nor false group (M = 4.24, SD = .46). This means that clinicians in the true group endorsed significantly less informal/boundary crossing CT than clinicians in the neither true nor false group.

Table 5.7 Tukey post-hoc test for factor 2 - fulfilled/engaging between inclination groups

<table>
<thead>
<tr>
<th>Inclination groups</th>
<th>N</th>
<th>Subset for alpha = 0.05</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>True</td>
<td>39</td>
<td>2.7667</td>
</tr>
<tr>
<td>Neither true nor false</td>
<td>107</td>
<td>2.8262</td>
</tr>
<tr>
<td>Not true</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>Sig.</td>
<td></td>
<td>.786</td>
</tr>
</tbody>
</table>

Subsequently, to get a more distinct picture of the data, the neither true nor false group was removed from the analysis and conducted a t-test between the true and not true groups only (see Table 5.8). The t-test showed a significant difference in factor mean score between true and not true groups with regards to three CT dimensions, factor 1 - entrapped/engaging (t (156) = 2.022, p = 0.045), factor 5 -
protective/overinvolvement \( (t(156) = 2.071, \ p = 0.040) \), and factor 2 - fulfilled/engaging \( (t(156) = -2.895, \ p = 0.004) \). Clinicians from the *true group* endorsed significantly lower levels of entrapped/rejecting CT \( (M = 3.98, \ SD = .64) \) and protective/overinvolvement CT \( (M = 3.64, \ SD = .75) \) than clinicians from the *not true* group \( (M = 3.73, \ SD = .67; \ M = 3.40, \ SD = .60 \) respectively). Additionally, clinicians who rated the like-statement as true, endorsed significantly higher levels of fulfilled/engaging CT \( (M = 2.77, \ SD = .54) \) than clinicians from the *not true group* \( (M = 3.06, \ SD = .54) \).

To summarise, the *true group* (positively inclined clinicians), reported significantly less entrapped/rejecting and protective/overinvolvement CT, and more fulfilled/engaging CT responses than clinicians in the *not true group* (see Table 5.8). Non-parametric analysis (Wilcoxon) gave the same results as the t-tests.

This finding only partially supports the hypotheses. Based on the literature, I predicted that positively inclined clinicians would endorse higher levels of both negative and positive CT than others would (see Chapter 4, section 4.2.3). Positively inclined clinicians did differ significantly from others in their level of endorsement of three CT dimensions. As anticipated, they endorsed positively connoted CT at higher level than others. However, they reported lower levels of negatively connoted CT than other clinicians in the sample.

Table 5.8 Comparison of factor mean scores between 'true' versus 'not true' inclination groups

<table>
<thead>
<tr>
<th>Factors means</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1 – Entrapped/Rejecting</td>
<td>2.022</td>
<td>156</td>
<td>.045</td>
</tr>
<tr>
<td>Factor 2 – Fulfilled/Engaging</td>
<td>-2.895</td>
<td>156</td>
<td>.004</td>
</tr>
<tr>
<td>Factor 3 – Aroused/Reacting</td>
<td>.657</td>
<td>156</td>
<td>.512</td>
</tr>
<tr>
<td>Factor 4 – Informal/Boundary Crossing</td>
<td>1.936</td>
<td>156</td>
<td>.055</td>
</tr>
<tr>
<td>Factor 5 – Protective/Overinvolvement</td>
<td>2.071</td>
<td>156</td>
<td>.040</td>
</tr>
<tr>
<td>Factor 6 – Ambivalent/Inconsistent</td>
<td>1.361</td>
<td>156</td>
<td>.175</td>
</tr>
<tr>
<td>Factor 7 – Mistreated/Controlling</td>
<td>1.287</td>
<td>156</td>
<td>.200</td>
</tr>
</tbody>
</table>
5.6 Summary

This chapter has presented the results from study 1, the national survey of CT to PRS. The study surveyed 267, predominantly experienced NZ clinicians, of whom most estimated having the competence to treat PRS. The majority of respondents reported their CT to an adult PRS with chronic suicidality that could include acute phases. Most clinicians estimated that the treatment was going well or had had relatively positive outcomes. EFA provided preliminary evidence that a seven-dimension CT constellation could be specific of PRS. Finally, the study found that just under 15% of clinicians felt positively inclined to PRS. Positively inclined clinicians reported significantly less negatively connoted and more positively connoted CT than other clinicians in the sample did. The following chapter discusses these findings.
Chapter 6
Study 1 Discussion & conclusion

As a tactic, I ask the suicidal person to actually "convince" me that suicide is the only solution left and communicate with him or her from that empathic focus. I try to participate in the consideration of suicide as an actual alternative without pressing against the suicidal decision. This, of course, does not connote agreement with the suicidal intention, but rather a way of connecting with the patient's experience and offering myself as a listener and companion at a time of crisis.10

This chapter discusses the findings from the first study. The chapter starts with a summary of the main findings, followed by the presentation of two alternative interpretations of them. After discussing the study's strengths and limitations, I make suggestions for future research and discuss implications for clinical practice. The chapter ends with a conclusion that reviews the state of the research after study 1 and upon entering study 2.

To the best of my knowledge, this study is the first quantitative investigation of the nature of CT to PRS. Factor analysis yielded preliminary evidence of a seven-factor structure of the TRQ with PRS, which provides a detailed, statistically sound and clinically relevant depiction of CT patterns toward PRS in our sample.

6.1 Summary of findings & discussion

The first finding of importance was that the prediction that the TRQ would provide a robust description of the factor structure in this data did not hold. This suggests that suicidality in patients elicits specific patterns of CT. The seven dimensions of CT to PRS included entrapped/rejecting, fulfilled/engaging, aroused/reacting,

informal/boundary crossing, protective/overinvolvement, ambivalent/inconsistent, and mistreated/controlling.

These factors represent the groups of items that correlated most strongly in this data. They are, so to speak, the CT dimensions identified to be common to all clinicians, independently of how clinicians personally rated, or endorsed, each factor. The seven factors together accounted for 49.87% of the total variance explained (TVE), which means that they represented half of all CT reactions reported by clinicians, regardless of their gender, profession, theoretical orientation, and regardless of whether the PRS selected presented with a personality disorder (PD). Finally, factors 1 (entrapped/rejecting) and 2 (fulfilled/engaging) alone represented close to 70% of the CT to PRS described by the model.

The main dimension of CT to PRS is the entrapped/rejecting factor (factor 1), which represented alone 25.2% of the TVE. It depicts a mixture of inadequacy and hopelessness, paired with apprehension and desires to reject the patient, which appears consistent with experts' formulations (D. G. Jacobs et al., 2003; Linehan, 1993; Michel & Jobes, 2011). Conversely, the factor accounting for the next greatest amount of variance (8.6% of the TVE), the fulfilled/engaging factor, conveys professional fulfilment and eagerness to engage with the patient. Thus, considered at a semantic level, factors 1 and 2 appear to describe opposing experiences. For example, factor 1, item 54 states “I think s/he might do better with another therapist or in a different kind of therapy”, while factor 2, item 1 states “I am very hopeful about the gains s/he is making or will likely make in treatment”. Similarly, factor 1, item 13 states “I dread sessions with him/her”, while factor 2, item 19 notes “I look forward to sessions with him/her”. Although mildly negatively correlated, the two main factors suggest that an ambivalent combination of entrapped/rejecting and fulfilled/engaging responses could be specific of CT to PRS. This calls to mind Yaseen and collaborators’ evidence for clinicians’ “conflicting emotional responses” of distress/hopefulness significantly discriminating between attempters and non-attempters, and predicting short-term
post-discharge suicidal behaviours (Yaseen et al., 2017). Interestingly, the current findings constitute further evidence suggesting that a contradictory CT combination could be characteristic of CT with PRS.

However, the second main finding is that, overall, clinicians reported a low level of endorsement of most factors, which again, contradicts what I anticipated. In fact, all factors had their mean score in the not true range of the scale, except for the fulfilled/engaging one (factor 2). This means that on average, clinicians reported that negatively connotated CT reactions did not, or only mildly, applied to them most of the time with the PRS selected. This finding can be interpreted in different ways, whether self-report data is taken at face value (which assumes that the relation between the emotional experience and its reporting is transparent); or not (where experience could be considered overstated or understated for various reasons).

Taken at face value, these findings suggest that on average, clinicians experienced stronger fulfilled/engaging responses (factor 2) than any other CT responses. Alternatively, social desirability response biases could have affected levels of endorsement. In this sample for instance, female clinicians reported significantly more fulfilled/engaging responses, and significantly less aroused/reacting reactions than male clinicians, which could reflect social gender expectations. In addition, by examining levels of endorsement by orientation groups, we found that psychodynamically oriented (PDY) clinicians reported stronger experiences of virtually all negatively connotated CT than eclectic (ECL) and CBT clinicians did. Taken at face value, this would mean that ECL and CBT clinicians experience less negatively connotated CT responses, potentially due to their training, the nature of their work, or their work experiences. Conversely, ECL and CBT clinicians might have been either less aware of, or less comfortable about reporting potentially controversial reactions such as aroused/reacting or informal/boundary crossing CT responses than PDY clinicians. In terms of profession groups, the study found that psychiatrists endorsed significantly lower levels of positively connotated CT responses (Factor 2: fulfilled/engaging), than both psychologists and psychotherapists. This could be a reflection of the nature of psychiatrists’ role, the
context of their practice, and the level of acuteness of the cases they are more likely to treat.

In summary, the study found that CT to PRS consists predominantly of entrapped/rejecting responses, at mild levels of endorsement, combined with fulfilled/engaging responses, however less representative in aggregate, at higher (i.e. moderate) levels of endorsement. The other five factors represented together the remaining 30% of the TVE. They were on average mildly endorsed at most by clinicians. In other words, factor analysis provided evidence of an underlying, or implicit, statistically significant matrix of CT patterns that clinicians, on average, tended to not endorse explicitly.

Finally, in terms of positive inclination to PRS, as indicated in the previous chapter, the study found that just under 15% rated the like-statement true (i.e. either true or very true), while approximately 45% of the sample rated that same statement not true (i.e. not true or not true at all). I refer to these two groups as either true/not true groups or “positively inclined’/’non-positively inclined” clinicians. To compare well-circumscribed unequivocal groups, this discussion disregards the neither true nor false group, representing the remaining 40% of the sample.

The findings only partially supported the hypothesis that positively inclined clinicians would endorse more of both negatively and positively connoted CT. First, there was no significant difference in level of endorsement between positively and non-positively inclined clinicians, for four of the seven CT dimensions. This means that, on average, clinicians with a positive inclination reported similar level of aroused/reacting, informal/boundary crossing, ambivalent/inconsistent and mistreated/controlling CT responses than non-positively inclined clinicians. Moreover, contrary to expectation, positively inclined clinicians reported significantly less entrapped/rejecting and protective/overinvolved CT (i.e. two dimensions predominantly negatively connoted) than non-positively inclined clinicians. However, as expected, the study found that positively inclined clinicians
reported significantly more fulfilled/engaging CT (i.e. the positively connoted dimension of CT measured) than non-positively inclined clinicians did.

In attempting to make sense of these findings, I speculated on two potential explanations, in terms of either defence mechanisms or what I called a “countertransference montage” (CT montage). In the following section, I will unfold the rationale behind each of these possible explanations successively. Subsequently, I will show that taking into account evidence on positive inclination seem to tip the discussion toward validating the second interpretation as CT montage.

6.1.1 Interpretation as defence mechanisms

First, I wondered if the low levels of endorsement of all CT factors except the positively connoted factor (factor 2 – fulfilled/engaging) could indicate the pervasiveness of defence mechanisms among clinicians. As noted in chapter 2, a defence mechanism is an unconscious coping mechanism that aim to reduce the anxiety associated with a representation (Schacter et al., 2009).

Referring to Maltsberger and Buie’s psychodynamic formulation of CT hate, entrapped/rejecting responses (factor 1), could signal a defence involving “CT hatred turned against the self”, where malice felt toward the patient is experienced as unacceptable and turned onto the self (‘It is not the patient that I hate but myself: I am incompetent and fail to help the patient’). The overall mild endorsement of entrapped/rejecting responses could further indicate a defence mechanism of “repression of CT hatred”. Indeed, clinicians reported on average that entrapped/rejecting CT tended to not apply to them most of the time with the patient selected, yet this particular group of statements was the most strongly correlated in aggregate. The fact that fulfilled/engaging responses were the most readily endorsed in our sample, beyond entrapped/rejecting responses in spite of being most significant in aggregate, could constitute ‘reaction formation, or, turning CT hatred into its opposite’ (See Maltsberger & Buie, 1974, pp. 628–629 for detailed description of these defensive postures).
This interpretation would imply that, despite clinical recommendations to consider the potential for CT (Jacobs et al., 2003), a lack of CT literacy could persist among clinicians in this sample.

### 6.1.2 Interpretation as ‘CT montage’

A second alternative explanation considers that the CT patterns observed could constitute a specific, adaptative, and possibly necessary coping stance on clinicians’ part.

There are a number of reasons why this may be the case. First, respondents were predominantly experienced clinicians, most of whom felt competent to treat PRS and estimated that the treatment was going well or had relatively positive outcomes. Furthermore, respondents volunteered their participation. Secondly, there are important similarities between the main CT dimension in the data, and the suicidal state. Indeed, the entrapped/rejecting factor conveys helplessness and hopelessness, but also captures an urge to escape what is perceived to be both a stressful and defeating situation, which mirrors suicidal patients’ description of their inner state, which has been conceptualised as “entrapment” (O’Connor, 2003; Taylor, Gooding, Wood, & Tarrier, 2011; Williams & Pollock, 2000). In fact, the factor was named accordingly in hindsight. Yet, the entrapped/rejecting factor was only mildly endorsed, and followed by fulfilled/engaging responses, which, conversely, were the most readily endorsed by clinicians. Again, in spite of being the most systematically described (i.e. statistically significant) in the sample, entrapped/rejecting responses were reported to be subjectively experienced as mild, so may have been managed or minimised, or were contained, and potentially ‘counter-balanced’ by fulfilled/engaging responses.

These findings could therefore constitute preliminary evidence that clinicians experience aspects of the suicidal state on some level and that they empathise with this, while keeping this resonance in control and relying on positive feelings to sustain their therapeutic engagement. Consistent with this, virtually all evidenced-
based treatments of suicidal behaviour emphasise the need to understand suicidality from the patient’s perspective (Jobes, Piehl, & Chalker, 2018). Advocates of a phenomenological approach to suicidality have stressed the need for clinicians to bear suicidal patients’ intense despair and hopelessness, while providing what Shneidman called “transfusions of (realistic) hope and succorance” (Schechter, Goldblatt, & Maltsberger, 2013; Shneidman, 1981, p. 348 [156]). In the similar vein, according to the Aeschi group, forming a genuine connection requires the clinician to see the world through the suicidal patient’s eyes (Jobes & Ballard, 2011, p. 57), also referred to as “empathic fortitude” (Jobes & Maltsberger, 1995, p. 208).

The CT combination observed, which I term “CT montage”, could represent an adaptive coping stance, where clinicians empathise emotionally with patients’ suicidality, while casting challenging CT responses aside enough to sustain hope and their willingness to engage therapeutically, in spite of the suicide risk perceived.

6.1.3 Evidence favouring the CT montage interpretation

The findings pertaining to positive inclination in clinicians appear to contradict the defence mechanism explanation, adding weight to the CT montage interpretation.

It was observed that non-positively inclined clinicians reported either similar levels of CT, or higher levels of endorsement for two negatively connoted CT dimensions (factor 1 – entrapped/rejecting and factor 5 – protective/overinvolvement), than positively inclined clinicians. However, to support the interpretation as defence mechanisms theoretically, non-positively inclined clinicians would be expected to find working with PRS more anxiety provoking (Leenaars, 1994; Wolk-Wasserman, 1987), therefore appear more defensive, hence less aware of their negative CT responses to PRS than positively inclined clinicians. Indeed, defence mechanisms are unconscious coping strategies that counter the anxiety associated with some representations (A. Freud, 1936), which would be expected to translate into lower endorsement of negatively connoted responses (e.g. denial) and greater
endorsement of positively connoted responses (e.g. reaction formation) (see Maltzberger & Buie, 1974 for description of these mechanisms). In this data, instead, non-positively inclined clinicians reported more negatively connoted CT responses than positively inclined clinicians, which tends to contradict the interpretation of the findings as defence mechanisms.

Considering the speculation of a CT montage instead, positively inclined clinicians' lower endorsement of some challenging CT responses would indicate an enhanced CT literacy paired with greater CT management skills. Consistent with the interpretation of a CT montage, the patterns of endorsement observed indicated that positively inclined clinicians experienced less entrapped/rejecting and protective/overinvolvement responses and more fulfilled/engaging responses to PRS than non-positively inclined clinicians did.

6.2 Strengths & limitations

Operationalising suicidality as the risk perceived by clinicians, which I refer to as “perceived suicidality”, had implications. On one hand, we know that negative CT can generate an underestimation of suicidal risk (Leenaars, 1994; Wolk-Wasserman, 1987), so that a sample of clinicians aware of the suicide risk could be inherently skewed. On the other hand, in doing so, I aimed to explore the nature of CT generated by the perceived risk for suicide itself, regardless of patients' presentation. Similarly, to avoid excluding clinicians who do not use the DSM nomenclature, the study invited participants to describe patients' presentation with the terms they would usually use in their practice. However, the study could benefit from replication using standardised assessments of patients' psychopathology. Patient’s personality could be described in more nuanced ways by using the Shedler-Westen Assessment Procedure-200 (SWAP-200) (Blagov, Bi, Shedler, & Westen, 2012; Shedler & Westen, 2007). The SWAP-200 operationalises the Alternative Model for Personality Disorders (AMPD) put forward in Section III of the DSM-5 (American Psychiatric Association, 2013; Waugh et al., 2017), and has been used in published suicide research (Ortigo, Westen, & Bradley, 2009). Patients’
suicidality could also be described more systematically, for instance with the Columbia-Suicide Severity Rating Scale C-SSRS (Madan et al., 2016), or with the Suicide Status Form (SSF) (D. A. Jobes, 2009). Nonetheless, by operationalising suicidality as “perceived suicidality” and by endeavouring to include clinicians from all orientations, we aimed to access naturalistic samples of both clinicians and patients. This represents a special feature of the study and, in the current state of knowledge, one of its strengths.

In terms of our assessment of clinicians’ positive inclination to PRS, we note that not liking working with PRS does not necessarily mean disliking it. Hence, I was cautious of not assuming that the clinicians who did not rate the like-statement as true, dislike working with PRS. We can only state that, for unknown reasons, they did not feel comfortable rating the like-statement true. Perhaps they found associating the terms “to like” and “suicidal patients” insensitive or inconsiderate. Furthermore, I considered the somewhat true rating of the like-statement as a middle ground, or neither true nor false answer. In doing so, I posited that what is somewhat true is simultaneously somewhat untrue. I therefore removed the neither true nor false groups from the analysis to compare inclination groups. However, as showed in the findings chapter, conducting a one-way ANOVA indicated that there was no significant differences in level of endorsement between the true and the neither true nor false group, except for factor 4 – informal/boundary crossing. This means that, apart from reporting more informal/boundary crossing responses, clinicians in the middle range of the scale reported essentially similar patterns of CT to PRS than positively inclined clinicians. These two points show the limitation of the like-statement in providing an insight into clinicians’ positive inclination to PRS. An open-ended follow-up question would have helped us make sense of participants’ rating of the like-statement. Yet, I intentionally screened for clinicians’ positive inclination to PRS with a single, potentially controversial, statement. Drawing on experts’ statements found in the literature, I aimed to identify clinicians who feel instinctively positive about working with PRS, rather than feeling competent at it. This short statement seemed to have been efficient at identifying
those of the respondents whose natural inclination to PRS goes beyond the average benevolent professional stance.

The study is subject to the limitations inherent to self-report measures, such as the failure to identify, therefore report, processes involved. In this respect, future work could benefit from more verifiable assessment of CT, for instance, from video recordings of sessions, and independent assessment of patients’ diagnoses and suicide risk. However, using a quantitative method of analysis may have compensated for some of the shortcomings of self-report measures. Pooling hundreds of observations did reveal contradictions between different levels of observation (aggregate and individual levels), which allowed us to further our understanding of the data and propose novel interpretations.

Drawn from a volunteer sample, our findings might not be representative of the population of clinicians conducting treatment with PRS in NZ, or elsewhere. First, there were important discrepancies in recruitment methods between professional associations (some emailed their members personally while others published information in an e-newsletter attached to an email), which may have affected clinicians’ interest regardless of their profession. Second, clinicians volunteered their participation. In this sense, this sample might represent a sub-group of clinicians who are positively inclined to clinical suicidology enough, to take a 15-minute survey on the topic it in the first place. Replication of the study, controlling for clinicians’ and patients’ characteristics, as well as cultural context, is required to assess the relative influence of these confounding variables on the findings.

Furthermore, in commenting on differences found in level of endorsement between theoretical orientations, we must consider that clinicians might have interpreted the survey instructions differently depending on their orientation. I proposed that higher level of endorsement of CT demonstrated greater CT literacy. Overall, psychodynamically orientated (PDY) clinicians appeared more aware of hence more able to report their CT, which translated into higher level of endorsement. However, we need to consider that PDY clinicians might have been more prone to
report rather than more aware of CT responses. Indeed, psychodynamic trainings foster CT literacy and encourage CT disclosure in self-reflective practice. Conversely, CBT and ECL clinicians might have had the tendency to report the result of these processes, that is, the emotional responses once managed, rather than the process itself. Future study should aim to control this possible bias by being more specific in the instruction. For instance, rather than asking clinicians to report how they feel most of the time with the patient selected, it could ask specifically how they tend to feel before they manage their emotional responses. Additionally, the survey could ask clinicians if they find that their emotional responses sometimes compromise the therapeutic relationship, and if they feel generally successful at managing them with the patient selected.

Using existing items from the TRQ also created limitation as shown by the poor internal consistency of factor 6. However, I maintained factor 6 as it appeared consistently across extraction and rotation methods, as well as in PCA alternative results (used to refine each factor). This suggests that EFA picked up a dimension of CT that the TRQ current item list fails to describe thoroughly (Tavakol & Dennick, 2011). Further research is needed to design new statements able to grasp the notion only partially picked up by the ambivalent/inconsistent factor (factor 6). The need for new statements supports the idea that suicide risk elicits specific pattern of CT.

Finally, in comparing the relative importance of the seven factors, we must remember that the amount of correlation between factors can affect the TVE. Factor 2 is however uncorrelated with four of the other six factors, and only mildly negatively correlated with the other two, and hence may be considered to be an “almost independent” factor.

6.3 Implications

6.3.1 Indications for future research

The study needs replication to assess the reliability of our preliminary findings of a specific factor structure for the TRQ with PRS. Future work could use confirmatory
factor analysis (CFA) to assess the extent to which the model fit a new dataset. Prior to this however, the ambivalent/inconsistent subscale would need further development to enhance the applicability of the TRQ to PRS. New items reflecting ambivalent CT responses and inconsistent behaviours could be derived from the literature and added to the questionnaire. For instance, “sometimes I feel that I both like and dislike her at the same time”, “I experience mixed and sometimes even contradictory feelings towards him”, “I tend to sway from feeling disengaged or bored in sessions, to worrying about her/him between sessions”. Additionally, controlling for clinicians and therapy/treatment characteristics by referring to standardised assessments of patients’ psychopathology would increase internal and external validity of group comparisons. In the meantime, the significant differences in factor mean scores between groups presented here could be used as a baseline to formulate and test new hypotheses.

### 6.3.2 Implications for clinical practice

The TRQ has a high potential for testing clinically derived hypotheses. Yet, comparing personal scoring to a statistical norm is of limited value clinically. Instead, I encourage clinicians to use the TRQ as a template to explore their CT qualitatively, to help inform a diagnosis or analyse a difficult therapeutic relationship. Given that CT literacy helps repair rupture in the therapeutic relationship (Safran & Kraus, 2014), adopting the TRQ as a qualitative self-administered assessment tool could prove beneficial in assisting self-reflective practice (Davis, Thwaites, Freeston, & Bennett-Levy, 2015). In practice though, a shorter CT checklist would suit clinicians’ time constraints better. Future work could develop a CT-PRS checklist, for instance by deriving a small number of open-ended questions from each of the seven factors.

### 6.4 Conclusions

Clinicians treating patients at risk for suicide experienced predominantly feelings of inadequacy, hopelessness and entrapment, which mirror well-established aspects of the suicidal state. Despite being the most common however (i.e. the factor
representing by far the most variance in aggregate), entrapped/rejecting responses were, on average, only mildly endorsed by clinicians. Conversely, fulfilled/engaging responses, the only positively connoted factor, were the most readily endorsed by clinicians in spite of being less representative in aggregate.

Referring to Maltsberger and Buie's psychodynamic formulation (1974), one could speculate that this combination of CT patterns indicate the pervasiveness of defence mechanisms among clinicians. Alternatively, I propose that there is greater evidence to suggest that this specific CT combination reflects an adaptative, and possibly necessary, coping stance or strategy, that I call a CT montage. Such CT montage could foster connectedness through experiencing aspects of the suicidal state at an implicit level, while preserving the ability to engage therapeutically despite the suicidal risk perceived. Considering differences in levels of endorsement by inclination groups tipped the balance in favour of this second interpretation. That is, consistent with the hypothesis of a CT montage, positively inclined clinicians responses appeared more consistent with greater CT management skills, as well as a higher level of positive CT to PRS, than non-positively inclined clinicians did.

While further research is required to establish the validity of this proposition, these preliminary findings provide novel initial insights into complex relational dialectics between clinicians and their suicidal patients.

In conclusion, study 1 produced an empirically derived model of CT to PRS, which offers a rich portrait of clinicians’ emotional responses to their suicidal patients. As intended, study 1 also provided an estimation of the prevalence of positive inclination to PRS among a non-probability sample of clinicians who volunteered their participation to a survey about clinical suicidology. Finally, the survey gathered positively inclined clinicians’ consent to be contacted about the second study. This subsequent study addresses the main research question of the project by seeking to gain an understanding of clinicians’ positive inclination to PRS.
6.5 Summary

This chapter summarised the findings for study 1 before arguing in favour of their interpretation as a CT montage. This interpretation suggests that clinicians could implement a CT montage that serves their clinical endeavours. Moreover, this study supported the hypothesis that only a minority of clinicians feel positively inclined toward PRS, and was successful at identifying and recruiting them for the second study. After examining the study’s strengths and limitations, the chapter provided indications for future research and clinical practice. The following chapter introduces and presents the method for the project’s second study.
Part III
Idiographic approach
Grounded theory study
Chapter 7
Study 2 Method

The nomothetic study found that just under 15% of clinicians in a NZ sample would declare that, overall, they like working with suicidal patients. This chapter introduces and presents the methods for the subsequent study of the project, designed to probe this evidence further. Study 2 aimed to gain an idiographic understanding as to why these clinicians like doing what the vast majority finds challenging, and to learn from them.

7.1 Introduction

As discussed in chapter 2, establishing and maintaining a therapeutic relationship that fosters a collaborative work between patients and clinicians is critical to achieving positive treatment outcomes with PRS (Konrad, 2011; Malsberger, 2001; Michel & Jobes, 2011). However, PRS can be difficult to treat. First, the topic of suicide itself tends to elicit latent emotions in people, including clinicians. Second, PRS’ ambivalence towards the treatment and the person of the clinician tend to trigger negative CT responses. The clinical literature indicates unequivocally that unattended CT responses can lead to counter-therapeutic behaviours, which can

have lethal consequences in the case of PRS. This demand of high vigilance regarding CT literacy makes clinical suicidology a particularly challenging practice.

On the other hand, positive feelings of closeness and affiliation are empirically associated with better outcomes in therapy. Given the necessity for a collaborative approach to treatment with PRS (Joiner et al., 2009b; Michel & Jobes, 2011), there are reasons to assume that positive feelings of closeness and affiliation, called here positive inclination, would be associated with better outcomes with PRS too. However, clinicians’ positive inclination to patients is rarely studied in relation to PRS. Furthermore, expert authors’ statements found in the literature, which describe the optimal stance with PRS as one of warm engagement that extends beyond the usual professional way of relating to patients (see Chapter 2, section 2.5.3), invite to consider that there could be value in studying the stance of positively inclined clinicians.

As anticipated, study 1 suggested that positive inclination to PRS was underrepresented in a sample of clinicians who volunteered their participation to a study about clinical suicidology. Furthermore, the study supported that the notion of competence and positive inclination were not equivalent. Indeed, while close to 80% of the sample (78.2%) felt that their level of competence allowed them to care for PRS, less than 15% (14.7%) deemed true that they liked working with PRS. Finally, study 1 showed that positively inclined clinicians endorsed higher levels of positively connoted CT, and lower levels of entrapped/rejecting and protective/overinvolved CT responses, which suggested that they could be more efficient at managing CT responses.

That a minority of clinicians would navigate the challenges inherent to clinical suicidology to the point of liking their practice is remarkable. The present research aimed to understand the underlying processes allowing clinicians to feel positively inclined despite the risk of suicide, in order to derive novel clinical insights pertaining to clinicians and suicidal patients in the clinical situation.
The present study proposed to advance knowledge in clinical suicidology by exploring the stance of the minority of clinicians who feel positively inclined towards PRS. To my knowledge, this work is the first to adopt the specific perspective which consists of examining the clinical encounter with PRS through the lenses of positively inclined clinicians.

7.2 Research questions

7.2.1 Primary research question

The primary research question for study 2 was:

1) For the minority of clinicians who reported liking working with PRS, why do they like it?

7.2.2 Secondary research questions

A set of exploratory secondary research questions followed from this primary question:

2a) What are clinicians’ subjective experiences of feeling positively inclined towards PRS?

2b) Does clinicians’ positive inclination to PRS affect their therapeutic stance (attitudes and ways of relating to PRS), and if so, in what ways?

2c) Does understanding clinicians’ positive inclination provide novel and helpful clinical wisdom pertaining to clinicians and suicidal patients in the clinical situation?

7.3 Toward a research method for study 2

Given the paucity of the literature on the topic, I resorted to investigate the question qualitatively by learning from positively inclined clinicians themselves.
7.3.1 Navigating explicit biases

The introduction chapter mentioned that the impetus for the present work goes back to my 4th year of study, in 2007-2008 (see Chapter 1, section 1.1). Since then, I graduated as a clinical psychologist in France, and practiced for a few years. I reflected on my preconceptions about clinicians’ positive inclination to PRS at the beginning of this project (see Chapter 3, section 3.3.1). However, after conducting study 1, I reviewed these preconceptions upon entering this qualitative phase of the project.

Some of my biases stemmed from conducting my masters research paper in France. The study consisted of the case study of a therapist who had chosen to work in a suicide prevention centre (France) (see Chapter 1, section 1.1). As years went by, and I furthered my observations as a practising clinician myself, I started gauging more fully the possible significance of these findings. I drew from the psychodynamic meta-psychology to conjecture on the reasons and possible consequences of clinicians’ positive inclination to PRS. More recently, my views and preconceptions developed from reviewing the literature for this project, and from conducting study 1. I laid down in memo-writing these preconceptions before starting data collection for the present study (see Appendix XI).

This preemptive reflective work highlighted the need to decide upon a method of investigation that would allow me to collect and analyse qualitative data while navigating my explicit biases. This was of heightened importance since the clinicians interviewed would be likely to refer to different theoretical frameworks from mine. Specifically, psychodynamic orientations tend to be discounted in training of psychologists in NZ. The method would need to help avoid imposing my preconceptions on the data unknowingly.

Conducting the present project in a country with a different training culture from mine pressed me to consider my research from an atheoretical, hence transtheoretical, standpoint. As Feyerabend proposed, predetermined theoretical
frameworks tend to constrain the creation of knowledge. Within a given theoretical framework indeed, what does not fit the model tends to be disregarded to promote theoretical coherence (Feyerabend, 1975). Yet, a theoretical framework is only a conceptual apparatus constructed to frame, represent and make sense of phenomena. My position draws on critical realism to propose that examining different representations of the same phenomenon could help fathom its reality further (see Chapter 3, section 3.2.2).

Second, my epistemological stance is one of post-positivism. Chapter 3 showed that, in my view, the quantitative/qualitative divide happens merely at the epistemic level. In principle, a positivist project can rely on qualitative evidence. Accordingly, this study did not seek to learn from clinicians’ subjective experience in an interpretative way. This work aimed instead to look for commonalities between clinicians’ subjective experiences to construct an understanding of clinicians’ positive inclination to PRS. Within the limitations inherent to qualitative research, the study aimed to produce clinical knowledge that would be transferable to other clinicians. In line with the critical realistic meta-theory, this study aimed to develop an explanatory model that comes as close as possible to the reality of the structures engendering positive inclination to PRS considered as a phenomenon (see Chapter 3, section 3.2).

7.3.2 Deciding upon a qualitative method

To avoid imposing a theoretical framework onto the data a priori, I discounted qualitative methods that stem directly from a theoretical framework (Willig & Stainton-Rogers, 2008). This concerns most qualitative methods of investigation, including ethnography, action research, conversation analysis, discourse analysis, narrative analysis, phenomenological research, etc.

This narrowed the possibilities down to thematic analysis and grounded theory (Braun & Clarke, 2006; Charmaz, 2006b). My epistemic posture inclined me to believe that, as long as I was the person conducting the research, each would
produce very similar results. However, I favoured grounded theory, due to its iterative nature that makes it particularly suited to develop an explanatory model about a phenomenon (Creswell, 2013).

Indeed, planning to work with qualitative data can be daunting. Yet, the grounded theory method (GTM) offers a systematic way to approaching qualitative data that provides a methodological frame while promoting flexibility. Furthermore, the constructivist approach to GTM provides guidance around navigating one’s biases explicitly by making them part of the research process (Charmaz, 2006b). Finally, the notion of ‘theoretical agnosticism’ advanced by Charmaz appeared to be a good fit for my epistemological posture. GTM suits a post-positivist critical realistic approach to knowledge. For these reasons, I decided to undertake study 2 using a constructivist approach to GTM (Bryant, 2017c; Creswell, 2013).

7.4 The Grounded Theory Method

Glaser and Strauss introduced the method of grounded theory in 1967 (Glaser & Strauss, 1967). According to Glaser, the methodology textbook was written in response to the inquiry about how they conducted the research for their book ‘awareness of dying’ (Glaser, 1998c; Glaser & Strauss, 1965).

The grounded theory method (GTM) emerged at the interface of Strauss’ pragmatism at the Chicago school of sociology, and Glaser’ positivism at Columbia University (Bryant, 2017a; Charmaz, 2006a). It was first proposed as a systematic method of doing qualitative research that competed, in terms of scientific rigour, with quantitative approaches that dominated research at the time (Glaser & Strauss, 1967).

The authors also aimed to offer an alternative to ‘verificationism’. Indeed, by mid-century, most social research consisted of verifying extant ‘grand’ theories such as those of Marx or Durkheim (Bryant, 2017a). Instead, Glaser and Strauss encouraged researchers to develop their own middle-range explanatory theories. They developed GMT as a systematic way to do so (Charmaz, 2006a). As Glaser who does
not sugarcoat his statements wrote, “grounded theory is not designed to honour and verify a pet concept of a well-known theoretical capitalist” (Glaser, 1998a, p. 13).

7.4.1 Basic principles

GTM comprises a set of tools that provide a rigorous yet flexible methodological framework to generate explanatory middle-ground theory from qualitative data. I give an overview of key characteristics of GTM below.

Constant comparative method

GTM relies on the constant comparative method. Researchers ground their work in the data by comparing constantly their emerging ideas with the data itself. They compare codes with codes, codes with new and previous data, categories with data, categories with new and previous codes, and so on. This way of going back and forth between data and analytical developments to compare them constantly, not against extant principles and theories, but against themselves, is what confers trustworthiness to the theory generated (Glaser & Strauss, 1967).

Iterative data collection and analysis

One essential feature of GTM is therefore that data collection and analysis are conducted iteratively. To generate explanatory theories grounded in data, researchers go back to the data in a systematic way as they develop their ideas. The method proposes a set of tools to achieve this aim (e.g. memo writing, diagramming). The researcher collects data, analyses it, before collecting more data to further the analysis. Making data collection and analysis an iterative process prevents straying away from the content of the data.

Coding & categorising
In GTM, coding is very much a way to engage with the data. Codes or themes are not created pre-emptively to test theoretical hypotheses. Researchers create codes as they read the raw data instead. For this reason, GTM describes codes as being “emergent”. In the early stages, the idea is to move quickly through the data to promote “spontaneity” and candour (Bryant, 2017b; Charmaz, 2006b, p. 48).

Charmaz describes coding as the “pivotal link between collecting data and developing an emergent theory to explain these data” (Charmaz, 2006b, p. 46). Coding is an evolving process that moves from a systematic descriptive level (initial coding), to a conceptual one (focused coding), through several iterations. During the initial coding phase, Glaser invited to use gerunds to promote theoretical sensitivity. Gerunds are verbal nouns (e.g. “thinking” is the gerund of “to think”). By putting an emphasis on processes rather than on finished actions, gerunds promote an engagement with the data by inducing a sense of affiliation with the narrator's perspective (Charmaz, 2006b, p. 136).

Ultimately, codes are grouped into categories, which eventually are turned into concepts. More specifically, codes that have an “overriding significance or abstracting common themes” are grouped together into categories (Bryant, 2017b). The researcher then tries to define the category’s properties, i.e. the conditions under which it operates and changes, and studies its relation to other categories. Categorising is a process of abstraction that turns codes into concepts. “Grounded theorists make their most significant theoretical categories into the concepts or their theory” (See glossary of Charmaz, 2006b).

According to Glaser, a core conceptual category, or core index, is usually found to organize the data in regards to the research question (Glaser & Strauss, 1967). An explanatory theory is woven by describing the categories emerging from the data, and examining their relationship to one another and to the core category. By this stage, the researcher is constructing an explanatory theory in response to his/her question. The analysis is said to have moved “beyond the data” (Bryant, 2017d).
**Theory developing**

The development or generation of new theories is the aim of the GTM. However, the concept of theory itself differs depending on the epistemological paradigm adopted. GTM as a method is atheoretical in nature so that it can be used in different paradigms. In a positivist paradigm, GTM will aim to develop possible explanations for a given phenomenon and explore the relationships between different variables. In an interpretivist paradigm, GTM will aim to understand the subjective meaning of an experience for the participants. Either way, as Charmaz proposes, theorising is a practice that entails “engaging the world and [...] constructing an abstract understanding about and within it” (Charmaz, 2014, p. 128). Theorising is essentially proposing a representation or a conceptualising of reality.

**Theoretical saturation**

In GTM, theoretical saturation can theoretically supersede sample size (Glaser, 1998b). In a study of 60 in-depth interviews, monitoring the degree of saturation, it was found that data saturation was reached after 12 interviews, and that basic elements of all categories were already present after 6 (Guest, Bunce, & Johnson, 2006).

According to Glaser and Strauss, “saturation means that no additional data are being found whereby the sociologist can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated” (Glaser & Strauss, 1967, p. 61). Saturation is reached when, regarding the research question, new data provides new instances of extant categories rather than generating “new theoretical insight” (Charmaz, 2014, p. 113).

**Memo-writing**
Memo-writing, or “memoing”, corresponds to the formalisation of field notes taking found traditionally in qualitative research. Over the years, the act of reflecting and writing about the data, even before starting data collection, has been integrated to GTM to become an essential analytic tool. The two main functions of memo-writing are to foster engagement with the data from an early stage, and to keep a record of the researcher’s train of thoughts in relation to the study. In the constructivist approach of GTM, memo-writing also provides a useful platform for researchers to keep track of their influence on the analysis, and on the development of knowledge.

**Theoretical sampling**

Put simply, theoretical sampling consists of collecting the data that is most likely to advance the study regarding answering the research question. Charmaz frames theoretical sampling as “seeking pertinent data to develop [an] emerging theory” (Charmaz, 2006b, p. 96). One of the central tenets of GTM ensuing from aiming to generate theories grounded in data, is that the method needs to “allow for the unexpected” (Bryant, 2017e, p. 14). Theoretical sampling corresponds to the methodological formalisation of this need.

To remain open to the data and to ground any advancement in the data itself, the methods used (e.g. sampling methods, types of data collected) are amenable to change throughout the research process. Researchers amend the design of their study as they go to further their understanding of the phenomenon studied. For instance, a phase of analysis can generate the need to conduct additional interviews with the same participants, to sample new participants or to gather a different type of data.

**Theoretical agnosticism**

Originally, Glaser and Strauss recommended leaving the literature search until after the analysis was complete (Glaser & Strauss, 1967). The main reason for this was to avoid imposing extant theories onto the data unknowingly.
In Glaser and Strauss’ view, casting preconceptions aside was largely possible and recommended (Glaser & Strauss, 1967). However, epistemology has evolved to consider the researcher as an inherent part of the process. This more contemporary view, referred to as constructivism, substitutes a wish for objectivism with one for transparency. Research is a human activity that is eminently subjective. In this context, although striving for objectivity is acceptable, wishing to be bias-free is however chimerical. Referring to the researcher as a *tabula inscripta* rather than a *tabula rasa*, constructivists advocate for a reflexive stance towards the research process (Bryant, 2017c).

Charmaz posits that GTM “[...] contains correctives that reduce the likelihood that researchers merely superimpose their preconceived notions on the data [...]” (Charmaz, 2006b, p. 51). Starting by coding line by line in a systematic way is one of them. The constant comparative method is another one. Rather than an atheoretical position, Charmaz defends Henwood and Pidgeon’s stance of ‘theoretical agnosticism’ (Charmaz, 2006b, p. 165; Henwood & Pidgeon, 2003). While it is not possible to be free of knowledge upon encountering the data, Henwood and Pidgeon encourage to focus on the creative aspect of the early stages of a study, by observing the greatest flexibility in coding and designing categories (Henwood & Pidgeon, 2003).

### 7.4.2 Different approaches to GTM

Over the years, Glaser and Strauss’ perspectives on GTM started diverging, so that different approaches to grounded theory exist today. Charmaz summarised the different directions taken as follows. Glaser remained the closest to the original formulation of grounded theory. He is consistent in conceiving GTM as a method of discovery, considers that categories emerge from the data, and relies on empiricism. In contrast, Strauss, who passed in 1996, had strayed apart along his career. With Corbin as a co-author, he moved GTM in the direction of verification (Charmaz, 2006a).
In a publication endorsed by Glaser (Glaser, 1998b), Rennie argued that the disagreement between Strauss and Glaser was epistemological in nature. While Glaser insisted that GTM consists merely of an inductive process, Strauss and Corbin espoused a posture of instrumentalism to use GTM in the hypothetico-deductivist framework, hence using a deduction process. It has been argued that, although Glaser remained epistemologically closer to the original aim of the method, neither his nor Strauss’ positions were ultimately sustainable (Rennie, 1998).

Charmaz and colleagues have developed a constructivist approach that moves GTM away from positivism without embracing entirely interpretivism. Charmaz explains that “[…] a constructivist approach places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data” (Charmaz, 2006b, p. 130). In contrast to both deduction, which argues from the general to the particular, and induction, which argues instead from the particular to the general (Bryant, 2017c), constructivism calls for a method of abduction, which “entertains all possible explanations for the observed data” (Charmaz, 2006b, p. 186). Referring Peirce’s work, Reichertz explains that abduction entails a cognitive process of mind wandering, rather than an explicit process of reasoning explicitly:

Abductive inferencing is, rather, an attitude towards data and towards one’s own knowledge: data are to be taken seriously, and the validity of previously developed knowledge is to be queried. It is a state of preparedness for being taken unprepared. (Reichertz, 2007, p. 9)

Abduction proceeds by mental leaps that brings about surprise to the researcher. It consists of a “cognitive logic of discovery” (Reichertz, 2007, p. 7).

Bryant invited to consider these differences as developments of a method in different directions, rather than antagonistic division (Bryant, 2017f). Methodological divergences prove that the method can be used in different epistemological paradigms. As Charmaz stressed, GTM guidelines are essentially
epistemologically neutral (Charmaz, 2006b). In this sense, GTM presented both the rigour and the flexibility I needed to carry out this study.

7.4.3 Approach adopted for this study

Given the paucity of literature on the topic of clinicians’ positive inclination to PRS, I needed a method that allowed for an exploratory stance. My goal was therefore in line with the claim of GTM.

Yet, I aimed to notice the commonalities between individual accounts. I was not interested in developing case studies of what liking working with suicidal meant for each participant, which a narrative approach could have achieved. Instead, I hoped to construct an explanatory model of clinicians’ positive inclination to PRS, to which all participants would relate. Ideally, an answer that could be generalizable to the practice of clinical suicidology. In this sense, akin to that of Glaser, my posture was one of positivism. I assumed that there should be a reason why only a minority of clinicians like working with PRS. The study aimed to understand this reason, or provide ground to formulate hypotheses about it.

Nonetheless, I did think that, as a researcher working with qualitative data, I would co-create the forms that this answer would take. I would not alter the nature of the phenomenon, since I believe that its nature is distinct from my ability to comprehend or represent it (see Chapter 3, section 3.2). However, my conceptual construction of the phenomenon will necessarily bear the mark of my subjectivity. In this sense, my posture moved towards one of post-positivism that embraces constructivism. To navigate my biases in relation to the study, my preconceptions need to be “articulated, confronted, and addressed rather than being swept aside [...]” (Bryant, 2017e, p. 8). Yet, I concur with constructivism at an epistemological level. My subjectivity taints the transient concepts I develop to represent the intransient world.
7.5 Methods & procedures

The study used a constructivist approach to grounded theory to construct an understanding of clinicians’ positive inclination to PRS from interview data.

7.5.1 Participants

Since study 1 acted as a recruitment tool for study 2, I intentionally matched participants’ selection criteria with those of study 1. To participate, clinicians needed to be a NZ registered psychiatrist, psychologist or psychotherapist, currently holding a practicing certificate.

Additionally, to participate in study 2, participants needed to feel positively inclined towards PRS. Clinicians needed to feel that overall, they ‘like’ working with suicidal patients.

7.5.2 Recruitment

Potential participants were identified with the national survey (study 1). All clinicians who rated the like-statement very true or true were invited to receive information about study 2. Of the 39 clinicians who endorsed the like-statement, 29 consented to be contacted about study 2, including 9 psychiatrists, 16 psychologists and 4 psychotherapists. I sent information about the study and a consent form directly to each of these 29 participants, using the email address they provided in the survey.

Based on empirical findings which suggested that data saturation can be reached after 12 interviews, and that basic elements of all categories are usually present after 6 (Guest et al., 2006), I anticipated that interviewing 10 to 20 participants should suffice to reach data saturation regarding the research questions.
7.5.3 Interview method

I listened to clinicians in semi-structured interviews of 90 minutes. To stay open to emergent data, the study design included a potential second interview.

Online interview

For convenience, I accommodated time and resource constraints by conducting interviews remotely online. Despite their limitations, online communication tools offer recognised and accepted potential for research (Janghorban, Roudsari, & Taghipour, 2014; Markham & Baym, 2009; Sullivan, 2012). Given the characteristics of the study participants, educated professionals and technically knowledgeable (i.e. took a survey online, communicate me their email address), I assumed that they would be able to use a video conferencing application online with minimal instructions.

I favoured Zoom® video conferencing to conduct interviews online. Although a 100% confidentiality is never guaranteed, Zoom® offers an end-to-end encryption that provides an additional layer of security. Additionally, Zoom® has an in-built recorder that includes a live notification to the participant. Finally, it records video and audio files separately, locally, on the computer used for the call. In my case, I used the video to help build a rapport with participants but destroyed the video file after each interview for I did not use it for the analysis. Audio files were destroyed after all interviews were transcribed and anonymised.

For the purpose of the study, I substituted participants’ names with pseudonyms generated randomly online.

For this second study, I did not offer participants any payment or reward. I considered that their willingness to participate merely to advance knowledge in the area would be further evidence of their positive inclination to clinical suicidology.

Interview style
I adopted an open-ended style of interviewing, which encouraged free association of ideas. I also invited clinicians to discuss the questions themselves, which helped me to reflect further on my own biases.

Being a clinician myself could have interfered with the posture I aimed to adopt to conduct research interviews (Hay-Smith, Brown, Anderson, & Treharne, 2016). However, in the present case, probably because participants were clinicians themselves, I did not feel like I had dual roles of clinician-researcher/patient-participant to navigate.

**Initial interview schedule**

The initial interview schedule was designed with the help of an adviser with expertise in GTM.

Given the lack of literature on the topic of clinicians’ positive inclination to PRS, it was agreed to enter data collection with a succinct set of questions, from which we would draw in subsequent interviews. To ensure that the interview focused on the research questions, descriptive information was collected by means of a short survey that participants completed and returned by email before the interview. After I introduced myself and reiterated information about the study as well as participant’s rights, the interview started by an open question aimed to initiate rapport building as shown in the initial interview schedule presented in Table 7.1.

Table 7.1 Initial interview schedule for positively inclined clinicians

<table>
<thead>
<tr>
<th>Initial interview schedule – Group A (Interviews 1 to 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Can you tell me about your experience of working with suicidal patients?</td>
</tr>
<tr>
<td>2) In the survey you took last year, you reported that, overall, you like working with suicidal patients. Can you tell me more about that?</td>
</tr>
<tr>
<td>3) Do you think that your enjoyment, the fact that you like working with suicidal patients, affects the way you work with them, and if so, in what way?</td>
</tr>
<tr>
<td>4)</td>
</tr>
<tr>
<td>5)</td>
</tr>
<tr>
<td>6)</td>
</tr>
</tbody>
</table>

**Revised interview schedule – Groups B, C & D (Interviews 4 to 12)**

| 1) | How do you experience working with suicidal patients, or patients who might be at risk for suicide? |
| 2) | In the survey you took last year, you reported that, overall, you like working with suicidal patients. Can you tell me more about that? |
| 3) | Do you think that the fact that you “like” working with suicidal patients, has an impact on the way you work with suicidal patients; and if so, in what way? |
| 4) | What do you find most difficult or challenging still, with suicidal patients? |
| 5) | Fact: In the survey last year*, we asked: “overall, would you say that you like working with suicidal patients” which, of a sample of clinicians currently working with suicidal patients, 15% rated True (or Very True), including you; 40% rated “Somewhat True”, middle range; and 45% rated Not True (or Not True at All). What do you make of that? |
| 6) | If a clinician who struggles with suicidal patients, or who doesn’t like working with suicidal patients, came to you for advice, what would you say? |
| 7) | Is there anything else you would like to tell me before we conclude the interview? |
| 8) | May I ask you why you participated in the study? |

---


I tested the application for video-conferencing, including accessing the meeting online, sound, video, and recording features, in a short conversation realised on campus with a colleague.

Moreover, to test the interview style and the content of the initial interview schedule, I conducted a mock interview with an emergency nurse also involved in suicide research, and who likes working with PRS. The test-interviewee felt heard and found that the interview style fostered openness and genuineness. Further,
although professionally inclined towards self-reflective practice herself, the interviewee found that the prompts were thought-provoking in a constructive way.

The interview schedule was refined throughout the analysis, in line with grounded theory method (see table 7.1). An illustration of this process is presented in appendix XIII (p. 340).

### 7.5.4 Procedures

Clinicians were invited to participate, using the email contact details they provided in study 1. Clinicians found information about the study attached to the invitation email, as well as a consent form to complete and return, either as a hard copy (by airmail) or a scanned document (email).

After clinicians provided consent to participate, the interview was scheduled over emails. Subsequently, participants received the invitation to the Zoom® meeting in an email too. Participants had to complete and return a short descriptive survey before the interview (see appendix XII).

The interviews lasted up to 90 minutes. Upon concluding the main interview, participants were reminded that the study design included the possibility of a second interview that they remained free to decline.

I planned to conduct interviews in groups of three until reaching data saturation. Potential participants were informed that, depending on the course of the analysis, they may not be interviewed despite having consented to participate.

### 7.5.5 Qualitative analysis

In line with GTM, data was collected and analysed iteratively, in sequences of three interviews followed by a period of analysis. I transcribed and anonymised all interviews before either printing them to work on paper (initial coding), or importing them to a qualitative data analysis software. Ultimately, all data were
imported and coded in NVivo 11 qualitative data analysis software (QSR International Pty Ltd).

**Coding practices & constant comparative method**

The data was coded iteratively, from codes to categories to concepts, going from a descriptive to a conceptual approach that eventually moved beyond the data (Bryant, 2017b). The data was analysed following the constant comparative method (Charmaz, 2006b).

The initial coding moved quickly through the data, coding line-by-line using gerunds. This process ensured that codes were emergent, that is, that they consisted in a description of the data rather than an attribution of pre-determined codes (Charmaz, 2006b). After a set of themes appeared to me, I conducted focused coding using them on new data and on previous interviews. This involved reading and coding the data several times successively to refine each category and understand their characteristics and relationship to one another, by comparing them with previous and new data. In the latest stages of the study, categories had evolved into the concepts of an explanatory model of clinicians’ positive inclination to PRS.

**Memo-writing and diagramming**

I used memo-writing and diagramming as analytical tools throughout the analysis. I started to use memo-writing before I undertook data collection to reflect on the research process in relation to my preconceptions (see Appendix XI). Diagramming was used early on in the process and throughout the analysis to understand the relationships between categories until they could be integrated into a coherent model.

**Trustworthiness**

The study promoted trustworthiness in two ways. First, another rater coded half of the data, either the GTM advisor for the study or a supervisor. The three of us met
in three meetings held at key points of the analysis to compare and discuss emergent codes, categories and concepts. Second, I presented the preliminary findings from the two first groups of interviewees directly to new participants for feedback.

7.6 Summary

This chapter introduced and presented the methods for study 2. I used a constructivist approach to the grounded theory method to develop an explanatory model of positive inclination to PRS. The following chapter presents the study findings.
Chapter 8
Study 2 Findings

Something unintelligible is discovered in the data and, on the basis of the mental design of a new rule, the rule is discovered or invented and, simultaneously, it becomes clear what the case is. The logical form of this operation is that of abduction. Here one has decided (with whatever degree of awareness and for whatever reason) no longer to adhere to the conventional view of things.\textsuperscript{12}

This chapter presents the findings for study 2. By a process of abduction, the study placed clinicians’ experience of forming a deep emotional connection with PRS at the core of the clinical encounter, which I named an “aroha connection”. The aroha connection appeared as the core category in the data for all other categories stemmed from, or made sense in relation to it. Describing these categories and the relations between them led to designing an explanatory model of clinicians’ positive inclination to PRS, which is simultaneously a conceptualisation of the processes involved in PRS’ improvement in treatment. This chapter describes the sample of participants before presenting the aroha model in four parts: the aroha connection itself, clinicians and patients’ role in the interaction, and possible outcomes. Appendix XIII presents an illustration of the analytic process which led to identifying the “connection” as the core category in these data.

8.1 Participants

I interviewed 12 clinicians in total (see Figure 8.1). Nine participants were recruited through study 1 as originally intended. These nine participants were part of the 29 clinicians who consented in the survey pre-emptively to be sent information about a second study.

However, recruiting participants proved challenging and most professionals declined the invitation to participate in a longer interview. Consequently, three additional participants were recruited from the network of existing participants using a snowball sampling method (see Figure 8.1).
Figure 8.1 Flowchart of participant recruitment for study 2

8.1.1 Personal characteristics

The 12 participants included two psychiatrists (two females), five clinical psychologists (four female, one male) and five psychotherapists (four female, one male). Using NZ current census ethnicity classification, two clinicians identified as
both Māori and NZ European, eight as NZ European, one as African European and one as European (see Table 8.1).

8.1.2 Professional characteristics

All but one participant had over 11 years of experience. All clinicians worked over 11 hours of face-to-face consultation with patients per week; except for one clinician whose supervision activities had become predominant over the years. Six worked in private settings, four in public settings and two in both types of settings. In terms of their primary theoretical orientation, clinicians referred to a variety of theoretical frameworks. In this sample, all psychotherapists trained within the insight based paradigm of psychotherapy. Within this paradigm, they referred to a range of theoretical frameworks such as transactional analysis, psychodynamic, psychoanalysis, psychodrama and gestalt. All clinical psychologists trained in NZ with a learning based paradigm. Most of them furthered their training during their career. They referred to a range of theoretical framework too, including DBT, ACT and mindfulness. One clinical psychologist also referred to psychodynamic theories. The two psychiatrists reported referring to an eclectic range of theoretical frameworks, including the bio-psycho-social model, resource based therapies, but also DBT and attachment theory (see Table 8.1).

8.1.3 Experience of patients lost to suicide

In the short descriptive survey preceding the interview, we asked clinicians whether they “considered” that they had lost patients to suicide. Of the twelve clinicians interviewed, eight reported that they had lost between one to over ten patients to suicide. However, clinicians pointed out that this was not a straightforward question to answer as who counted as a “patient” was complex.
<table>
<thead>
<tr>
<th>Group Interview</th>
<th>Name</th>
<th>Recruitment method</th>
<th>Profession</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Location</th>
<th>Work setting</th>
<th>Primary theoretical orientation</th>
<th>Experience in years</th>
<th>Average hours with patients per week</th>
<th>Patient suicided</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Eliza</td>
<td>National survey</td>
<td>Psychotherapist</td>
<td>F</td>
<td>European</td>
<td>SI</td>
<td>Private</td>
<td>Transactional Analysis</td>
<td>&gt; 11</td>
<td>5 to 10</td>
<td>0</td>
</tr>
<tr>
<td>A2</td>
<td>Adelia</td>
<td>National survey</td>
<td>Psychotherapist</td>
<td>F</td>
<td>NZ European</td>
<td>NI</td>
<td>Private</td>
<td>Psychodynamic</td>
<td>&gt; 11</td>
<td>&gt; 15</td>
<td>34</td>
</tr>
<tr>
<td>A3</td>
<td>Natalia</td>
<td>National survey</td>
<td>Clinical psychologist</td>
<td>F</td>
<td>NZ European</td>
<td>SI</td>
<td>Public</td>
<td>ACT (trained in CBT)</td>
<td>&gt; 11</td>
<td>11 to 15</td>
<td>2</td>
</tr>
<tr>
<td>B1</td>
<td>Landon</td>
<td>National survey</td>
<td>Psychotherapist</td>
<td>M</td>
<td>NZ European</td>
<td>SI</td>
<td>Private</td>
<td>Psychodynamic</td>
<td>&gt; 11</td>
<td>&gt; 15</td>
<td>1</td>
</tr>
<tr>
<td>B2</td>
<td>Nolan</td>
<td>National survey</td>
<td>Psychologist</td>
<td>M</td>
<td>NZ European</td>
<td>NI</td>
<td>Both</td>
<td>Contextual Behavioural sciences – (ACT)</td>
<td>&gt; 11</td>
<td>11 to 15</td>
<td>2 &quot;one in treatment and one a few years later&quot;</td>
</tr>
<tr>
<td>B3</td>
<td>Hassie</td>
<td>National survey</td>
<td>Psychiatrist</td>
<td>F</td>
<td>NZ European</td>
<td>NI</td>
<td>Public</td>
<td>Resource based therapies</td>
<td>&gt; 11</td>
<td>&gt; 15</td>
<td>3 &quot;while under my care&quot;</td>
</tr>
<tr>
<td>B4</td>
<td>Oceane</td>
<td>National survey</td>
<td>Clinical psychologist</td>
<td>F</td>
<td>NZ European</td>
<td>NI</td>
<td>Public</td>
<td>Eclectic</td>
<td>&gt; 11</td>
<td>11 to 15</td>
<td>Not sure &quot;first one in 1999&quot;</td>
</tr>
<tr>
<td>C1</td>
<td>Paige</td>
<td>National survey</td>
<td>Psychiatrist</td>
<td>F</td>
<td>African European</td>
<td>NI</td>
<td>Public</td>
<td>Eclectic</td>
<td>&gt; 11</td>
<td>11 to 15</td>
<td>&gt; 10</td>
</tr>
<tr>
<td>C2</td>
<td>Bernice</td>
<td>National survey</td>
<td>Clinical psychologist</td>
<td>F</td>
<td>NZ European – Maori</td>
<td>NI</td>
<td>Private (clinic)</td>
<td>CBT</td>
<td>&lt; 5</td>
<td>11 to 15</td>
<td>0</td>
</tr>
<tr>
<td>C3</td>
<td>Renee</td>
<td>Snowball</td>
<td>Psychotherapist</td>
<td>F</td>
<td>NZ European</td>
<td>SI</td>
<td>Private</td>
<td>Psychodrama</td>
<td>&gt; 11</td>
<td>11 to 15</td>
<td>0</td>
</tr>
<tr>
<td>C4</td>
<td>Donna</td>
<td>Snowball</td>
<td>Psychotherapist</td>
<td>F</td>
<td>NZ European – Maori</td>
<td>SI</td>
<td>Private</td>
<td>Psychodynamic/Gestalt</td>
<td>&gt; 11</td>
<td>11 to 15</td>
<td>2</td>
</tr>
<tr>
<td>D1</td>
<td>Linnett</td>
<td>Snowball</td>
<td>Clinical psychologist</td>
<td>F</td>
<td>NZ European</td>
<td>NI</td>
<td>Public</td>
<td>Eclectic</td>
<td>&gt; 11</td>
<td>11 to 15</td>
<td>0 &quot;Not a current client&quot;</td>
</tr>
</tbody>
</table>

*SI stands for South Island of NZ, *NI stands for North Island of NZ
8.1.4 Localisation of participants & mode of interviewing

Incidentally, six clinicians were located in the South Island, and six in the North Island of New Zealand. Eleven of the clinicians participated in interviews remotely, and one participated in a face-to-face interview.

Remote interviewing \((n = 11)\) was carried out with both audio and video in five cases. In three cases, a poor internet connection led us to stop the video, at least partially, to increase the quality of the audio connection. For the remaining three, the interviewee did not manage to get their camera to work, or did not like using it. In these last cases, interviews were conducted with audio connection only.

Figure 8.2 Localisation of participants in NZ
8.2 The aroha\textsuperscript{13} model

At the core of clinicians’ encounter with PRS, I found clinicians’ experience of forming a deep emotional connection with their patients. This connection, which I named an \textit{aroha connection}, consisted of an interpersonal regulation of emotion resulting in a state of emotional synchrony between clinicians and patients. This state of emotional synchrony appeared to be both soothing for patients and satisfying for clinicians. The therapeutic element of the interaction for patients was therefore simultaneously the rewarding element for clinicians.

This section details the aroha model starting by describing the aroha connection located at its core (i.e. core category); extends outwards to describe the role of each protagonist of the interaction, the aroha clinician and patient at risk; and finishes by identifying possible outcomes. The different elements of the aroha model, subheadings of this chapter, correspond to the main categories which emerged from the analysis. Each category can be further divided into subcategories as is made explicit in the text. These categories and subcategories are also presented in appendix XIII (See Table 1 p. 358). Aspects of the model are illustrated with excerpts from interviews that refer to participants using pseudonyms generated randomly online.

\textsuperscript{13} In Te reo Māori, “aroha” means love, compassion and the essence of life, which is to breathe life into someone.
Figure 8.3 Aroha model
8.2.1 Aroha connection

This section describes the aroha connection found nested at the heart of the model, by distinguishing ontological (i.e. what it is), phenomenological (i.e. how clinicians experience it), and epistemological aspects (i.e. what clinicians know or understand of it). The section finishes by presenting a rationale for adopting this specific terminology.
Figure 8.4 The aroha connection
8.2.1.1 Ontological aspects: Implicit & interpersonal

The aroha connection appeared in the negative space of the data\textsuperscript{14}. This means that clinicians’ narratives circled around what they considered to be the core element of the clinical encounter with PRS—this narrative being universally difficult for participants to articulate initially. This connection was described as an experience that occurs between individuals, and as such, it may stand largely outside of conscious awareness. Therefore the two main ontological characteristics of the aroha connection were to be implicit and interpersonal.

As the participants spoke freely about their practice with PRS, they often referred to the experience of an implicit, i.e. non-verbal, way of connecting with their patients, and of “sensing” them. However, this “sensing” was never the main point they were making. Instead, references to this connection appeared at the border of their narrative, or as the last thing they mentioned when describing components required in treatment. They appeared to assume that this connection could not be valuable information. When invited to describe what this connection actually was, clinicians found themselves having difficulty articulating their experience in words.

Excerpt 1 - Ontological aspects – Implicit & interpersonal

\textbf{Natalia [Clinical psychologist]:} It’s interesting, how… I’m finding it interesting how hard I’m finding to put words on these processes.

Some interviewees assumed that a body of knowledge concerning this connection existed, but that they did not know of it. Adelia declared that she does not get “terribly theoretical about these things”. Bernice pointed out that she did not know

\textsuperscript{14}“Negative space is, quite simply, the space that surrounds an object in an image. Just as important as that object itself, negative space helps to define the boundaries of positive space and brings balance to a composition” definition retrieved from (Creative Bloq, 2018)
“the science behind it” but could see the positive effect it had on her patients. Perhaps precisely because they lacked the knowledge to frame their experience theoretically, interviewees tended to consider their reflections pertaining to this connection somehow improper within the scientific context of the study. They expressed the fear of coming across as irrational, hence unprofessional.

Excerpt 2 - Ontological aspects – Implicit & interpersonal

**Donna [Psychotherapist]**: I mean I... Am ... um... I don't [pause] I don't know how to put this. Well I do know how to put this into words. I don't know how to put it in words that won't have you think, I’m a... you know... a lunatic or something.

Other interviewees sounded confident in their conclusion that striving to convey this experience in words was of limited value, suggesting one has to live it to understand it truly.

Excerpt 3 - Ontological aspects – Implicit & interpersonal

**Oceane [Clinical psychologist]**: […] just doing what I can do. I can’t, I can’t really explain it very well. If you haven’t experienced it um, you might think I’m a bit mad but I’m just telling you how it appears to me.

Clinicians each had their own way of describing this experience. Apart from Landon and Linnett who alluded to neuroscience to rationalise their experience, interviewees referred to non-scientific or metaphysical terms and concepts. Paige referred to an “art” and a “dance”. Donna talked about a “flow of energy”, and about “auras” which she associated with her Māori heritage. Oceane referred to her “spirituality”, and described the experience as a “deep knowing that bypasses words”. Examples of terms used by participants are provided in Table 8.2.
Table 8.2 Clinicians' subjective description of the connection in their work with PRS

<table>
<thead>
<tr>
<th>Participant</th>
<th>Profession</th>
<th>Examples of terms used to describe the connection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oceane</td>
<td>Clinical Psychologist</td>
<td>“Spiritual”; “deep knowing which bypasses words”; “wise mind experience” (i.e. concept referring to patients’ ideal outcome state in DBT, applied here to the clinician’s stance); deep connection</td>
</tr>
<tr>
<td>Landon</td>
<td>Psychotherapist</td>
<td>“Limbic resonance”; “togetherness”; “attachment process”</td>
</tr>
<tr>
<td>Hassle</td>
<td>Psychiatrist</td>
<td>“Good connection”; “to feel the person”</td>
</tr>
<tr>
<td>Natalia</td>
<td>Clinical Psychologist</td>
<td>“Magic”; “connection”; “attachment process”</td>
</tr>
<tr>
<td>Linnett</td>
<td>Clinical Psychologist</td>
<td>“Human to human connection”; “empathic connection”; “deep and meaningful connection”; “warmth and connection”; “attachment”</td>
</tr>
<tr>
<td>Nolan</td>
<td>Clinical Psychologist</td>
<td>“Being human with human”; “compassion”</td>
</tr>
<tr>
<td>Paige</td>
<td>Psychiatrist</td>
<td>“Connection”; “fluid”; “elusive”; “an art”; “a dance”</td>
</tr>
<tr>
<td>Renee</td>
<td>Psychotherapist</td>
<td>“Connection”; “soft eye”; “sensing one”; “Tele” (i.e. psychodrama concept which refers to a flow of feeling, of energy between people in the present, which is either neutral, positive, negative or conflicted); “palpable”; “attachment”</td>
</tr>
<tr>
<td>Eliza</td>
<td>Psychotherapist</td>
<td>“Connection”; “Love”; “mutuality”</td>
</tr>
<tr>
<td>Donna</td>
<td>Psychotherapist</td>
<td>“Attunement”; “energy flow”; “auras”</td>
</tr>
<tr>
<td>Bernice</td>
<td>Clinical Psychologist</td>
<td>“Figuring out how to fit into someone’s world”; “sort of an attachment process”; “connection”; “vehicle of change”</td>
</tr>
<tr>
<td>Adelia</td>
<td>Psychotherapist</td>
<td>“Warm empathic connection”</td>
</tr>
</tbody>
</table>

The second fundamental characteristic of this phenomenon was to occur in the interpersonal realm. The aroha connection was described as happening at the interface of each protagonist’s world, in a phenomenological space where the two
subjectivities merge. For clinicians, this resulted in a sense of togetherness that stemmed from the clinical encounter.

Excerpt 4 - Ontological aspects – Implicit & interpersonal

Eliza [Psychotherapist]: [...] Again, it comes back to the relational aspect that it’s actually between us rather than, from one to the other. It’s not that this client tells me in so many words that you are trustworthy, it’s that we create something together that allows that mutuality to be there. And yeah, that’s very satisfying.

This sense of togetherness implied a symmetric rapport between two human beings, rather than a classical asymmetric one between a professional, holding a position of clinical knowledge, and a sufferer. Interviewees described this symmetric quality of rapport as being necessary to empathise effectively with the suicidal mind. In fact, a strong sense of identification with patients filtrated through clinicians’ narratives, which conveyed at times a merging of experiences. Interviewees’ tendency to slip from the third to the first personal pronoun when recounting their patients’ experience illustrated this strong identification on their part.

Excerpt 5 - Ontological aspects – Implicit & interpersonal

Eliza [Psychotherapist]: So in some ways, when things are very tough, people can put another foot in front of another foot, as long as they know that if it really becomes intolerable, I can kill myself.

8.2.1.2 Phenomenological aspects: Emotional attunement

Upon first encounter with the PRS, interviewees described striving to develop an emotional understanding of the other. Interviewees maintained that they could get to a point where they could feel what their patients are feeling, though they were not entirely sure how they were able to do this. Clinicians did note becoming emotionally attuned to the PRS, which they saw as generating a sense of a “deep
knowing” of the other’s emotional state. This emotional attunement appeared to be the cornerstone of the clinical encounter with PRS.

Excerpt 6 - Phenomenological aspects – Emotional attunement

Renee [Psychotherapist]: [...] I’ve got to explain this: I know, and you know, when you’re riding a horse or something like that, you have like soft eyes. So you’re taking things with your whole being rather than looking or listening. Yeah well, I think that’s how I take people in, more in, and not… sometimes I think I don’t listen particularly well because I’m taking the whole person, and their worthiness will stand out. And when I write things down later I’m surprised that I actually remembered what they said. There’s something about sort of sensing one. Yes.

Some interviewees alluded to this emotional attunement with reference to the emotions experienced, while others described it in terms of its physiological manifestations.

This emotional attunement included clinicians’ emotional experience of the clinical encounter mirroring that of the client.

Excerpt 7 - Phenomenological aspects – Emotional attunement

Tess [Interviewer]: How do you experience, subjectively, personally, conducting therapy with patients who might be at risk for suicide?

Nolan [Clinical psychologist]: [sigh] [Long pause] …that’s an awesome question... cause... [Pause] hopefully, I tend to experience them, the feeling I’ve got... [Sigh] normally kind of comes from the feeling they’ve got.

Nolan provided instances of what that might mean for him as the therapist. With a “really depressed” client, Nolan explained that he would feel “low” and “desperate”.

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With a “complex trauma slash borderline personality type of presentation”, he would experience a “more all over the place type of feeling”.

Other interviewees alluded to this emotional attunement by describing its physiological manifestations.

Excerpt 8 - Phenomenological aspects – Emotional attunement

**Natalia [Clinical psychologist]:** [...] There’s a thing that happens in the therapeutic interaction, whatever you call it, transference or countertransference or just... life or just whatever, that a person feels so hopeless it’s catching almost. It’s a bit like you go into the room and you feel like lead balloons fall onto your stomach. And you come out and you’re both looking like the weight of the world is on your shoulders [...]}

Some interviewees made clear that the physiological manifestations of an emotion preceded the affective component, and in fact, pointed them in direction of the emotion itself, for themselves hence for their patients. Labelling the emotion was the explicit and intentional cognitive process of identifying and naming what they had experienced physically. Landon was particularly eloquent about these mechanisms. As a Mindbody therapist15, he relies on his own physiological responses to grasp what the client is experiencing.

Excerpt 9 - Phenomenological aspects – Emotional attunement

15 Mindbody is an approach that considers that mental, physical, societal and cultural aspects all play an important role in people’s health and well-being (The mindbody network, 2018).
8.2.1.3 Epistemological aspects: Assessment & therapeutic tool

The epistemological aspects pertaining to the aroha connection correspond to clinicians' understanding of its mechanisms and functions in the clinical situation. As touched upon above, interviewees' emotional sense of their patients informs their cognitive appraisal of the clinical situation. With experience, the implicit processes underlying this connection became a clinical tool these clinicians trusted and utilised, both for assessment and therapeutic purposes.

Assessment tool

First, interviewees used their implicit or intuitive knowing as a risk assessment tool. Adelia called it a “gut feeling”. She recounted a situation where, after a missed appointment, she had a strong “gut feeling” that the patient concerned was unsafe. She followed this intuition by checking on the patient, and obtaining reassurance from a family member that the patient was fine. The patient attended the next session during which he insisted being fine too. A few weeks later however, the patient missed another appointment, which instantly caused Adelia’s strong “gut feeling” to return. She took immediate action to check on her patient again, this time finding out that he had killed himself. Although not sure of what this “gut feeling” actually is, Adelia argued that when it is consistent and strong, she deemed it worthy of trust. Upon engaging in treatment, Adelia informs new patients that she relies also on such intuition as a clinical tool.
Oceane also noted trusting particular strong emotions when assessing for suicidality. She described the experience as a “deep knowing”, which she postulated stems from a fundamental survival instinct. Like Adelia, Oceane could make decisions based on these feelings arising in her, which bypass explicit deductive processes.

Excerpt 10 - Epistemological aspects – Assessment & therapeutic tool

**Oceane [Clinical psychologist]:** [...] But if they’re very close to death or that they’ve given up or whatever it is, that’s making me... I just know that I trust that instinct, because I think it’s something to do with fundamental lifesaving, surviving sort of thing, mechanism or something that we have. And I can’t tell you how it works, but I just know that I do trust my spirituality and I do trust myself when I make these judgments.

Interviewees complied with best-practice guidelines around suicide risk management. Depending on their role and the context of their practice, interviewees completed standardised assessments, monitored their patients’ risk and kept record of their practice, in line with professional expectations. They often appeared to refer to their explicit/cognitive appraisal of the clinical situation so as not to overstate the role of their more implicit/emotional assessment practices, in order to emphasise their professionalism. For example, despite arguing that she trusted her instincts, Oceane declared, “you wouldn’t want somebody to just say ‘oh I just feel he’s suicidal’, right? We’ll go with that!” Thus, Oceane performed standardised clinical assessments to produce tangible evidence to triangulate with her clinical intuitions. However, when these two levels of assessments produce conflicting messages, interviewees tended to prioritise their implicit level of knowing.

Excerpt 11 - Epistemological aspects – Assessment & therapeutic tool
This dialectic between implicit/intuitive and explicit/cognitive assessment appeared to occur in clinicians’ mind continuously as they conducted treatment with PRS. The two levels seemed to coexist, be intertwined, and to inform one another. Clinicians relied on this dialectic to navigate the clinical situation, while learning from it to refine their attunement in real time.

Since the implicit/intuitive appraisal of the situation preceded the explicit/cognitive one, clinicians found themselves behaving in a particular way before an explicit decision had been made. Clinicians described learning about their patients in the clinical situation through reading their own emotional/physiological responses as well as their own behaviours. To illustrate this point, Paige referred to the case of a highly suicidal person she once treated. Years down the line, doing better at the time, the patient explained that what had made a difference was that Paige sat on the floor next to her. Paige, who had forgotten that she did so, was reminded then that behaviours driven intuitively could sometimes make an immense difference in treatment.

Excerpt 12 - Epistemological aspects – Assessment & therapeutic tool

**Paige [Psychiatrist]:** [...] I think we do intuit sometimes but sometimes we equally miss it. But yes, I think, you do intuitively recognize that this person needs me to do this or yeah, they look small and scared or whatever, and I’m, I don’t want them to feel like that.
Reciprocally, learning explicitly about the clinical benefits of a given behaviour, in this case “matching and pacing”, was reinforcing for clinicians.

Excerpt 13 - Epistemological aspects – Assessment & therapeutic tool

**Paige [Psychiatrist]:** But I think we all innately do that you know. We intuitively do some of that but you can quite deliberately do it and I do it more deliberately now that I learnt about it some four years ago.

**Therapeutic tool**

The deep connection to patients appeared in the data as the therapeutic agent of the interaction. In first instance, the aroha connection consisted of an interpersonal emotional regulation system, before developing into an attachment over time. These two processes, emotional regulation and attachment appeared to be inter-dependent, with the second being a product of the first. In clinicians’ experience, this dual process of interpersonal emotional regulation and attachment were at the core of the therapeutic influence of the clinical encounter on patients.

The first process underlying the experience of an aroha connection involved interpersonal emotional regulation. Interviewees were aware of striving to apprehend patients’ reality at an emotional level, before sitting with the shared emotion. By resisting the urge to try to fix or to evacuate difficult emotion, clinicians were able to provide PRS with a sense of emotional assistance, or holding, that has a soothing effect for them.

Unlike their suicidal patients, study clinicians have the ability to regulate intense negative emotions. They have experienced personally and professionally that even extremely uncomfortable emotional states can pass, including intense distress and suicidality. Therefore, clinicians entered the clinical encounter with the confidence gained from the experience of having journeyed with PRS, from a profound emotional distress through to an emotionally regulated state that ultimately
included a sense of hope. Reassured that people usually do get better, interviewees could enter the clinical encounter with an attitude of openness and curiosity about the other, paired with a sense of hope that they hold within themselves. Interviewees described their stance as “holding hope”.

Excerpt 14 - Epistemological aspects - Assessment & therapeutic tool

**Natalia [Clinical psychologist]:** [...] yes, sometimes it’s just holding an attitude of [hope], and allowing that to be in the room rather than having to work to give it to the person. To put it out there, almost to allow them to pick it up if they wish to [...].

Patients therefore experience the ability to regulate difficult emotion vicariously first, from entering a state of emotional synchrony with clinicians who have themselves the ability to regulate emotions. The inter-subjective experience that distress can pass fills patients with a sense of hope.

Excerpt 15 - Epistemological aspects - Assessment & therapeutic tool

**Donna [Psychotherapist]:** [...]they’re going to feel...Within that sort of energy flow if you like, between us, they’re going to feel held and respected and understood in that place, well hopefully they are, in the place they’re in without having to be overwhelmed by... um a sense of not being seen or a sense of shame [pause]. So if there is a level of acceptance from me that, this is where they are in their existential crisis, it is most likely to have a profound impact on them, being understood in that place.

Over time, an attachment appears to develop from this place of emotional unison. Interview data suggested that the work carried out explicitly in treatment mediated the transition from emotional attunement to attachment. To assist their patients in re-constructing a narrative of their experience and history meaningfully, clinicians needed to work from a place of emotional synchrony with them. Adelia described her therapeutic role as “evoking understanding in relation to experience”. Clinicians relied on their own emotional literacy to help patients articulate their experience in
words. Natalia corrected herself to use the pronoun “we” instead of “they” as she described the collaborative work accomplished in treatment.

Excerpt 16 - Epistemological aspects - Assessment & therapeutic tool

*Natalia [Clinical psychologist]:* They often find that, we often find together that there’s much more diversity and hope [...] to their experience that they initially recognise. And I think that this kind of leaning in [...] and becoming curious, and exploring, acts almost like an exposure exercise. The feeling is no longer so scary, and that it can be a great relief to people that they don’t have to get rid of it. They can have an experience of learning that it can be there and they can still... be alive.

By inviting patients to become curious about their own experience, clinicians encouraged them to weave a link between cognitive and emotional experiences, thereby increasing patients’ sense of agency over their emotional states. Over time, patients developed the ability to handle by themselves what they initially experienced and coped with inter-subjectively with their clinician.

At an explicit/cognitive level, clinicians and patients work together at the tasks prescribed by the therapeutic modality in which they work, whether it is for example DBT, psychodynamic therapy, ACT, CBT, Psychodrama. Meanwhile, at an implicit level, clinician and patient navigate and regulate emotional states collaboratively. As patients feel deeply understood by clinicians and supported consistently over time, an attachment can grow.

Excerpt 17 - Epistemological aspects - Assessment & therapeutic tool

*Natalia [Clinical psychologist]:* [...] I think they experience a sense of connection, and, and an opportunity, I guess now I think about it, it’s a bit of an attachment process [...].

By fostering a sense of connectedness, this attachment has a therapeutic influence on patients. As patients’ sense of connectedness grows, suicidality lessens.
In interviews, clinicians used analogies with the primary care giver/child relationship to describe the processes at play in treatment, further suggesting that a form of attachment is occurring in their work with PRS.

As clinicians and patients become attached to one another, an actual relationship grows, involving reciprocal trust and care. For Eliza, being trusted is a prerequisite to creating something collaboratively with the patient and journeying together in meaningful ways, which she like to capture with the expression “being companions in the unknown”. Bernice experienced this form of attachment as the mutual “belief” that one has the ability to walk this emotional journey with the other. Eliza and Renee referred also to this therapeutic attachment as “love”.

Eliza [Psychotherapist]: I think yes, I think. There is a lot of what I would call ‘love’ that is happening in the psychotherapy room [Pause].
8.2.1.4 Terminology

Aroha

The Māori term “aroha” appeared to capture the essence of the emotional transaction at play in the clinical encounter between the clinicians interviewed and their suicidal patients.

Translating “aroha” to the English term “love” is too simplistic, as there are multiple and differing layers to this term. In Te reo Māori\(^\text{16}\), the notions of love and life force are different facets of the same term, “aroha”. As a verb, aroha means to love, to feel pity, to feel concern for, to feel compassion for, and to empathise. As a noun, it means affection, sympathy, charity, compassion, love, and empathy. Etymologically, aroha is composed of “aro”, which means centre or heart, but also to pay attention, to consider or to be inclined towards, and “hā”, which translates as the essence, to breathe, and is commonly translated as “breath of life”. (Dictionary, 2018).

According to an explanation of how the first human was made in the Māori world view, provided by Toā Waaka, cultural adviser for this study (personal communications, March 20th, April 30th, and August 8th, 2018), Tāne Mahuta/Tāne Te Waiora, the guardian force of nature and the universe, sneezed the first breath of life into Hine-ahu-one, the feminine element made from the red clay. The term aroha is etymologically affiliated with this primordial act of sneezing life into the first human being, and is derived from “aro ki te haa”, which means “the essence of life”. Aroha is the life force or creative force that stems from the guardians of the nature. In a book of key concepts of the Māori culture, Cleve Barlow defines aroha as follow (Barlow, 1991):

\(^{16}\text{Māori language.}\)
A person who has aroha for another expresses genuine concern towards them and acts with their welfare in mind, no matter what their state of health or wealth. It is the act of love that adds quality and meaning to life. According to the elders: ‘Love is not skin deep like the tattooed face of a chieftain, but swells up continually from the depth of one’s heart’ (p. 8)

According to Waaka, aroha also means giving life back to people so they may live in the world of light and not die in the dark of the puku, the abdomen, or the korokoro, the throat.

Thus the different facets of the term aroha appeared to capture the complexity of clinicians’ experience of the clinical encounter with PRS better than other English language terms for different aspects of “love”.

**Connection**

The term “connection” was retained, as it was the most commonly used by interviewees to refer to the core process of the clinical encounter. Moreover, the term connection conveys a sense of intimacy that reflects the depth of the emotional bond woven into treatment. Finally, the term connection suggests the implicit/intuitive nature of the phenomenon, which makes the processes underlying it elusive and hard to put into words according to interviewees.

In the following excerpt, Natalia summarised her experience of the aroha connection.

**Excerpt 21 - The aroha connection - Terminology**
Natalia [Clinical psychologist]: I think it’s really really cool that it can happen in a therapy session, isn’t that incredible?! Because often people only get there in a few relationships in their life. That’s an incredible gift. [It] seems a bit magical sometimes to me. And yet, that’s what I found. When I can sit there and be present and lean in, and be curious and open to what that person brings in, and really hear them, and I can hold the hope myself, and allow to be there in the room, and notice [...] the forms of their experience, that goes maybe beyond the hopelessness and despair [...], that suddenly that connection can happen, and that’s almost like, suddenly, [...] like being seen for the first time [...] 

This section has provided a description of the mechanisms found in the data to be at the core of clinical encounter with PRS, which is conceptualised as an aroha connection. The following section will detail clinicians’ part of the interaction, in terms of the characteristics and skills they displayed that seemed to foster the occurrence of an aroha connection.

8.2.2 Clinicians’ part of the interaction

Clinicians intentionally fostered an emotional environment designed to facilitate the occurrence of an aroha connection. Indeed, as Natalia’s quote above exemplified (see excerpt 21), the data was replete with things clinicians’ intentional actions, such as the attitudes they hold and the latent emotions they manage, to promote an emotional environment that allows a deep connection to occur.

This section will describe clinicians’ strong willingness to engage with PRS; their stance of genuine care and hope; and their advanced emotional literacy skills. Finally, the way clinicians integrate their explicit and implicit understandings of the clinical situation to navigate it in real time is described.
Figure 8.5 Clinicians' part of the aroha connection
8.2.2.1 Willingness to engage

The first characteristic that clinicians exhibited was a strong willingness to engage with PRS. They emphasised the importance of being willing to engage in treatment despite patients’ ambivalence; letting the encounter be absolutely about the other; and being willing to form a therapeutic attachment.

The success of treatment was described as depending on clinicians’ willingness to engage with patients in the first place. However, clinicians acknowledged that this willingness is challenged when the patient is not inclined to collaborate, or even fights against becoming engaged in the encounter. As discussed in the literature review (see Chapter 2), PRS’ ambivalence toward life and death can be enacted in an ambivalence towards treatment. Developing an attachment may be what the suicidal patient needs, and hence wants on some level, but also, on another level, what the patient fears hence avoids. Natalia’s proposition that, “part of being suicidal is you have to start disconnecting” (See excerpt 18), invites consideration that the direction of treatment opposes that of suicidality, in that it is inherently about connecting. Complying with treatment could therefore be conceptualised as letting go of the “symptom suicidality”. Patient’s ambivalence is consistent with this being a difficult process in which they may push back in important ways.

To maintain a drive to work with PRS in the face of this ambivalence, clinicians noted needing to see beyond patients’ contradictory behaviours. Landon provided an eloquent instance of an unwavering willingness in the context of a strong ambivalence from his patient:

Excerpt 22 - Clinicians’ part – Willingness
Landon [Psychotherapist]: I’m totally reliable. She can walk into my office and she’s a quite hostile to me sometimes. I don’t mind. [...] She says ‘you dress too well, your chairs are made of animal leather, I’m a vegan I refuse to sit on your chair’. So I have to provide her with a chair made from cloth material. And yet all that to me seems quite intriguing. It doesn’t seem to be an insult. It’s kind of her being very real. [...] All of these things that are wrong with me doesn’t stop the problem that she’s bonded to me. She’s fighting against being bonded to me.

Landon interpreted his patient’s hostile behaviour as the reflection of her own struggles. The patients’ presence combined with her hostility betrayed her simultaneous need and dread to form an attachment to another human being. In this example, Landon does not sound personally affected or hurt, and he does not get defensive, ensuring that he does not make any of his patient’s behaviours about himself.

In the second component of the willingness to engage, interviewees showed a strong determination to let the therapeutic encounter be about the other. According to Donna, this sense of “service” to the other is a fundamental prerequisite to working clinically with PRS.

Excerpt 23 - Clinicians’ part - Willingness

Donna [Psychotherapist]: [...] so it's got to be, 90% about the other. [...] So I think, sometimes it's about... [Sigh] I’m going to use that old fashioned term, about ‘service’. [...] That doesn't mean I don't get paid for what I do, but it's not merely a transaction [pause]. I do really believe that [...] quite a large percentage of it is about service, and by that I mean it's in the service of, if you like, humanity or in the service of the other [...]

In order to synchronise with their experience, clinicians spoke of adjusting constantly to their patients’ needs, emotional tone, and pace. In this sense, the clinician’s role often consisted of not taking any measures, and of resisting the
natural urge to solve/fix problems. This clinical stance was observed to cause frustration even for the most seasoned clinicians.

Excerpt 24 - Clinicians’ part - Willingness

*Landon [Psychotherapist]*: [...] you know they should talk about [their trauma], they know they should, but they’re trying very hard not to talk about it. And I think that’s a difficult transaction at that point.

[...] Yes it is frustrating because you know what would help the patient but you know you have to wait. As you can tell from me, I like to do things [chuckles].

However difficult this may be, the findings indicated that interviewees use CT literacy skills to manage their emotional responses, and that they respect their patients’ pace of elaboration and psychological processing.

Finally, clinicians have to be willing to form and allow a reciprocal attachment. This means allowing oneself to experience deep emotions in order to connect with another person in ways that generate a sense of intimacy. Clinicians appeared to use their emotional self as a clinical tool to promote togetherness.

Excerpt 25 - Clinicians’ part - Willingness

*Paige [Psychiatrist]*: I think the other point is that, no matter what, whatever you do, you do give up of yourself to people like that [...

In so doing, clinicians take the risk of feeling personally affected too. This is typically the case if the other part of the emotional dyad, the patient, dies by suicide. More than half of the sample (n=8) had lost patients to suicide, and all of them had been deeply affected by it. Donna recounted her psychological and emotional turmoil after a woman who came to meet with her once, killed herself the following day.
Nolan lost two patients to suicide, including one while under his care. In both cases, he felt compelled to go to the funeral service to reach a sense of closure. Nolan needed to make sense of these deaths on a personal level too.

The first characteristics common to all clinicians in the study was an unwavering willingness to help people in general, and PRS in particular. Their strong drive remained unshaken by patients' ambivalence, by having to put their needs aside to prioritise those of their patients, nor by the perspective of getting emotionally involved.

8.2.2.2 Genuine care & hope

The second characteristic that clinicians exhibited consisted of a specific clinical stance that conveyed genuine care for their patients and hope. They described this stance as a prerequisite to achieving positive treatment outcomes with PRS. In clinicians' experience, PRS need to feel cared for to start trusting their clinician, hence be able to connect emotionally with them, and eventually develop a therapeutic attachment.
Hassie [Psychiatrist]: I think it’s very important that people feel that you’re present, and that they feel valued and that you’ve got real interest in them. I think it’s really important.

Caring genuinely for PRS appeared as an inherent part of the therapeutic process. Bernice used the term “to delight” in her clients. Eliza and Renee used the term “love”. I asked Renee to elaborate as to why she had to “love” her patients for the work to be any good. She explained that it was another way to say that she has to “let them in”, which comes back to the notion of interpersonal realm.

Excerpt 28 - Clinicians’ part – Genuine care and hope

Renee [psychotherapy]: Well I think when I meet someone and we make the decision together, I think something opens up in me and I take them in. And for as long as I’m working with them, they’re also part of my psyche. [...] I give them a room in my heart so that I can think about them and be with them more, when I’m with them.

Furthermore, clinicians emphasised that the genuine care required need to be consistent. Interviewees nurtured the therapeutic relationship beyond the limited timeframe of their practice. In some instances, the bond was maintained concretely with in-between-sessions phone calls or messaging. In other cases, clinicians fostered an emotional holding symbolically, sometimes in creative ways. For example, Renee who spends part of the year overseas devised ways to care “by proxy”. First, she developed a collaboration with a trusted colleague with whom her patients are invited to meet when she is away. Additionally, for her most fragile patients, she sets a time during the week where she and the patient agree to think about each other.

Hassie pointed out that the type of care required differed from that experienced in ordinary life. The difference being that in her personal life, she would need the other person to meet her needs too. In contrast, in her clinical practice, she puts herself in
specific dispositions where she cares *a priori*, regardless of the other’s disposition towards her. Hassie talked about “offering [oneself] in a professional way”. In the following excerpt, Donna made a similar distinction.

**Excerpt 29 - Clinician’s part – Genuine care and hope**

**Donna [Psychotherapist]:** [...] It’s almost like I don’t have to actually really like them like them as in, like them as in you could be my friend. But I have to find, I don’t find it difficult to find something... genuinely likable about most people.

Clinicians conveyed the genuine care and hope needed in treatment by the quality of their presence rather than with words. They fashioned phenomenologically the emotional environment required to promote PRS improvement in treatment. For Oceane, this meant conveying that she had “all the time in the world”. She argued that, given their vulnerability, PRS generally open up and confide in her provided she could convey a genuinely interested. To achieve this, she explained having to be “very much in the moment and very much in touch with [her] humanity and [her] spirituality”. Natalia made a very similar comment.

**Excerpt 30 - Clinicians’ part – Genuine care and hope**

**Natalia [Clinical psychologist]:** [...] you need to be aware enough of what’s going on inside of you in order to be able to be present with that person in the room. And I guess that’s probably the thing that [...] would be very difficult to train for some people, is if they are not interested, or really don’t want to go near what’s happening inside of them. Then, that’s going to be very very hard for them to enter [chuckles], be present in the room properly.

The clinicians interviewed appeared to fashion the emotional environment they feel their patients need. This emotional environment consisted of a combination of genuine care and hope, which clinicians held within themselves and conveyed to their patients phenomenologically. As Natalia argued in the last excerpt (see excerpt
clinicians need to be in touch with “what’s going on inside” of them, i.e. to be aware of their emotional responses, in order to adopt and maintain the desired stance.

8.2.2.3 Emotional literacy

The skills clinicians expressed needing and talked about the most were emotional in nature, which is not surprising given the emotional nature of the core process of treatment. The clinicians interviewed all had in common a piercing awareness of their emotional responses, and of their potential to either facilitate or jeopardise treatment. Regardless of their framework of reference, clinicians considered their emotional responses as precious information about their patients, as well as about themselves, in the clinical situation. They described being aware of and managing their emotional responses as a key skill to hone to achieve positive outcomes with PRS, and their professional responsibility in order to promote safety in the relationship. Although very few used the term, this predominantly implicit emotional navigation of the clinical situation corresponds to the management of countertransference (CT).

This section presents evidence on interviewees’ CT literacy by distinguishing the three main purposes it served: accepting the risk; caring genuinely; and navigating professional boundaries.

To engage therapeutically with PRS, clinicians emphasised having to cope with the reality of the suicide risk. When people develop a pattern where they cope with extreme emotional states by threatening their own life, they can, and sometimes do, end up dying. Yet, clinicians needed to work with or despite the fact that suicide is always a possible outcome. Focussing on the possible outcome that is suicide would be clinically paralysing rather than enabling.

Excerpt 31 - Patient’s part – Emotional literacy
Interviewees hence did not consider suicide as the problem they have to deal with in therapy. In their views, if there is suicide then there is no therapy. By nature, suicide and therapy mutually exclude one another, and suicidality cannot fruitfully remain the focus of therapy.

**Excerpt 32 - Patients’ part – Emotional literacy**

**Landon [Psychotherapist]:** She came to therapy saying ‘well, I’ve had a lot of therapy in my life and if this one doesn’t work I am going to kill myself’. She has to realise that puts a lot of pressure on you. Sorry about that, but that’s the truth. [Pause] But I haven’t taken on as my responsibility to keep her alive. My responsibility is to provide her with an alive therapy and she can do what she wants with that.

Hassie explained that a number of kids in her caseload could kill themselves. “The only way you can work with them”, she said, “is by not getting overwhelmed by that anxiety”.

**Excerpt 33 - Clinicians’ part – Emotional literacy**

**Hassie [Psychiatrist]:** I mean it’s horrible when that happens... [...] You know something horrible could happen but it’s not in the forefront of my mind [Pause]. And I think you can’t really afford for it to be in the forefront of your mind.

Hassie found similarities between her emotional situation in the clinical encounter and that of a parent raising a child. Children need to make experiences to mature into full grown-ups. However, with living comes risk, and one has to accept it to let
children learn and grow. There is no substitute for experience. However, when suicidal behaviours get in the mix, the risk takes up a new dimension that makes it difficult to accept. Yet, Hassie emphasised that the issue remains the same: to build a life worth living, PRS too have to live, make their experiences and their own choices. If you “get stuck” in the idea that you are responsible for people’s life, she declared, and that you can actually keep people safe, you “stop being helpful” to them.

Interviewees’ ability to cope with the risk had improved over the years. Natalia referred to the “panic” she felt as a psychology student, and most participants recalled a seminal experience that shifted their perception and acceptance of the suicide risk. This is the case of Adelia who remembered being caught in a patient’ anxiety that her son would suicide. She took the case up to her supervisor who replied, “well, he might kill himself. He might just kill himself”. Adelia explained that, at that moment, “something released” in her, that changed her ability to manage suicide risk henceforth. For those concerned, losing a patient to suicide was also always a founding experience. Oceane for example recalled that the suicide of a patient that she was particularly fond of, early on in her career, left a long lasting impression on her.

Clinicians described being professionally responsible for complying with protocols, for observing the principle of “do not harm”, for having the patients’ best interest at heart, and for striving to manage their CT to promote the relationship. However, they insisted they were not responsible for people’s lives. Ultimately, the “decision” to live or die is on the side of the patient. To work with PRS, clinicians disassociated the notion of suicide risk from that of professional responsibility. This required advanced CT management skills.

Excerpt 34 - Clinicians’ part – Emotional literacy
However, in the short term of the apex of a suicidal crisis, clinicians spoke of doing everything they can to protect patients from themselves. Depending on the clinician’s profession and role, this could mean having to exercise control over the patient’s situation. Although necessary, Paige stressed that such control over patients’ agency can reinforce a sense of helplessness. Taking control over the situation could therefore only be exceptional and short termed.

Excerpt 35 - Clinicians’ part – Emotional literacy

**Paige [Psychiatrist]:** So you might need to, for example, hospitalize them and put them under close observation. In that moment, you take a lot [of control]. But you’re trying to move in and out of that as quickly as is safe and possible, to give the person back their control. Otherwise, they’re going to feel really disempowered.

Finally, with experience, clinicians developed an emotional understanding of suicidality that allowed their anxiety to subside. For Bernice, understanding the psychological function of suicidality sent the anxiety associated with the risk to the background. Eliza pointed out that suicidality can sometimes even be protective for people. Recalling the claim of a patient that contemplating suicide was what kept her alive the previous year, Eliza argued that, in some cases, suicidality can be a “pro-life defence”.

The second case in which clinicians appeared to use CT literacy, was to develop the genuine care their patients need. Clinicians insisted that the care required could not be feigned for PRS are very astute at sensing latent emotions. Oceane argued that
PRS, especially the subgroup of BPD patients, can be “exquisitely sensitive to what the other person’s emotion is”. In the same vein, Nolan proposed that a PRS who notices clinicians’ anxiety, ambivalence or reluctance to hear about suicidal thoughts would simply not open up. Bernice made a similar reflection.

Excerpt 36 - Clinicians’ part – Emotional literacy

**Bernice [Clinical psychologist]**: […] these kind of clients, I find also, pick up on non-verbal cues a lot, very easily. So I think if you’re not confident, that they could pick up on that, which would impact on them.

However, the clinicians interviewed did not find difficult generally to like PRS. Hassie for example, came to consider during the interview that her ability to like most people could be the reason why she felt competent with PRS, hence liked working with them.

Excerpt 37 - Clinicians’ part – Emotional literacy

**Hassie [Psychiatrist]**: And actually maybe that’s something why I quite like working with them, because I think I am able to like almost everybody. I don’t mean that in my personal life. But when I’m there to be available to someone and it’s not about them not meeting my needs, I can usually manage to like, I can almost always manage to like them, feel warm towards people.

Interviewees worked with the premise that anyone is “likable”. Hence, the ability to care genuinely for PRS depended on their ability to find a way in, which itself depended on their ability to manage their emotional responses. In practice, this consisted of finding “something likable” about the person, often a characteristic they can relate to, which would become like a seed from which a genuine care can grow. This characteristic would act as a window onto patients’ humanity, sometimes originally shadowed by a troubled or hostile behaviour. Clinicians emphasised having to listen a lot in order to find a way in, a grip point or emotional
anchor to their warmth. Paige explained that sometimes it could be a very small or an “odd thing”.

Excerpt 38 - Clinicians’ part – Emotional literacy

**Paige [Psychiatrist]:** The way I normally engender some kind of optimism or connection I think is always to try to find a point of... is it empathy, or understanding, or something that I can like or delight in about the person... And sometimes it’s [...] an odd thing you know. I have a patient who I saw once and she was telling me about [her father] and I think it was quite a hard upbringing but she told me about [him] doing [magic]. It was just such a delightful moment. Ever since then, there was a different quality of our interactions.

Getting to know people, within professional boundaries, helped clinicians connecting with them. Paige argued that hearing about people “abusive background” can sometimes be discouraging, so that inviting patients to recollect good memories, or talk about something they like, can function as a “platform” for her to feel hope and start building a positive bond to them.

Interestingly, when clinicians found hard to find something likable about a patient, they systematically attributed this hindrance to themselves. They felt professionally responsible for noticing and managing the CT responses that interfered with their ability to care genuinely for patients.

Excerpt 39 - Clinicians’ part – Emotional literacy

**Hassie [Psychiatrist]:** [...] I certainly find I have people I don’t like. Of course you do. And [...] I suppose I’d actually be struggling with that thinking, what am I finding hard to like here? What kind of, what’s going on that I’m finding this person hard to like? And I guess I’d just try and figure that out, and try to move it to a point where I can like them.
Clinicians referred primarily to objective aspects of CT in interview, that is, their emotional responses that provided information predominantly about the patient. Yet, interviewees also referred to subjective aspects of CT, that is, emotional responses that provided information predominantly about themselves. With experience, clinicians had sometimes learnt to identify the specific situations that were likely to trigger interfering emotional responses. Eliza for instance considered that artistic talent was blinding for her. She conceded not always having been a good therapist to some of her most gifted patients. After she noticed it, Eliza started avoiding working with artistically talented people when she could.

Excerpt 41 - Clinicians’ part – Emotional literacy

**Eliza [Psychotherapist]:** [...] I even think way back [...], there was a woman who would go and play the piano just so beautifully [pause] and I did not quite see the depth of her suffering. She was not one of the ones that suicided but I could see that in fact, I was too entranced by the beautiful music that she produced on the piano.

Indeed, clinicians stressed that positively connoted CT responses can also interfere with therapy.

Excerpt 42 - Clinicians’ part – Emotional literacy

**Donna [Psychotherapist]:** [...] I don’t find it difficult to find something genuinely likable about most people. When I don’t, I know, this is ‘oh let’s have a wee chat in supervision! What is this about?’ Often it doesn’t last. We are supposed to understand our own projections onto others, but occasionally something catches you a bit by surprise.
Hassie [Psychiatrist]: Well you always need to notice your own responses and that, there’s a kind of information that’s partly about you and partly about them. I guess sometimes if you really really like someone, that’s partly about you and partly about them. And you need to think about that too.

Based on their own experience, the clinicians interviewed postulated that a reluctance to work with PRS could be related to the reluctance to explore one’s deep emotions.

Excerpt 43 - Clinicians’ part – Emotional literacy

Oceane [Clinical psychologist]: I think it’s about the kind of supervision people have and about being in touch with your own emotions and sitting with why they might not want to work with suicidal clients. Because not everybody has to, just like not everybody wants to work in different areas, but just really sitting with that and the uncomfortable emotion I suppose is important.

Along the same lines, Adelia argued that clinicians “are afraid to meet in the client what they are afraid to meet in themselves”. Yet, Landon pointed out that without being CT literate, clinicians would not necessarily be aware of this. Landon himself realised only later on in his career that his own latent fear was keeping him from being able to sit with difficult emotion to the extent that he could now.

Excerpt 44 - Clinicians’ part – Emotional literacy

Landon [Psychotherapist]: [...] I think it’s a very fundamental thing because if a clinician is not able to sit with their own fear then how can they sit with the other person’s fear? [...] It was a hard one battle for me to get to that point. I didn’t know I couldn’t sit well with people’s fear. I thought I could. Because you know, [I started treating people in the 90s]. [...] [But] this is only in the last 6 or 7 years that I have changed the way I am with people.
When, despite their best efforts, interviewees cannot manage their CT responses, they implemented alternative strategies. Paige would sometimes draw from someone else's connection.

Clinicians’ part – Emotional literacy

**Paige [Psychiatrist]**: Sometimes if I find I’m not making a connection I look to see if there is someone in our team who does connect with that person and I’ll either springboard off their relationship or I’ll try and let them work directly with the person. If I think I’m not the person to connect with some. But quite often you can find, if you watch someone else working with them... the little things that [they know] about them can give you a way to be able to relate as well, and you can kind of piggyback on that.

In exceptional cases where, often for personal reasons, clinicians sensed that managing CT was going to be too demanding for them, they could refer the patient to another clinician. However, this would need to happen as early as possible and ideally before having started engaging with the patient per se. Indeed, clinicians emphasised that in most cases, referring a patient once a relationship is established would be counter-therapeutic instead.

Finally, interviewees used CT literacy skills to navigate professional boundaries in real time of the clinical encounter. Paige argued that the level of connection required in treatment results in a form of intimacy. Thus, clinicians have to navigate interpersonal boundaries constantly to promote the desired level of connection, while fostering their patients’ independence at all time. For Donna, the “subtlety” of the task for clinicians consists precisely of fostering the appropriate level of emotional connectedness while guaranteeing the safety of the relationship.

Bernice and Linnett both illustrated this subtlety by referring to using self-disclosure as a tool to promote connectedness with patients. Bernice argued that, despite being strongly discouraged to use it in training, she found out early on in her practice with PRS that disclosure was in fact an extremely useful clinical tool.
Similarly, Linnett proposed that therapy is about “normalising the human experience”, which makes self-disclosure an irreplaceable tool for clinicians. Linnett ensured that she used self-disclosure in clinically meaningful ways by verifying at all time that her interventions served the patient’s needs rather than her own.

8.2.2.4 Implicit/explicit dialectic

Finally, the data suggested that a dialogue between implicit/emotional and explicit/cognitive levels of appraisal occurred continuously within clinicians, and informed their decision-making and behaviour in in real time of the clinical encounter.

Clinicians emphasised that having mastery over the procedural aspects pertaining to the monitoring and management of suicidal risk was the prerequisite to being able to navigate the situation at an emotional level. Oceane argued that the more these skills become “procedural”, i.e. automatic, the more clinicians could actually invest the relationship. She explained that clinicians needed to do “all the basics right”, to be familiar with all the procedural aspects they need to tick off, so they can actually “sit with the emotionality in the situation”. She compared these two levels of skills with those of a musician doing scales in order to interpret a piece of music. Being able to master the scales is not enough to interpret the music, but it is required. Ultimately, to interpret the music, one needs to bring in emotionality. Oceane implied that the same goes for conducting treatment with PRS. In a similar vein, Adelia explained that different streams of thoughts went on simultaneously in her mind when she conducted therapy. One consisted of her emotional reactions while the second was a rational appraisal of the situation that could refer to theory for instance. Adelia constantly referred to both these threads in real time to navigate the clinical situation.

Indeed, theoretical frameworks played the crucial role of compass for all the clinicians interviewed. Clinicians referred to theoretical frameworks to make sense
of their emotional responses and those of their patients, and find guidance around how they should let them inform their behaviours.

Excerpt 45 - Clinician’s part - Implicit & explicit dialectic

**Eliza [Psychotherapist]**: I think it’s the technique I use and I’m comfortable with, that gives me a theoretical framework to think into. And that’s really only in the back. What happens face to face in the room, is the most important aspect, that I can listen, to the person in front of me from my intuitive place inside of me, and hear things that have not been spoken, or read signs in the face or in the body that have not been expressed.

The clinicians in this study referred to a variety of paradigms, including learning based, insight based, and biopsychosocial approaches to mental health. Within each of these approaches, clinicians referred to a variety of theoretical frameworks. Proponents of the learning based paradigm referred to classical CBT as well as to other developments such as DBT, ACT and mindfulness. Proponents of the insight based paradigm referred to psychoanalysis, transactional analysis, psychodrama, or Gestalt. Yet, regardless of their nature, theoretical frameworks provided clinicians with the conceptual tools they needed to make sense of their emotional experience in order to navigate the clinical situation by informing their therapeutic strategies and behaviours in real time.

Excerpt 46 - Clinicians’ part - Implicit & explicit dialectic

**Hassie [Psychiatrist]**: [...] one of the significant things I suppose is what I've learned how to do it. Because I can remember years ago when I first started working in psychiatry, and I didn't like working with suicidal patients. [...] I guess over the years I've learned. [...] There's a book, and I'm not sure that anyone reads it anymore but it was called “relationship management of the borderline patient”, and I think I found it a really really helpful book. And the dialectical behaviour I found very helpful. So I have a sense that I kind of know what to do.
Interviewees had all furthered their training in some ways. Generally, they trained in new treatment modalities that furthered their clinicians’ understanding of the interpersonal emotional dynamics at play in psychotherapy with PRS.

Excerpt 47 - Clinicians’ part - Implicit & explicit dialectic

**Natalia [Clinical psychologist]:** [ACT] provided me with a framework to allow me... to... being willing to, attend to and to sit with painful emotions and painful reactions that happen in the therapy room. That, I think, has been what’s changed a lot. By giving me that framework it’s allowed me to be willing to take what would otherwise feel like very risky therapeutic steps.

Finally, clinicians emphasised having to be in particular dispositions to allow such internal dialogue between implicit and explicit levels of appraisal to occur. Phenomenologically, Oceane referred to this state by using the DBT concept of “wise mind” (Linehan, 1993, p. 214). As for Landon, he proposed to describe the stance required as a “mindfulness in real time”.

Excerpt 48 - Clinicians’ part - Implicit & explicit dialectic

**Landon [Psychotherapist]:** In a way it’s kind of like a mindfulness in real time [pause]. Something like that. You can call it that if you want to call it something. Something like that. It's a mindfulness in real time. You know the person is feeling something. You're feelings it with them. You're explaining what's happening. You're making them much more aware of their body, when often they have not been.

On one hand, clinicians sought to master the knowledge they needed in order to being able to focus on the emotionality in the situation, comparable to a top-down type of processing. On the other hand, they strove to become aware of their physiological experience of the encounter, comparable to a bottom-up type of processing. The explicit knowledge was therefore made implicit while the implicit was made explicit, continuously, in real time of the clinical situation.
This section has presented clinicians’ characteristics in terms of their dispositions towards PRS, the nature of their therapeutic stance and the skills they needed to conduct treatment with PRS. The following section presents patients’ part of the interaction, as perceived in interviews through clinicians’ lenses.

8.2.3 Patients’ part of the interaction

By virtue of the deep emotional bond they form with them, clinicians appeared to be in an insider position vis-à-vis their suicidal patients’ emotional states. They empathised deeply with what they patients feel, including during suicidal crises, before accompanying their patients through their subsequent emotional and existential journey. This collaborative experience granted clinicians both an emotional understanding and a clinical knowledge of their patients’ experience.

This section represents clinicians understanding of patients’ ambivalence towards treatment, their suicidality, and their emotional dysregulation. Finally, we will see that clinicians aimed to help their patients improve their emotional literacy in therapy.
Figure 8.6 Patient's part of the aroha connection
8.2.3.1 Ambivalence towards engagement

Clinicians experienced their patients’ ambivalence within the therapeutic relationship.

Excerpt 49 - Patients’ part - Ambivalence

Linnett [Clinical psychologist]: So there’s this push/pull kind of thing. Yes I want you/no I don’t, come here/go away, you know, I like you/I hate you, that kind of black and white dynamic that can develop with people with complex trauma background or you know, with sort of personality, borderline personality characteristics.

They saw past challenging behaviours to see hope in patients’ ambivalence. As long as patients come to meet their clinician, they are not entirely determined to die.

Excerpt 50 - Patients’ part - Ambivalence

Eliza [Psychotherapist]: So then I probably do have the belief that, you know, if they were absolutely clear and sure, they wouldn’t even be sitting in my room. There’s enough of themselves that still looks to stay in life, which then allows them to be involved with their psychotherapist.

Engaging in treatment is a different type of action from attempting suicide, but both behaviours proceed from a drive to make a change.

Excerpt 51 - Patient’s part – Ambivalence

Landon [Psychotherapist]: If you're going to suicide then it’s actually trying to fix the problem. You're thinking of killing yourself because you want to do something. “Can't stand this anymore, something's got to happen.” There’s some energy behind that. There's actually life behind that.
8.2.3.2 Suicidal ideation & behaviours

Suicidality and suicide risk appeared in the data as profoundly human and not different in nature from any other form of distress or difficulty. Clinicians had come to understand that suicide ideation and behaviours constitute an attempt to escape a mental state perceived as unbearable.

Suicidal behaviours are therefore the tip of the iceberg, which indicate the underlying issues that should be the object of therapy. As such, it is not the object of therapy and cannot remain fruitfully the focus of therapy.

Excerpt 52 - Patients’ part – Suicide ideation & behaviours

**Landon [Psychotherapist]:** [...] you can’t do anything about a patient once they’re dead. You know there’s reality [...]. [But] if we just listen to suicidality and talked about that all the time, I don’t feel we’d make progress.

Clinicians argued that ambivalence towards treatment and suicidal behaviours both point in the direction of an underlying history of trauma, which would have resulted in attachment issues. Landon pointed out that, ultimately, patients’ ambivalence towards the treatment and the person of the clinician signals attachment issues.

Excerpt 53 - Patients’ part - Suicide ideation & behaviours

**Landon [Psychotherapist]:** [...] there’s a tremendous ambivalence with her that she knows that if she connects with me then, she has a reason not to suicide because there’s a bond and an attachment. [...] She would say ‘I do enjoy being here but it doesn’t last when I get away from here you know’. So you have both things happening that she’s enjoying it, but she doesn’t want me to think that I’ve fixed the problem. She wants both.
Bernice proposed that the experience of fear is at the core of PRS’ most challenging behaviours. PRS need to bond as much as they fear it. For the clinicians interviewed, patients’ distrust and fearfulness to bond originated in a history of trauma.

8.2.3.3 Emotional dysregulation

Natalia explained that, when historically trusting and relying on others came at a very high cost, people would have integrated that forming an emotional bond to others is not safe. By initiating and reinforcing distrust, a history of trauma would engender attachment issues. Linnett explained:

Excerpt 54 - Patients’ part – Emotional dysregulation

Linnett [Clinical psychologist]: [As children], we literally depend on the adults for our life. If those same adults are the source of trauma and fear, then of course trust is going to be disrupted and it's such a tricky dynamic to negotiate.

In clinicians’ experience, PRS present commonly with a history of mistreatment, neglect, or sexual abuse. Paige alluded to the “harsh upbringings” and “abusive backgrounds” of most of her patients. Landon defined the trauma as the “the terror that is not responded to”. He argued that a lack of emotional attunement can have devastating consequences for children.

Excerpt 55 - Patients’ part - Emotional dysregulation
Thus, clinicians sought to address patients’ underlying history of trauma. Based on their experience of conducting treatment with PRS, clinicians associated patients’ history of trauma with their inability to regulate emotion. The emotional dysregulation in turn was associated with suicidality. The inability to regulate emotions could result in a paroxysmal distress that the suicidal behaviour aimed to evacuate.

8.2.3.4 Implicit/explicit dialectic

The clinicians interviewed thus achieved the ultimate participative observation by developing a theoretical and a phenomenological understanding of their patients’ suicidality. From a state of emotional synchrony, clinicians encouraged a similar dialectic between emotional and cognitive levels of functioning in their patients that they implement for themselves. Recall that Adelia spoke of “evoking understanding in relation to experience”. With clinicians’ assistance, patients built emotional literacy skills. Through increasing patients’ sense of agency and self-efficacy over their emotional states, improving emotional literacy appeared to be associated with eliciting hopefulness in them.

This section has considered PRS’ characteristics according to their clinicians. In interviewees’ experience, suicidality often stems from a history of trauma. By causing distrust, the history of trauma engenders attachment issues that are associated with emotional dysregulation. In turn, emotion dysregulation is
associated with suicidality. In treatment, clinicians strive to establish an aroha connection that can induce an attachment, and repair some of the damage incurred by patients’ complex background. However, this process is complex and takes time, and outcomes are never guaranteed. The following and last section of this chapter examines possible treatment outcomes as they appeared in clinicians’ narratives.

**8.2.4 Possible outcomes**

The aroha connection is interpersonal or inter-subjective by nature. Consequently, its outcomes affect both protagonists simultaneously. What is satisfying for patients, i.e. soothing and ultimately therapeutic, is simultaneously satisfying for clinicians. Reciprocally, negative outcomes affect clinicians profoundly too, although only the patient’s life is literally at risk. For clarity, this section distinguishes possible outcomes for patients and clinicians, before considering possible obstacles to achieving positive outcomes in treatment.
Figure 8.7 Possible outcomes of the aroha connection
8.2.4.1 Possible outcomes for patients

The aroha connection appeared to be the therapeutic agent of the clinical encounter. In the short term, it had a satisfying/soothing effect for patients. As the relationship advanced, the experience of a secure attachment could develop, and have a down regulation effect on suicidality. However, the risk was always present in the background, as death was always a possible outcome of the clinical encounter.

Deep satisfaction

The aroha connection consisted primarily of an interpersonal emotional regulation system that had a deeply satisfying, i.e. soothing, effect on patients. PRS entered the encounter feeling disconnected and emotionally dysregulated until clinicians strove to achieve an emotional synchrony with them. In Natalia’s words, feeling emotionally attuned to another person could result for patients in the experience of “being seen for the first time”. Simultaneously, patients experienced the ability to regulate emotion vicariously, through clinicians’ own ability to regulate the shared emotion. Landon had a sense of using “his capacity to be calm to calm” his patients (see excerpt 19). The aroha connection acted as an inter-subjective emotional regulation that was immediately soothing and validating for patients.

Experienced-based learning

In clinicians’ understanding, patients could build the skills to regulate emotion on their own through repeating this experience in treatment, which constituted an experience-based learning. Natalia pointed out that it worked like an exposure exercise. The aroha connection would thus allow patients to regulate emotions vicariously until they acquired the ability to regulate emotions for themselves. Using a psychoanalytic terminology, we could say that the aroha connection provided a channel through which dysregulated emotions are being projected onto clinicians. They are then metabolised or regulated by clinicians themselves, before being internalised again, or “introjected” again, by patients.
Furthermore, as patients and clinicians journey emotionally together, the full potential of the aroha connection could unfold into the experience of a secure attachment. For Bernice, “actions speak louder than words”. By being genuine and consistent in the care they provide, clinicians would offer patients something they might not have had in their life. Bernice emphasised that this could make a big difference as, in her experience, patients “respond really well”. Thus, the data suggested that a therapeutic secure attachment could take place in a few clinical encounters only.

Excerpt 56 - Possible outcomes – For patients

**Natalia [Clinical psychologist]:** I think it’s really really cool that it can happen in a therapy session, isn’t that incredible?!! Because often people only get there in a few relationships in their life, and that’s an incredible gift. And I’m not entirely [sure], you know, it seems a bit magical sometimes to me. And yet, that’s what I found.

In clinicians’ experience, patients can draw from this therapeutically crafted attachment to create new ones in their personal life. In Natalia’s view, patients can feel gradually worthy and capable of forming connections with another person through experiencing a secure attachment in therapy, which would give them a sense of hope. This sense of hope, born from experiencing a caring and nurturing emotional connection with another person, appeared to mediate the relationship between connectedness and suicidality. According to interviewees, when people feel they matter, and feel cared for, they start experiencing hope again.

Excerpt 57 - Possible outcomes – For patients
Linnett [Clinical psychologist]: Without that human to human connection we're not going anywhere. That's particularly important with someone who is suicidal because they've gotten to the point where they don't think human connection matters anymore and they want to leave this earth. So, to be able to be present and have that person experience that, even for a moment, I think helps the person want to stay on the earth and want to stay alive.

Linnett heard from some of her long-term patients that the human connection, which they experienced through the quality of her presence, had been therapeutic for them.

Excerpt 58 - Possible outcomes – For patients

Linnett [Clinical psychologist]: I've been fortunate enough to have had feedback from clients who got through that and out on the other side and told me that that has made the difference. They said 'I felt like you were really there, that you were really really listening to me. You didn't get frightened or freaked out when I said I'm going to kill myself. You would just be calm and there, and help me get through and it felt like you cared'.

Linnett therefore contended that the connection that can occur within the therapeutic relationship is the “most important thing”. By using their skills to form an emotional bond with PRS, clinicians were essentially forming an attachment to them. This therapeutic attachment could repair some of the damages incurred by patients’ attachment issues, including their low sense of self-worth and suicidality. However, clinicians emphasised that mid to long-term therapy is generally required to achieve this type of long lasting positive outcomes.

Death

Finally, death was also always a possible outcome. Most interviewees recounted feeling deeply shocked and affected by the suicide of their patients. Some knew of
colleagues who changed career after having lost a patient to suicide. As discussed in the section about clinicians, learning to work despite the risk was an inherent and critical part of clinical suicidology according to the clinicians interviewed.

**Excerpt 59 - Possible outcomes — For patients**

_Hassie [Psychiatrist]: [...] this is life and death for them and it’s not for us. So they’ve got a lot more invested in it than we have, [and] they’re a lot better at it than we are. So I think you have to be able to accept that. Like I said I get manipulated, of course I get manipulated and I get it wrong sometimes but as I said, you know [sigh] it is life and death for them and it’s not for us and I think you can’t always feel in command of what you are doing [long pause]._

Clinicians’ awareness of their PRS’ enduring psychological pain was manifest in their narratives. They accepted challenging behaviours as the mark of their patients’ struggle, and accepted that improving can take time. They also credited their patients as the expert of their own difficulties. When patients did not improve, dropped out, or died, clinicians considered that they or the treatment, had failed the patient, and not the other way around.

**8.2.4.2 Possible outcomes for clinicians**

The experience that dominated clinicians’ experience was one of satisfaction. In fact, clinicians appeared compelled to help, as if working with highly distressed patients was a vocation rather than a deliberate choice. The level of emotional connection involved resulted in cognitive and emotional fatigue nonetheless, which required clinicians to self-care.

**Deep satisfaction**

Without an exception, clinicians described their practice with PRS as a rewarding experience. In fact, interviewees rarely referred to the challenging aspects of the
practice, except when prompted to discuss other clinicians’ potential reluctance to work with PRS.

At a first, most readily accessible level, clinicians were aware of liking helping people. They liked that they could make a difference in people’s life. Landon liked the ability to help highly distressed people to calm down. Adelia liked the feeling of “being of help in having people glad to be alive”. Most participants also liked helping patients building a life worth living.

**Excerpt 60 - Possible outcomes – For clinicians**

**Bernice [Clinical psychologist]:** yeah I think my satisfaction and the whole reason why I like this is because, when I do work like this, it feels like I’m making a difference in somebody’s life for the better for them [...].

However, there was another layer to this gratification, which corresponded to a sense of deep satisfaction.

**Excerpt 61 - Possible outcomes – For clinicians**

**Linnett [Clinical psychologist]:** It’s incredibly, incredibly satisfying and actually a privilege you know to help... To be beside someone and help someone through that very painful part of life. Yeah. I think that’s it. [...] So yes very very satisfying and a privilege, and a real privilege, to have people trust and trust me enough to share their deeply personal painful experiences.

Interviewees conceived suicidal tribulations as the most intimate thoughts a person can have. They felt privileged that people would share their experience with them in the first place.

**Excerpt 62 - Possible outcomes – For clinicians**
Eliza also associated the sense of being trusted with that of satisfaction. She felt profoundly satisfied by the sense of mutuality that could emerge from the aroha connection.

Excerpt 63 - Possible outcomes – For clinicians

Eliza [Psychotherapist]: [...] It’s very satisfying. Then I come home from work at the end of the day I am thinking ‘yep, some good work happened’. And it may have been that somebody was very distressed but nevertheless we connected well and then I feel satisfied, yes.

This profound sense of satisfaction nurtured and reinforced clinicians’ positive inclination. Yet, this does not mean that they found working with PRS enjoyable moment to moment. Landon used an analogy with the primary care giver/infant dyad to illustrate this distinction.

Excerpt 64 - Possible outcomes – For clinicians

Landon [Psychotherapist]: [...] It’s a generality to say that we both have to be enjoying the work we’re doing for it to be successful. Like a mother and baby, or child, are not a happy couple, or happy mum and baby unless, they’re enjoying what they’re doing. But then, you watch a mother with a two years old and a lot of the experience is not enjoyable [laughs].

Oceane too deemed finding the experience deeply satisfying very different from finding it enjoyable.
Clinicians’ sense of satisfaction was therefore an outcome of the therapeutic encounter and of the ability to connect emotionally with PRS. Landon could not see how it could be otherwise. He argued that anything that happens in therapy is relational, due to therapy being by nature a “together experience” and a “co-created experience”.

Interviewees’ deep sense of satisfaction appeared also intimately related to the notion of life. Clinicians felt profoundly satisfied to help people emerging from dark places, and back into the light, or into life. Oceane invoked her spirituality multiple times. To describe the journey to this other side of darkness, she envisioned a butterfly:

Excerpt 66 - Possible outcomes – For clinicians

**Oceane [Clinical psychologist]:** [...] what makes it enjoyable is about being able to connect with them and to try to get them to see my point of view and see hope or change their mind or... I used to envision it as a butterfly, sort of inside them. I would just try to dig, just a tiny bit and I would just try to dig that bit, rather than having it submerged in a blackness.
In a similar vein, Adelia described experiencing shivers whenever life showed in a clinical situation, the kind of shiver she gets when she hears “the karakia\textsuperscript{17} on the Marae”\textsuperscript{18}, she said. She would think to herself, “this is life talking”.

Clinicians appeared drawn to their practice, rather than having chosen it consciously. Hassie for example had chosen to work in an impatient unit where she knew she would end up with many PRS. Although noticing that she had a high tolerance for risk, she still was not entirely sure why she made this decision in the first place.

Clinicians all demonstrated a deep concern for human suffering, which seemed to resonate deeply with them while compelling them to help. They appeared called, drawn, obliged in a sense, to be present for their fellow human beings. At times, interviewees sounded as if not addressing human suffering would be more difficult or painful to them, than trying. Natalia “does not like” that people have to feel this way. Other clinicians expressed similar feelings.

**Excerpt 67 - Possible outcomes – For clinicians**

**Bernice [Clinical psychologist]**: It’s just... I don’t like that, there’s so many people distressed in this world. [...] They deserve to be happy and confident. So therefore, if I can help in some way for them to get there then...that’s awesome! [Chuckles]

**Excerpt 68 - Possible outcomes – For clinicians**

**Oceane [Clinical psychologist]**: I suppose a lot of people in our civilisation, like young people, end up being incredibly isolated and sad and killing themselves. I feel very very sad to think of people in that situation um... And feeling that there’s no hope or... nobody who can help them out sort of thing, that is really sad for me.

\textsuperscript{17} Karakia: Māori incantation, ritual chant
\textsuperscript{18} Marae: open area in front of a Māori meeting house, where formal greetings and discussions take place
Paige [Psychiatrist]: Quite often for example you're dealing with a person, [...] [who has] been exposed to situations from before they were born and which have resulted in them feeling the way they do about themselves and their lives and their future. I can't go back and change that now. [...] And you know you can feel quite sad about that but at the same time you think ‘oh if I can make a small difference, it’s okay’ [pause].

Clinicians in the sample found existential issues, including contemplating suicide, fundamentally human, and had in common an interest and a natural inclination towards them. Adelia talked about an “on-going exploration that is centrally important” to her, regarding “lack of controlness” and “existential terror”. For Natalia, part of being human means reflecting on existence and non-existence. There are the two sides of the same coin. Oceane and Hassie found spirituality to their practice. Renee, Nolan and Landon talked about the fundamental thing of being humans together.

Furthermore, their interest in existential issues started long before they became clinicians. In this sense, their practice appeared like a vocation. Donna referred to her nursing background, and justified that she always liked the “realness” of working at the “gritty edge of the human beings”. She explained having always been interested in exploring how people find meaning to life. Similarly, Eliza declared that contemplating and reflecting about the lack of control over life was “very much already [her] philosophical or psychological position” before she became a psychotherapist. Finally, Linnett recalled wanting to do this kind of work from an early age.

Excerpt 70 - Possible outcomes – For clinicians
Linnett [Clinical psychologist]: [...] since I was probably in my early to mid-teens, I was very clear I wanted to be doing a work that was meaningful in that way. I couldn’t just be, you know, on the stock market or selling stuff that people don’t need. I was really clear I wanted to do something that would be meaningful and helpful to my fellow humans.

Linnett conjectured that her early desire to do this kind of work originated in her own thwarted need for connectedness. Coming from a background where she had “very sadly, a very disconnected mother” she said, as well as father, she would have sought human connectedness for herself first.

Excerpt 71 - Possible outcomes – For clinicians

Linnett [Clinical psychologist]: [...] So seeking that for myself... And I’m feeling quite tearful as I say this, partly sleep deprivation [Linnett was on call the night before the interview] and in part because this touches me very deeply. But my own seeking for human connection, for deep and meaningful connection not just, I mean, the superficial stuff as well. But actually the deep meaningful communication.

Adelia and Landon made similar links between their own thwarted needs, the development of emotional literacy and their clinical vocation.

Excerpt 72 - Possible outcomes – For clinicians

Landon [Psychotherapist]: [...] I was brought up with a lot of fear. So I had to attend to that and get comfortable with that in myself. And getting comfortable with that fear has made me, I would use my body much more easily sitting with people. And um, I don’t say it’s magic but it’s made a big difference to the comfortableness of sitting with people who have had significant trauma.
The data hence suggested that clinicians’ empathic ability could originate from their own fundamental yearning for connectedness. Linnett contended that she learned to develop meaningful connections for herself before feeling the drive to share her experience with others, both personally and professionally. In retrospective, she said she had “always been empathic”, indicating that her empathic skills could have developed from a young age.

Like Landon who used the concept of limbic resonance, Linnett referred to the neuropsychology of attachment to justify the depth of her satisfaction. Alluding to research conducted on attachment, she argued that there is robust evidence that the need to connect emotionally and attach to others is fundamental to human beings’ survival.

Excerpt 73 - Possible outcomes – For clinicians

Linnett [Clinical psychologist]: You know babies in those, some Eastern Block orphanages, they’ve been given feed and change, but without connection they fail to thrive. They die! And so we absolutely need this. And it’s experienced at a non-verbal level and in a very visceral, physical, level. And we’re, we are hardwired to know when that’s real. We’re absolutely hardwired to know.

Linnett indicated that she speaks about this at every opportunity she gets, including to her clients. She draws the brain to talk about the limbic system, the amygdala, the fight/flight response and explains the crucial role of the mammalian brain in attachment, before talking about the “latest instalment, the prefrontal cortex, and the uniquely human challenges that it brings”. Linnett argued that this neuroscientific approach refers to our humanity, and “brings understanding and compassion for people”.

Interestingly, Paige insinuated that a relationship between her sense of satisfaction and the reward system in the brain could exist by using the terminology of addiction “to get high”.

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Excerpt 74 - Possible outcomes – For clinicians

Paige [Psychiatrist]: Because when you have worked and worked and worked, and then another time when you see the person and they're better. And they will often say that to you, “you know that really changed it and made a difference”, they're carrying on... That's really rewarding. It's like I, you couldn't pay me enough for that. It's exhilarating. It feels like yeah, I did something, it was worthwhile. You know, if I only do that once in my life it's worthwhile. I really get high on that! [Chuckles].

Practice –based learning

Clinicians also felt competent, which participated to their sense of satisfaction. By virtue of the emotional synchrony they establish, clinicians could feel their patients improving from within the relationship. For example, Landon explained not feeling the need to question his patients explicitly about suicidality at each session because he is “sitting with them and they're telling [him] how distressed they are or what's happening in their world”. Effectively, clinicians trusted their ability to sense whether a deep meaningful emotional connection is established and a patient is improving.

When the connection was not happening, clinicians thus could adjust to this phenomenological feedback in real time to attempt establishing one. This fine-grained self-regulated navigation of the therapeutic relationship appeared to provide an immense opportunity for professional growth. Clinicians had grown confident in their ability to help PRS from this practice-based learning. Clinicians’ sense of competence was thus built phenomenologically.

Excerpt 75 - Possible outcomes – For clinicians
Clinicians’ sense of competence had increased over the years as they learnt to trust their own judgment and ability to navigate the clinical encounter. With experience and also by referring to a theoretical framework that made sense to her, Natalia felt like she became “willing to take what would otherwise feel like very risky therapeutic steps”.

As humble and critical of themselves as they were, clinicians were also aware of providing something very special.

**Excerpt 76 - Possible outcomes – For clinicians**

**Oceane [Clinical psychologist]:** I suppose it's something to do with feeling deeply that I'm good at being with the person and I'm good at my job because I'm very experienced and that's very reinforcing, [...] so I do enjoy it. I do enjoy being with people and communicating with a meta deep level and that can be helpful, that's great. I'm not really sure how to describe that anymore. [Pause].

Clinicians’ sense of competence had increased over the years as they learnt to trust their own judgment and ability to navigate the clinical encounter. With experience and also by referring to a theoretical framework that made sense to her, Natalia felt like she became “willing to take what would otherwise feel like very risky therapeutic steps”.

As humble and critical of themselves as they were, clinicians were also aware of providing something very special.

**Excerpt 77 - Possible outcomes – For clinicians**

**Linnett [Clinical psychologist]:** [...] In retrospective, I've always been empathic, I know that, I thought everybody could do that [laughs] I thought that everybody can just sit still and tune in and that they could feel what other people are feeling but I've since found out that it's not true [chuckles].

They provided something very fundamental and very important, that went beyond normal professional duty of care. Something rare, that not everyone could provide.

**Excerpt 77 - Possible outcomes – For clinicians**
On one hand, most interviewees were surprised that only 14.7% of 267 clinicians in the survey declared that they liked working with PRS, and felt saddened by it. On the other hand, interviewees were aware of liking doing what most clinicians find challenging.

Excerpt 78 - Possible outcomes – For clinicians

**Hassie [Psychiatrist]:** [...] it’s having a sense that I can contribute to something that a lot of people find really difficult. That I can kind of, you know, remain relatively functional in the context of [patients’] relating, which is really difficult. I don’t think I’m perfect at it or anything but um... [Pause]

In interviewees' narrative, “challenging” was often associated with “interesting”. This was the case for Hassie, but also for Natalia, and Adelia, who argued that “difficult is interesting”. Aware of their level of competence, the clinicians interviewed found sometimes difficult to let someone else be in charge of the most delicate situations.

**Emotional & cognitive fatigue**

Finally, establishing an aroha connection is also emotionally exhausting for clinicians. Natalia explained that working with PRS takes up a lot of her emotional, cognitive and clinical skills, and referred to the “emotional burden” of the practice as the most challenging aspect for her.
Others found that the practice became more tiring over the years. The more connected clinicians got, the more satisfied, but also the more tired they felt. For Landon, this feeling of fatigue is a direct consequence of the activation of the parasympathetic nervous system. Yet, he wondered if aging was also part of it.

Excerpt 79 - Possible outcomes – For clinicians

**Landon [Psychotherapist]:** [...] The thing I did notice was I got more tired, allowing more autonomic nervous system to resonate with the other person. Because, if you have the sympathetic nervous system go off you also have the para-sympathetic nervous system go off afterwards and I was getting a lot more tired. I have had a lot harder work, for a while. [...] It's not as marked [now] [...] Well it's hard as you get older to figure out whether you getting tired is just because you're older isn't it? [Laughs].

Interviewees had strategies to manage the emotional load of their practice. They insisted that self-care needs are high and paramount to remain functional in working with PRS. According to interviewees, clinicians need a reliable and functional professional and personal support system to work with PRS. They need supervision, consultation, peer-vision and/or reflective-practice groups. Ideally, clinicians also need to manage their caseloads if they can, as no one can deal with several highly suicidal patients at one given time. Finally, clinicians need a personal support system as well as a social network. Many interviewees also indicated that undertaking personal therapy should be a pre-requisite to working with PRS.

8.2.4.3 Potential obstacles to positive outcomes

I did not ask participants directly about potential obstacles to positive outcomes. However, some interviewees volunteered the information, particularly in the first two groups of interviews, which were particularly open ended. In addition, clinicians mentioned possible obstacles when prompted to make recommendations for clinical practice.
This section examines the obstacles mentioned by interviewees in two categories, a distal type of obstacles consisting of the mental health system or specific context of their practice, and a proximal type consisting of clinicians’ own emotional responses, or CT. As discussed previously, it is worth repeating that the clinicians interviewed did not consider PRS’ behaviour as an obstacle to treatment. They did not hold patients responsible for therapeutic hiccups or failures.

The obstacle most cited by interviewees was the broader context of their practice. Overall, clinicians did not feel supported in their practice by the NZ public mental health system. They found that a dissonance existed between the system’s goals and patients’ needs, and their absence of agency over this occasioned frustration and sadness in them.

Excerpt 80 - Possible outcomes – Potential obstacles

**Oceane [Clinical psychologist]:** [...] I’m thinking about some cases where I think more could have been done. [sigh] I’m thinking of a [case of an 18 years old]. I don’t feel this man, this young man was treated properly by the mental health system... um... and I had an enduring sense of sadness about him. [...] Sometimes the health system will look like they’re doing enough but they’re not really. So I do have some sadness about cases like that...

Clinicians argued that the NZ public mental health system aims to stop people from killing themselves rather than helping them build a life worth living, which is the wrong goal to have for only the second is amenable to treatment.

Excerpt 81 - Possible outcomes - Potential obstacles

**Landon [Psychotherapist]:** Well our services try to make sure we don’t have suicides. It’s almost as if you know, it’s only if we don’t have suicide that the service is successful... Suicide happens. [...].

Excerpt 82 - Possible outcomes - Potential obstacles
As a result, patients can feel misheard, which can reinforce suicidality.

Excerpt 83 - Possible outcomes - Potential obstacles

**Nolan [Clinical psychologist]:** Mental health services are not aiming at the right thing. There are some brilliant people within the services, but the overall goal... I would say the pressure is how do we make sure we keep off the front page of the paper, we keep off the coroner asking hard questions, we... [Pause] it's a very cynical way of saying we stop people from dying rather than, how do we actually help people’s mental health.

Landon had to comply with a six-session framework in the public system where he worked for the last 20 years. He argued that such framework does not allow addressing the person's trauma. The dyad needs time to form a trusting relationship so that people can understand themselves in a more “fundamental way”, he explained. In his private practice, he found that a 2 to 3 years’ timeframe was optimal to address an underlying history of trauma. He noticed inconsistencies in the NZ public suicide prevention discourse.

Excerpt 84 - Possible outcomes - Potential obstacles

**Landon [Psychotherapist]:** In fact, quite a few patients would complain, 'look I’ve been in the mental health service, and all they ask me is am I going to kill myself. They don’t ask me about me’ they might say.

Landon had to comply with a six-session framework in the public system where he worked for the last 20 years. He argued that such framework does not allow addressing the person's trauma. The dyad needs time to form a trusting relationship so that people can understand themselves in a more “fundamental way”, he explained. In his private practice, he found that a 2 to 3 years’ timeframe was optimal to address an underlying history of trauma. He noticed inconsistencies in the NZ public suicide prevention discourse.

**Landon [Psychotherapist]:** [...] the suicide people came and talked to us [...] about suicide. They talked about the therapies that they thought would be helpful. I said, ‘you have identified that trauma is quite a predictor of suicidality, but none of the therapies that you suggest deal with the trauma, why is that?’ And of course, that couldn’t be answered.
Bernice felt that her clinical resources could be threatened in the near future. It seemed to her that the service management team did not understand patients’ need. They are “business savvy but perhaps not mental health savvy”, she explained. Bernice found DBT very helpful for instance, but it includes a high level of resourcing (individual sessions, group sessions, skills groups, etc.), that might not seem “cost effective” to people running the place. Yet, she argued that looking at it in terms of the “treatment gains and the progress that the young people are making” tells “a different story”.

Interviews felt hindered in their endeavours by what they described as an institutionalised aversion to risk. Linnett invoked this to make sense of the low level of endorsement of the like-statement in study 1.

**Excerpt 85 - Possible outcomes - Potential obstacles**

*Linnett [Clinical psychologist]: [...] I also think in New Zealand you know, with the highest suicide rate, that certainly D.H.Bs\(^{19}\) and others have become quite risk averse as well. And so, they tend to want to go 'I'm not dealing with this I'm going to pass them on', 'I don't want to have this on my shoulders, if someone takes their life'. So I think that's part of that story as well. Yeah, I'm not surprised to hear those statistics.*

Hassie described NZ public mental health systemic aversion to risk as the most challenging aspect of her job. Recall that Hassie stressed that people need to experience life outside of the hospital to build a life worth living (see section 8.2.2.3 about clinicians). At times, despite the risk, she trusted her clinical judgement that discharging patients represented their best chance for recovery. However, an aversion to risk coming from a hierarchy or other services can sometimes override

\(^{19}\) District Health Boards (NZ public health services)
or obstruct her clinical strategies. In her view, the systemic aversion to risk can in some cases reinforce suicidality.

Finally, in NZ, psychiatric emergencies services are primarily called Crisis Resolution Services (CRS). They offer 24 hours psychiatric assistance in each adult mental health communities all over the country. In principle, clinicians can refer suicidal patients to them when required. However, clinicians who worked outside of the public mental health system did not find the Crisis team responsive nor helpful.

Oceane, who used to work in the public mental health system, explained that being part of the same organisation than the Crisis team made supporting patients at risk easier. In contrast, now that she practiced outside of the public system, she found “extremely difficult” to get the crisis team involved.

Excerpt 86 - Possible outcomes - Potential obstacles

Oceane [Clinical psychologist]: The part that is really difficult is getting the mental health service to do their job, and to be available or to admit the person to the system when you need them to. [Pause] but the actual suicidal person is fine. It’s working with the system that’s the hard part.

Nolan shared Oceane’s experience. Conceding his own cynicism, he considered part of his role as “protecting” his patients from clinicians or services who have the “wrong goals”.

Excerpt 87 - Possible outcomes - Potential obstacles

Nolan [Clinical psychologist]: [...] If you call the crisis team and say I’m feeling very desperate, they say ‘are you going to kill yourself today’. You say no, they’ll say ‘ok, call us back next week we’ll book you in for an appointment’. [It’s the] inconsistent support people get, depending on who answers the phone.
These interferences coming from the NZ public mental health system represented the biggest obstacle for the clinicians interviewed. By being outside of their control, this type of distal hindrance caused the most frustration for them.

The second type of obstacles consisted of CT interference affecting the therapeutic relationship. Although demonstrating advanced CT skills themselves, interviewees commonly identified the lack of CT literacy as the most common pitfall when prompted to reflect on the challenges inherent to working with PRS. Interviewees contended that clinicians need a willingness to be introspective to develop the level of CT literacy required to work with PRS.

Excerpt 88 - Possible outcomes - Potential obstacles

Natalia [Clinical psychologist]: [...] you do need to have access to what’s happening inside of you though. You need to be aware enough of what’s going on inside of you in order to be able to be present with that person in the room. I guess that’s probably the thing that would be very difficult to train for some people.

As discussed, clinicians need to be CT literate to establish an aroha connection with patients. First, they need to manage their own responses to empathise and sit with patients’ distress, while resisting the urge to fix. Clinicians do experience their patients’ emotional disturbance within the relationship, which challenges their own ability to regulate emotion. Second, clinicians need to manage their latent emotions toward death and suicide to be present in the room despite the risk of suicide, and able to focus on their patients’ needs. The management of these complex CT responses in high-risk situation is extremely challenging, especially with non-collaborative patients. Clinicians need to achieve emotional literacy for themselves before they can navigate the emotional complexity of clinical situations with PRS in order to achieve the desired level of emotional synchrony.

Excerpt 89 - Possible outcomes - Potential obstacles
Furthermore, clinicians need to extend their empathy to their patients’ relatives. A lack of collaboration from patients’ family can represent an important obstacle to treatment too, especially when clinicians work with young people. Renee shared a case where the patient’s parent interrupted the treatment abruptly. She found the experience very distressing and assumed it had been so for the patient too. Similarly, Hassie elaborated on the need to deal with young people’ parents or legal guardians, as they can interfere with clinical decisions.

Excerpt 90 - Possible outcomes - Potential obstacles

**Adelia [Psychotherapist]:** [...] if people don’t have a sense that they’re open to their own difficulties and their own lives, then I don’t think they’d be open to the difficulties on, clients, patients’ sides.

Hassie [Psychiatrist]: [...] It’s kind of commonly fathers that’s actually, but you get it with mothers too, who would be experiencing a lot of anxiety about their own parenting. And what they’ll do is they’ll be incredibly critical of us. And that’s really unpleasant. What I need to do is moving to a point of really understanding where they’re coming from. It’s the same with the young people. Usually when I feel like I don’t like them, usually it’s cause I don’t... I mean if I can actually get to understand them a bit better, I can get through that.

CT literacy is therefore also required to foster relatedness with difficult parents.

Interviewees thus argued that the critical need for CT literacy should have implication for clinicians’ training. For some interviewees, undergoing personal therapy should be a pre-requisite to work with PRS. Linnett maintained that experiencing therapy personally was beneficial to her clinical practice.

Excerpt 91 - Possible outcomes - Potential obstacles
Landon found “distressing” that training programmes, such as those for clinical psychologists in NZ, generally do not include personal therapy. In his view, undergoing personal therapy would help trainees sitting with their feelings.

However, interviewees also knew that the special thing they could provide is only partially teachable. Paige for instance proposed that the way she navigates boundaries in extreme situations to connect with highly distressed people is very much an art. She argued that the ability to connect emotionally with people is quite hard to train without a pre-existing set of interpersonal skills to build on. However, you can teach people to be “more curious about others”, she declared, and some techniques of deliberate “matching and pacing” can compensate for some interpersonal shortcomings. In the same vein, Donna contended that a lack of clinical timing in trainees reveals interpersonal blind spots that, in her experience, training fails to overcome.

8.3 Summary

This chapter presented the findings from the second qualitative study. GTM applied to interview data led to construct an exploratory model of clinicians’ positive inclination to PRS. This model is concomitantly a working model of the processes involved in treatment. After describing the sample of clinicians, the chapter detailed the aroha model by distinguishing the aroha connection itself, clinicians’ and patients’ part of the interaction, and possible outcomes. The following chapter discusses these findings.
This chapter discusses the findings from the second study. To my knowledge, this is the first work attempting to gain an in-depth understanding of clinicians’ positive inclination to PRS. Applying the grounded theory method (GMT) to interview data led to conceptualise the aroha connection as the interpersonal process at the core of the clinical encounter with PRS. This chapter summarises the main findings of the study before discussing them. After considering the study’s strengths and limitations, indications for future research and clinical practice are provided.

The aroha model formulates the interdependence of clinicians’ positive inclination and of the therapeutic influence of the clinical encounter for patients. As anticipated, exploring clinicians’ positive inclination shed light on the processes involved in PRS’ improvement in treatment. These findings suggest that recent advances on the neuroscience of psychotherapy could be of particular relevance to clinical suicidology.

9.1 Summary of findings & discussion

The study's main finding is that clinicians' satisfaction and patients' improvement in treatment both stemmed from the experience of a deep emotional connection lying at the core of the clinical encounter. Moreover, the findings suggested that clinicians could actually fashion an emotional environment that promoted the

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occurrence of such connection, which they implemented phenomenologically. To achieve so, clinicians used advanced CT literacy skills to synchronise emotionally with highly distressed individuals, before “sitting with”, i.e. regulating the shared emotion. Finally, short-term and mid to long term benefits could be distinguished for both patients and clinicians. In the short term, this connection created an interpersonal emotional regulation where patients could benefit from clinicians’ own ability to bear and regulate difficult emotion. Akin to a primary care giver who uses her/his capacity to be calm to calm an infant. This interpersonal emotional regulation appeared to be deeply satisfying for both patients and clinicians. In the mid to long term, clinicians seemed to cultivate and maintain over time a stance of genuine care for their patients and hope that provided a consistent emotional ground upon which an attachment could grow. In clinicians’ experience, this attachment can have a therapeutic influence for patients. Suicidality appeared to subside as patients’ sense of connectedness developed. In Te reo Māori, “aroha” means love, compassion and breath of life. I named “aroha connection” the therapeutic emotional bond found at the core of the clinical encounter, and “aroha clinicians” the professionals who are willing and able to form such a connection with PRS.

9.1.1 Aroha connection or the therapeutic influence of the relationship

These findings reaffirmed the critical role of the therapeutic relationship in achieving positive treatment outcomes with PRS (Bedics, Atkins, Harned, & Linehan, 2015; Dunster-Page et al., 2017; D. A. Jobes & Drozd, 2004; Joiner et al., 2009b; Michel & Jobes, 2011), while substantiating it. The study invites to consider that the relationship is not merely the collaboration required to implement the treatment; but rather, that it could be the therapeutic agent itself. This means that a strong relationship is indeed essential, but perhaps not merely for the intervention to be effective as it has been argued (Konrad, 2011; Linehan, 1993), but because it is the intervention itself. The notion that the relationship itself exercises the therapeutic influence in treatment is not a new one in psychotherapy. Remember that Freud argued as early as 1912, that aspects of the transference
consisting of “friendly and affectionate aspects” were “the vehicle of success in psycho-analysis exactly as it is in other methods of treatment” (S. Freud, 1958, p. 106). The manipulation of the transference for therapeutic purposes is indeed a key feature of psychodynamic treatments (Safran & Muran, 2000).

Also consistent with the literature, the study provided further evidence that CT management plays a pivotal role in achieving positive outcomes in clinical suicidology (T. E. Ellis et al., 2018; Maltsberger & Buie, 1974; Perry et al., 2013; Richards, 2000; Yaseen et al., 2013). Clinicians in the study used advanced CT literacy skills to monitor and manage their emotional responses in order to achieve a state of emotional synchrony with PRS, despite patients’ ambivalence and the suicide risk. This, which required an acute emotional awareness, was described by a participant as a state of “mindfulness in real time”. Another clinician used Linehan’s concept of “wise mind”. In DBT (Dialectical Behavioural Therapy), Linehan proposed the concept of wise mind as an integration of reasonable and emotional minds that “also includes an emphasis on intuitive, experiential, and/or spiritual ways of knowing” (Linehan, 1993, p. 242). In very similar ways, interviewees’ navigation of the clinical encounter appeared informed by a continuous dialogue between implicit/intuitive and explicit/cognitive levels of appraisal. This calls to mind Ferenczi’s argument that conducting therapy consisted for clinicians in alternating constantly between “empathy, self-observation, and making judgement” (Ferenczi, 2002, p. 96). Of note, in Linehan’s writings, the wise mind is the goal to achieve for patients, rather than a desired therapeutic stance for clinicians. However, by pointing to the similarity between clinicians’ stance and the state of wise mind, these findings suggested that the clinical encounter tends toward a unison of clinicians and patients’ experiences.

Also within the competency of CT literacy, clinicians used both their cognitive and emotional selves to navigate the complex interpersonal dialectic in treatment. Clinicians adjusted their emotional involvement in real time of the encounter to engineer the bond that would foster a therapeutic attachment, while promoting independence in their patients. In line with experts’ opinion, the study suggested
that the nature of the therapeutic relationship needed by PRS goes beyond one of cordial professionalism (Orbach, 2001; Shneidman, 1981, 2004). Referring to a psychodynamic theoretical framework, Maltsberger insisted that with PRS, the emphasis should be on the real relationship rather than on the transference. He contended that to treat PRS, “[...] the therapist must come out from behind the couch and join the patient in a face-to-face encounter”. He further argued that, “one of the principal characteristic of the real relationship must be that the therapist will love the patient and not conceal this fact” (Maltsberger, 2001, p. 160). Similarly, some interviewees used the term “love” to describe the interpersonal dynamic of therapy, and all insisted that one has to care genuinely and feel warm towards PRS to achieve positive outcome. In line with the neuroscientific evidence that shows parallels between attachment in early life and the processes of psychotherapy, participants drew analogies between their role with PRS and the parent-child relationship. (Bateman & Fonagy, 2004; A. N. Schore, 2012).

In terms of outcomes, in the short term, the interpersonal emotional regulation, which could occur upon first encounter, occasioned instant relief for patients and instant gratification for clinicians. In the mid to long-term, an attachment could develop and foster a sense of connectedness that foiled patients’ suicidality. Interviewees contended that, through building a relationship with them, patients grew confident in their ability to build a secure and nurturing attachment outside of therapy. In the same vein, Maltsberger and Buie argued that over time, “[the patient] uses the therapeutic relationship to grow and to accept life in the real world for what it is-something less than a narcissistic paradise but populated with other people who can reliably offer some love, if not total gratification” (Maltsberger & Buie, 1974, p. 632). The findings suggested that such attachment could occur in treatment in a relatively short period of only a few sessions. The difference between this type of attachment and one occurring naturally in personal life was difficult to pinpoint. One interpretation could be that the therapeutic frame provides a controlled hence more secure emotional environment in which an attachment can grow in an accelerated version. Recall that clinicians stressed the need to make the encounter exclusively about the patient, and not expecting to have their own needs
met. In a sense, by using CT literacy to manage their own responses while focussing on patients’ needs, clinicians subtract effectively half of the emotional variables found otherwise in human relationships, and corresponding to their own needs. By managing CT to navigate the relationship at an emotional level, clinicians could in fact fashion implicitly the emotional environment patients need to learn to trust in order to practice forming an attachment to another human being safely. Let us call “therapeutic attachment” the process through which patients bond to a professional in an emotionally controlled environment to develop emotional literacy in a short time frame.

Just as they felt their despair, emotionally attuned clinicians could feel their patients’ suicidality dropping and hopefulness rising. As they achieved positive outcomes, clinicians’ sense of competence grew, along with an enduring sense of purpose and satisfaction. The depth of the emotional connection affected the strength of clinicians’ sense of reward. These findings invited to consider that clinicians’ positive inclination could be indicative of their ability to achieve positive outcomes with PRS. The relationship between outcomes and professional inclination becomes more patent when examining clinicians’ positive inclination.

9.1.2 Positive inclination to PRS

The study provided layers of answers to the primary research questions concerning the reasons for clinicians’ positive inclination to PRS. At the surface, I found clinicians’ desire to help, their sense of doing something profoundly human and meaningful, and a sense of competence. At the very core of clinicians’ positive inclination, I found a sense of profound satisfaction. Clinicians strove to achieve emotional synchrony with their patients, which induced a therapeutic attachment. As connectedness developed, patients’ suicidality decreased while clinicians’ satisfaction grew.

A practice-based learning system hence reinforces clinicians’ positive inclination to PRS. Clinicians had the emotional skills necessary to achieve positive outcomes in
treatment with PRS. As they repeated positive experiences in treatment, clinicians grew confident in their professional abilities while feeling personally satisfied. In turn, their personal satisfaction and sense of competence reinforced their desire to help PRS and their motivation to hone their professional skills further. The reinforcing loop thus went as follow: These clinicians like working with PRS because they feel competent to do it; they are competent, therefore they tend to achieve positive outcomes; they achieve positive outcomes, therefore they feel satisfied; they feel satisfied, therefore they like it; and so forth.

Figure 9.1 Practice-based learning reinforcing system of clinicians’ positive inclination to PRS

At this level of interpretation, the findings merely lend credence to self-determination theory (SDT) (Ryan & Deci, 2017). As anticipated, aroha clinicians demonstrated an intrinsic motivation, strongest level of self-determination. Intrinsic motivation is achieved when a sense of coherence among goals, values and regulation has evolved into an inherent autonomous motivation, and results in interest and enjoyment of the task (see Chapter 2, section 2.5 about positive inclination). In addition, SDT postulates that the need to satisfy three basic psychological needs is at the root of positive motivation. These include the need for
autonomy, competence, and relatedness (Baumeister & Leary, 1995; Gagné & Deci, 2005; Ryan & Deci, 2000). The present study certainly found that clinicians’ positive inclination or positive motivation was nurtured by their sense of competence and relatedness. Conversely, the interference causing most frustration in clinicians was the lack of support from the NZ public mental health system. In light of SDT, clinicians’ lack of control over the broader context of their practice could be interpreted as an unmet need for autonomy. Nevertheless, clinicians’ positive inclination, as operationalised in this study, reflected an intrinsic motivation to work with PRS.

However, this is but one aspect of the answer for the study did not seek to find out whether clinicians like working with PRS, but why they do. The singularity here is not that interviewees demonstrated an intrinsic motivation, but that they did so in extreme cases where the majority of their peers do not. How did interviewees develop the ability to achieve emotional synchrony with highly distressed individuals, in spite of the risk of suicide? How did they acquire the skills required to achieve positive outcomes in extreme situations, in the first place? Which of clinicians’ willingness or ability to help came first? In response to these questions, the study suggested that clinician’s skills emerged from a fundamental urge to repair a personal need for connectedness. In the last interview, volunteering some formulations as to why her skills developed, Linnett recounted that her basic need for connectedness was thwarted by having had emotionally “disattuned” primary care givers. She believed that her empathic skills were rooted in her own historical yearning for connectedness. Linnett would have learned to form meaningful emotional connections for herself first, before feeling the drive to share the experience with others. She recalled wanting to exercise this type of “meaningful profession” from a young age. As indicated in the finding chapter, a historical personal need for connectedness filtrated in other interviews too.

The question henceforth is why would finding emotional connectedness for oneself result in a drive to form connections with others? At a symbolic level, clinicians’ willingness to help was reinforced by their sense of doing something profoundly
meaningful. Without having been suicidal themselves necessarily, clinicians might have had fundamental experiences of disconnectedness that allow them to relate to PRS. This means that the experience of emotional (dis)connection would make sense to clinicians personally. In this sense, the study relates to the theory of the wounded healer although taking it a step further. The concept of “wounded healer” proposes that clinicians’ own psychological wounds can carry a curative power (Zerubavel & Wright, 2012). However, in a slightly different way from this, the present findings suggested that clinicians’ skills could stem from a personal journey to attend to their own fundamental needs in early life, rather than from experiences of psychological hardship in adult life. Indeed, clinicians demonstrated a form of universal empathy, despite that most specified that they did not experience being suicidal personally. Linnett emphasised that ultimately the aim of therapy was to normalise the human experience, for patients and clinicians alike, which reinforced this sense of reciprocity. Clinicians self-disclose to normalise patients’ experience. Reciprocally, by sharing their own, patients normalise clinicians’ experience too. The universality of this connection goes beyond suicidality.

These data thus invited to consider the neurological underpinnings of clinicians’ satisfaction, hence, of their positive inclination. The findings suggested that establishing an aroha connection could activate the reward system in the brain, thus implying that clinicians could potentially be satisfied to the point of being physiologically addicted to emotional connectedness. Recall that participants alluded to “getting high” on connectedness, or getting a “parasympathetic activation syndrome” after sessions (see Chapter 8, section 8.2.4.2). This finding raise the question of whether clinicians could find a form of physiological balance for themselves through connecting emotionally with their patients. Research in neuroscience has shown that the interpersonal regulation involved in attachment activates the reward system in the brain for evolutionary reasons (Peter Fonagy & Bateman, 2006; Insel, 2003; Stein & Vythilingum, 2009). Mothers’ dopamine-associated reward-processing region of the brain is activated by the smile of their child, which calls to mind Landon’s metaphor of “receiving the smile of a child” to depict his sense of reward in therapy (Strathearn, Li, Fonagy, & Montague, 2008).
Advances in neuroscience suggest that interpersonal dialectics similar to those of attachment in early life could be at the roots of the therapeutic influence of psychotherapy. This body of research appears to support the model developed qualitatively in the present study.

### 9.1.3 Indicators of neurobiological underpinnings

Allan Schore integrated neuropsychiatric and neuropsychological evidence from the past three decades to propose that attachment theory is in essence a “regulatory theory”, defined as “the interactive regulation of biological synchronicity between organisms” (A. N. Schore, 2000, p. 23). The primary care giver regulates the infant's psychobiological states non-verbally, through “olfactory-gustatory and tactile-thermal sensory modalities” first, then predominantly through synchronic gaze (A. N. Schore, 2003b, p. 7). These experiences of dyadic psychobiological attunement affect the production of neurohormones and hormones that epigenetically shape neural pathways of regulation in the infant’s maturing brain:

> The mother’s participation in interactive regulation during episodes of psychobiological attunement, misattunement, and reattunement not only modulates the infant’s internal state, but also indelibly and permanently shapes the emerging self's capacity for self-organization. More specifically, access to her regulatory functions is a fundamental prerequisite to the emergence of those homeostatic structural systems that are neurobiologically maturing during a critical period of infancy. (A. N. Schore, 2003b, p. 26)

Conversely, non-optimal or lack of attunement during periods of important neuronal growth can cause self-regulatory systems deficiencies and is associated with psychopathology in later life (Kraemer, 1992; Nephew, Huang, Poirier, Payne, & King, 2017; Ovtscharoff & Braun, 2001). For instance, studies have shown that, in response to a specific stimulus of attachment threat, BPD patients display patterns of activations in the right cortex that suggest an underlying neural trauma (Buchheim et al., 2008; Kiefer et al., 2017). Neurological evidence hence supports the fundamental tenets of attachment theory that, “the real relationships of the
earliest stages of life indelibly shape our survival functions in basic ways, and that for the rest of the life span attachment processes lies at the center of the human experience” (J. R. Schore & Schore, 2008, p. 9).

While this discussion will not go more in depth into this rich body of literature, it is worth noticing that the study’s qualitative findings support that the ontogeny of emotional and physiological self-regulation is interpersonal (A. N. Schore, 2003a). Evidence shows that experience shape the physical architecture of the brain (Kandel, 1998), and that, although at its apex in infancy, the right-brain to right-brain implicit interpersonal dialectic at the core of attachment is present throughout the life span (J. R. Schore, 2012). Furthermore, evidence suggests that similar interpersonal affect regulations are indeed at play in therapy (A. N. Schore, 2014), which makes pathological emotional dysregulations effectively amenable to psychotherapy (Barsaglini, Sartori, Benetti, Pettersson-Yeo, & Mechelli, 2014; Buchheim et al., 2012; Cristea et al., 2017; Marceau, Meuldijk, Townsend, Solowij, & Grenyer, 2018). The model derived qualitatively in the present study appears remarkably congruent with bodies of work providing evidence of the neurological underpinnings of the therapeutic influence of psychotherapy.

9.2 Strength & limitations

The local context of the study needs to be considered in appraising the potential transferability of these findings. Ultimately, the validity of my propositions will be established by deriving hypotheses and testing them, either quantitatively or qualitatively again, in new samples and/or in other cultural contexts. Likewise, the legitimacy of using the Māori term “aroha” could be questioned, given that the principal investigator for this work is neither Māori nor a New Zealander. However, the study adopted a constructivist approach to GTM which encouraged a co-construction of the model from the views of 12 NZ clinicians including 2 who self-identified as Māori, as well as a researcher. Furthermore, I undertook cultural consultation during the analysis, and made the decision to use the term “aroha” in agreement with a Māori cultural adviser.
This work shares other limitations of qualitative studies, such as the risk for the researcher to superimposing personal preconceptions by forcing interpretative patterns onto the data. Here again, adopting a constructivist approach to GTM aimed to compensate some of these shortcomings by acknowledging, writing memos about, and discussing biases from the study’s early stages (see appendices XI and XIII). Moreover, the study sought to increase trustworthiness in three different ways. First, another rater, either a supervisor of the adviser on the study, also coded half of the data. Second, supervisor, advisor and the principal investigator discussed the study design and the coding process in meetings, before data collection started, during initial coding and at the transition between initial and focused coding. Finally, I elicited clinicians’ feedback on the preliminary findings from interview number eight onwards, to test the aroha model against the last four interviewees themselves, after they had completed the interview schedule.

Ultimately, the aroha model consists of a representation of the reality of clinicians’ positive inclination to suicidal patients re-constructed with a method of abduction (Bryant, 2017c). The limitation is therefore that, despite using the same research questions with the same sample of clinicians, a different researcher would have developed a different model. However, I concur with an epistemic stance of post-positivism, which means that, despite acknowledging that these findings are necessarily tainted by my subjectivity, the model attempts to describe the reality of phenomena occurring in psychotherapy with PRS nonetheless. In fact, presenting these findings to practicing clinicians indicated that they have important face validity. However, in accordance with a post-positivist paradigm, future work is required to assess the validity and generalisability of these findings.

As discussed, the model developed in the study turned out to be extremely congruent with the theory of regulation, or modern attachment theory (J. R. Schore, 2012), so that the contribution to knowledge can seem slim. Conversely, it could be argued that this congruence increases the study trustworthiness while providing further support for the therapeutic influence of attachment in psychotherapy (Cozolino, 2017). Furthermore, given the filiation that exists between history of
trauma, BDP and suicidality (Bateman & Fonagy, 2004; Peter Fonagy & Bateman, 2006), the study invites to consider the potential relevance of attachment informed treatment for PRS. Other elements of the aroha model bear important similarities with existing bodies of knowledge. For instance, the intersubjective implicit dialectic found at the core of the model is consistent with the realm of “implicit relational knowing” (Stern et al., 1998) described by Schechter and colleagues as a key element of the therapeutic alliance with PRS (Schechter, Goldblatt, & Maltsberger, 2013). Furthermore, as these authors noted, the genuine care described by participants as a prerequisite to establishing an aroha connection is comparable to the “radical genuineness” described by Linehan as the highest level of validation (Linehan, 1993). Finally, the implicit/explicit dialogue carried out collaboratively by patients and clinicians is encapsulated in the concept of mentalization developed by Bateman and Fonagy (Bateman & Fonagy, 2004). Thus, I argue that adopting a stance of theoretical agnosticism helped highlighting the important overlaps, and potential complementarities, that exist between different theoretical frameworks, and between theoretical orientations in relation to treating PRS.

Limitations also ensue from inferring knowledge about PRS from clinicians’ experience of them. Clinicians’ perception of their patients’ needs and of treatment outcomes is eminently subjective, hence inherently skewed. Nonetheless, I argued that clinicians involved in therapy work with PRS could represent the most emotionally literate, articulate, and readily available human lens onto suicidality. Of course, it is incredibly important that research give a voice to PRS, and future work could seek PRS’ perspective on the aroha model, either individually or as a dyad with their clinician. Nevertheless, whilst neither a replacement nor a substitute for lived experience, positively inclined clinicians in this study proved to be a valuable source of information about PRS.

The study sought clinicians who like working with suicidal patients as a proxy for a positive inclination. The strength of the study’s design was to provide participants with a qualitative platform to elaborate on what “liking working with PRS” meant
for them. The first groups of interviews used a method of intensive interviewing to elicit participants’ own interpretation of the questions, hence moderating the level of my own imprint on the data (Charmaz, 2006b). Akin to clinicians, attuned interviewers get feedback on the accuracy of their propositions in real time. Effectively, until I used terms that sat right with them, interviewees manifested their disagreement outright in interview (see Appendix XIII). Overall, the study found that clinicians did not find their practice “likable” rather than “profoundly satisfying”. This does not mean that clinicians who do not endorse the term “like” do not establish aroha connection with PRS or that they do not feel also profoundly satisfied in treatment. Moreover, these findings do not rule out that other clinicians, who do not find the work deeply satisfying and/or do not establish aroha connections with patients, can achieve good outcomes with PRS nonetheless. Further research is granted to examine these questions.

A critique for this work could be the absence of a comparative design. However, the argument for not comparing groups of clinicians is twofold. First, the clinical literature is replete with discussions of the challenges associated with working with PRS. Second, I found ethically questionable to seek clinicians who “do not like” working with PRS, especially in a country critically affected by suicide like New Zealand. Furthermore, considering the lack of knowledge on CT literacy in NZ, the study could have been stigmatising for clinicians with possible consequences for patients. However, participants’ recollection of their own original difficulties with PRS, as well as those of their supervisees, compensated for the absence of negative cases. The study could have also benefited from collecting other type of data, such as from focus groups of clinicians specialised in the treatment of PRS. Unfortunately, time and resource constraints did not allow for it. Theoretical sampling was therefore not implemented by recruiting different types of participants rather than by amending the interview schedule according to the analysis. These 12 individual interviews provided a rich data set from which to develop preliminary formulations in response to the research questions.
Other limitations include the technical problems encountered by conducting interviews online, the fact that English is my second language, and that I was not familiar with the terminology used by some interviewees. Yet, these limitations increased the frequency of micro ruptures-repairs in the research relationship that ultimately helped building a rapport with interviewees. Finally, in the context where the research question probed the clinical encounter with PRS, I felt that my own clinical background was a facilitator rather than a hindrance to collecting data. As the study progressed, and I learnt from earlier interviews, I found that my posture changed from one of student/researcher to one of peer-clinician/researcher, which I experienced as a phenomenological co-endorsement of the study findings.

9.3 Implications

9.3.1 Indications for future research

In terms of fundamental research, future work should seek further validation of these findings. A survey could assess the face validity of the model for clinicians. The relationship between clinicians’ satisfaction and therapy outcomes with PRS could also be explored further. In clinical suicidology research, despite its limitation, there could be value in assessing the potential of an index of clinicians’ satisfaction as a measure, by proxy, of patients’ therapy outcomes.

Moreover, given that the same brain structures are involved in basic functions of preservation and emotional regulation (LeDoux, 2003), there could be value in investigating the relationship between the aroha connection, or regulation theory (principle of an implicit affect regulation) and suicidality. In fact, the body of knowledge on the neurobiological underpinnings of suicide behaviour is rapidly growing. Yet, rather than relying on neurobiology to predict suicidal behaviours (Lutz, Mechawar, & Turecki, 2017), further work could seek to fathom the processes responsible for the therapeutic influence of the aroha connection, by probing its neurological manifestations in real time during the clinical encounter.
The aroha model provides a theoretical framework to conceptualise clinicians’ drive or reluctance to work with PRS, as well as maybe, their degree of safety in working with PRS. Specifically, future work could explore further the possible relationship between aroha clinicians’ historically thwarted fundamental needs and the development of their clinical skills, either qualitatively or quantitatively. Incidentally, gaining insight into the ontogeny of such skills could provide a mirror image of the ontogeny of suicidality.

In terms of applied research, future work could seek aroha clinicians’ assistance in developing a training programme for the treatment of PRS. Such training programme could include features specific to the NZ cultural context.

### 9.3.2 Implications for clinical practice

This study confirmed that the critical importance of CT literacy to work safely with PRS cannot be emphasised enough. This should have direct implication for training, supervision, and mentoring of clinicians in NZ and elsewhere.

Clinical professions need to acknowledge that, at least with PRS, psychotherapy is eminently an emotional practice. As such, it requires advanced emotional literacy skills from clinicians. The consequences for this are twofold. First, training programmes, supervision, and mentoring of clinicians should include in-depth and non-judgmental analyses of all types of emotional responses to patients. Incidentally, insight based therapy should be encouraged for clinicians personally, regardless of the type of therapy they conduct. Indeed, as the APA practice guidelines recommended, CT literacy is a prerequisite to working with PRS regardless of theoretical orientation (APA, 2003). Second, this should result in the recognition that the nature of skills required is only partially amenable to rational thinking. Thus, clinicians should not be expected to be able to form a therapeutic connection, hence to achieve positive outcomes, with every PRS. However, clinicians should bear the responsibility for developing the ability to recognise their own limitations in working with certain PRS, without feeling judged for it.
Naturally, to access the level of CT literacy required, clinicians need to evolve in a system that is not risk averse. Indeed, these findings unequivocally conveyed an inadequacy of the NZ public mental system regarding the treatment of PRS. NZ public mental health system would benefit from validating aroha clinicians as a chosen intermediary to inform public health policies targeting PRS.

### 9.4 Conclusions

Exploring qualitatively clinicians’ positive inclination to PRS indicated that the experience of a deep emotional connection with patients lied at the core of the clinical encounter. This connection, called here “aroha connection”, was deeply satisfying for both patients and clinicians. The aroha connection consisted of an interpersonal emotional regulation, which, in time, induced a therapeutic attachment. Suicidality decreased as connectedness grew. Clinicians used advanced CT management skills to cultivate genuine care towards PRS, and to navigate boundaries in intimate-like therapeutic relationships while promoting independence in their patients.

The study suggested that aroha clinicians could start developing their emotional skills early in life by seeking to repair their own thwarted need for connectedness. Achieving emotional synchrony in extreme clinical situations, which one participant referred to as an “art”, might only be partially teachable. However, training CT literacy skills would increase clinicians’ competence in working with PRS, as well as their ability to recognise their own limitations.

Basic research could build on these qualitative findings to explore the neurological mechanisms that underlie the aroha connection in dyads of clinicians and PRS. Alternatively, with the help of aroha clinicians, the findings could be applied to designing a programme training the ability to form aroha connection with PRS.
9.5 Summary

This chapter discussed the second study’s findings in light of the existing literature on CT to PRS, and of the modern attachment theory. After considering the study’s strengths and limitations, the chapter provided indications for future research and clinical practice. The following chapter triangulates findings from study 1 and 2 in order to assess the merits and limitations of the mixed methods design in advancing the project’s general research questions.
Part IV
Discussion & conclusion
Chapter 10
General discussion

What most of us still call ‘our conscious thoughts’ are really like dolphins in our mind, jumping briefly out of the ocean of our unconscious for a short period before they submerge themselves once again. This ‘dolphin model of cognition’ helps us to understand the limits of our awareness.21

This chapter discusses the project as a whole. After presenting a brief recap of the general research questions and the research protocol, the chapter reviews the answers each study brought to their respective set of questions. Following this, a discussion combines qualitative and quantitative findings to reflect on key notions found across studies, including that of positive inclination, CT montage, and of the importance of implicit processes in psychotherapy. Finally, the chapter considers the strengths and limitations of the mixed methods design as a strategy for this project, and offers recommendations for future research and clinical practice.

10.1 Overview of the project

10.1.1 General research questions

This project sought to gain an understanding of clinicians’ positive inclination to patients at risk for suicide (PRS), while examining its potential effect on the clinical encounter. It was anticipated that exploring the clinical encounter through positively inclined clinicians’ lenses would advance knowledge in clinical suicidology, and provide insights into PRS’ psychological needs in therapy.

The general research questions were (see Chapter 2, section 2.6):

- Why do some clinicians, a minority of them, like working with PRS?
- Can we derive clinical wisdom from understanding the therapeutic stance of positively inclined clinicians?
- Does examining the therapeutic encounter through the lens of positively inclined clinicians provide novel insight into PRS’ psychological needs in treatment?

However, in order to assess the legitimacy of these queries, the research aimed to answer the following preliminary questions:

- Do the majority of clinicians experience predominantly negative CT responses to PRS?
- Do only a minority of clinicians feel positively inclined towards PRS?

### 10.1.2 Research design

The project sought to answers these questions using a mixed methods design. The first study aimed to answer the preliminary questions by surveying a sample of NZ clinicians to explore systematically the nature of CT to PRS using the Therapist Response Questionnaire (TRQ), while estimating the prevalence of positive inclination to PRS among them. In addition, the survey screened for positively inclined clinicians, and invited them to the subsequent study. The second study aimed to answer the general research questions by using the grounded theory method (GTM) to construct qualitatively an explanatory model of clinicians’ positive inclination to PRS from interview data.

### 10.1.3 Elements of answer

**Study 1: Answering the preliminary questions**

In answer to the preliminary questions, Study 1 suggested that working with PRS elicited predominantly feelings of entrapment and desires to reject the patient,
however, only mildly endorsed by clinicians. On the other hand, the study found that, although less representative in aggregate, the CT dimension most endorsed by clinicians expressed feelings of fulfilment and a willingness to engage with PRS. This means that, while reporting predominantly CT responses of entrapment and rejection in aggregate (i.e. factor structure), clinicians endorsed individually higher levels of CT responses of fulfilment and engagement. The study argued that this apparent contradiction could reflect a “CT montage”, where clinicians empathise emotionally with the suicidal experience, while preserving their willingness to engage therapeutically. The study produced a complex portrait of CT to PRS that seemed to be only partially consistent with the literature (see for instance Maltsberger & Buie, 1974). However, the study had several limitations that order caution regarding drawing such a conclusion. For one, the sample surveyed consisted of clinicians who volunteered their participation to a study on clinical suicidology and, therefore, might not be representative of all clinicians. Furthermore, this study was one of the first to explore systematically the nature and level of CT to PRS so that no baseline against which to compare these results exists. Replication of the study is therefore granted before further conclusions can be drawn.

Second, in terms of prevalence of positive inclination to PRS, the study found that just under 15% ($n=39$) of the clinicians surveyed declared “liking working” with PRS, of which 29 consented to be invited to the subsequent study.

**Study 2: Answering the main research questions**

Study 2 developed qualitatively an explanatory model of clinicians’ positive inclination to PRS that formulated the inter-dependence of clinicians and patients’ satisfaction in treatment, thereby providing elements of answer to the three general research questions. Using an abduction method led to locate clinicians’ experience of forming a deep emotional connection with their patients at the core of the clinical encounter. This, which I named an aroha connection, consisted essentially of an interpersonal emotional regulation, which could develop over time into a
therapeutic attachment. Interviewees seemed to use advanced CT literacy skills to fashion a safe emotional environment that promoted the emergence of an aroha connection. Finally, the data hinted that aroha clinicians’ exceptional emotional skills could develop from early in life.

The study answered the main research questions by suggesting that clinicians like working with PRS because they find it meaningful and profoundly satisfying, due to advanced emotional literacy skills that allow them to synchronise emotionally with highly distressed individual despite the risk of suicide. Furthermore, clinicians’ skills granted them an insider position vis-à-vis their patients’ experience, which allowed them to provide valuable information regarding an optimal clinical stance with PRS, and PRS’ needs in treatment.

10.2 Combining findings from study 1 and 2

The different methods that exist to combine mixed methods findings are contingent to the type of design implemented (Moran-Ellis et al., 2006). In this project, each study was designed and analysed independently to answer a specific set of questions, which limits the degree to which their findings could be integrated (O’Cathain, Murphy, & Nicholl, 2010). Nonetheless, the two studies informed each other so that considering them together advanced our understanding pertaining to key notions found across studies.

This section shows that combining qualitative and quantitative findings helped refining the notion of positive inclination, CT montage, and of the role of implicit processes in treatment, before broadening the discussion to address the notion of paradigm shift in psychotherapy. Finally, I draw from this combination of findings to venture a new working hypothesis before considering the strengths and limitations of the mixed methods design as a general strategy for this project.
10.2.1 Positive inclination to PRS

First, combining quantitative and qualitative methods of investigation helped nuancing the notion of “positive inclination to PRS”. Study 2 shed light on the survey data concerning the limitation of the like-statement in assessing clinicians’ positive inclination to PRS. Recall that study 1 used the like-statement to estimate the prevalence of positively inclined clinicians in a sample of NZ clinicians. The study found that 14.7% (n=39) of clinicians in the sample (N=267) rated either true or very true that “overall, they like working with suicidal patients”. Yet, it would be ill advised to infer that close to 85% of clinicians surveyed “do not like” or “dislike” working with suicidal patients. Instead, as discussed in chapter 6, clinicians might have found it difficult to relate to the term “like” in the context of clinical suicidology. As discussed, the only reasonable claim we can make is that, for unknown reasons, close to 85% of clinicians in the sample did not feel comfortable endorsing the like-statement (see Chapter 6, section 6.2 strengths and limitations). In support of this, study 2, which provided clinicians with a qualitative platform to elaborate on their views on the like-statement, indicated that, despite having endorsed the like-statement, most clinicians declared that the term “like” did not sit right with them. The terms “satisfying”, “rewarding” and “meaningful” described their clinical experience of PRS more accurately. Of note, study 1 participants were not aware that their rating of the like-statement would precipitate their invitation to the second study. For all we know, more participants from study 1 might have been interested in taking part in study 2 despite not endorsing the term “like” in this context.

Combining findings commands further caution concerning inferences made from the like-statement. Study 2 seemed to indicate an association between endorsing the like-statement and establishing a deep connection with patients. However, this does not mean that clinicians who did not endorse the like-statement do not establish emotional connection, achieve less positive outcomes or find no satisfaction in their work (see study 2, Chapter 9, section 9.2, strengths and limitations). This project does not provide grounds to speculate that the aroha
connection evidenced in study 2 is the preserve of clinicians who endorsed the like-statement. For one, most interviewees in study 2 expressed reservations about the term “like” themselves. A few participants in study 2 even stipulated that the immediate context of their practice on the day affected the way they rated the like-statement in the survey. Second, in hindsight, study 1 provided evidence that the sample as a whole (N=267) showed CT patterns that conveyed empathy with the suicidal state and CT management, named here a CT montage, despite that less than 15% endorsed the like-statement. In saying this, we bear in mind that the sample from study 1 might not be representative of all clinicians working with suicidal patients. Given their willingness to take part in a 10 to 15 minute survey on clinical suicidology in the first place, the 267 participants in study 1 might have represented a sub-group of “positively inclined enough” clinicians.

Considered as a whole, this research advanced knowledge on the nature of CT to PRS, while providing further support for the importance of CT literacy in clinical suicidology. Consistent with other empirical work on CT (Betan et al., 2005; Tanzilli et al., 2015), study 1 showed that clinicians can self-report their emotional responses to patients regardless of their orientation. Study 1 further indicated that clinicians empathise deeply with PRS’ emotional states. That is, pooling hundreds of observations resembled a description of the suicidal state, although clinicians did not endorse these emotional patterns explicitly. Again, this contradiction was interpreted as the sign that clinicians empathise with their patients’ emotional states while managing their CT to maintain their therapeutic engagement despite the suicide risk. Subsequently, study 2 provided further evidence supporting that emotional literacy, or CT literacy, was essential to conduct treatment with PRS, regardless of clinicians’ orientation and of their context of practice. This research therefore supported that treating PRS is an emotional practise in essence, thus agreeing with APA recommendations to use CT as a clinical tool with PRS regardless of orientation and regardless of whether or not CT is directly addressed in treatment (APA, 2003). Finally, study 2 confirmed that positive inclination to patients is not countertransferential as such, in the sense that positively inclined clinicians reported a wide range of CT responses to PRS, in terms of nature and
intensity. However, positively inclined clinicians appeared confident in their ability to manage these responses.

### 10.2.2 Hypothesis of a CT montage

Second, the qualitative data supported the hypothesis of a CT montage made in study 1. Study 1 showed a contradiction between CT patterns and their level of endorsement. On average, clinicians endorsed only mildly the most statistically significant dimension of CT (Factor 1 – Entrapped/Rejecting). Conversely, the only positively connoted CT dimension (Factor 2 – Fulfilled/Engaging) was the most readily endorsed by clinicians despite being less significant in aggregate. In attempting to make sense of these findings, I proposed two alternative interpretations, either in terms of defence mechanisms, or as a CT montage. However, non-positively inclined clinicians endorsed higher levels of two different challenging CT dimensions, which tipped the balance in favour of the CT montage interpretation. That is, non-positively inclined clinicians showed CT literacy by endorsing higher levels of challenging CT responses, which tends to contradict the hypothesis of a defensive posture on their part (see Chapter 6, section 6.1.3).

Study 2 added further support to the CT montage interpretation in two ways. First, study 2 confirmed that clinicians apprehended their patients’ state at an emotional level. Clinicians declared feeling in treatment what their patients feel. Second, interviewees could discriminate between their emotional responses and those of their patients. Clinicians appeared to sit with difficult emotions, i.e. regulate them, while keeping their own emotional responses in check, i.e. managing their CT. Consistent with the proposition of a CT montage, clinicians’ qualitative emotional experience in therapy was essentially the mirror of that of their patients’, however perceived at mild level, due to their ability to regulate emotional states. As they did this, clinicians witnessed their patients’ improvement, which conferred them a sense of competence and meaningfulness. Also consistent with study 1 where CT responses of fulfilment were most highly endorsed, the feeling that dominated clinicians’ experience in study 2 was ultimately one of satisfaction.
Finally, the duality found between patterns of correlation (implicit) and clinicians’ level of endorsement (explicit) in study 1 could be reflected in study 2 interviewees’ experience of having different streams of thoughts, an explicit/cognitive and an implicit/emotional one, as they conduct treatment with PRS.

10.2.3 Importance of implicit processes

Thus, study 1 findings hinted that therapy involved different layers of emotional processes, which study 2 supported and took further. Quantitative and qualitative approaches complemented each other in providing evidence that suggests the major role played by implicit processes in therapy practice.

By definition, implicit processes are difficult to study. However, this does not mean that they are not amenable to scientific investigation. Although evacuating the complexity of reality to promote scientific rigour can work in some cases, this research suggested strongly that clinical suicidology is not one of them. This calls to mind Maltzberger’s assertion that, when it comes to PRS, “scientific rigor comes at a certain price”, because “it is difficult to devise empirical trials for some of the more complex approaches to the treatment of patients inclined towards suicide” (Maltzberger, 2001, p. 159). Instead, consistent with the concept of “implicit relational knowing” (Schechter et al., 2013), both studies supported that interpersonal and implicit emotional dialectics play a critical part in achieving positive outcomes with PRS.

In this context, the reflection on the nature of scientific knowledge developed in the methodology chapter is key (see Chapter 3, section 3.2). Both nomothetic and idiographic approaches hinted the existence of underlying structures affecting the behaviours observed. In that sense, adopting a critical realistic meta-theoretical framework suited the project particularly well. As touched upon in chapter 3, critical realism proposes that ontology is stratified in three layers, or domains, that are, the empirical (i.e. what we can observe), the actual (i.e. occurrence of phenomena), and the real (i.e. the fundamental structures that cause phenomena)
This postulates that our experience of reality is dependent on, yet different from, the nature of phenomena, which are themselves dependent on, yet not reducible to, the structures which cause them. Again, study 1 showed a discrepancy between patterns of correlation picked up by the statistical analysis, and participants’ conscious rating of statements. This means that participants were not aware of the implicit structures influencing their actual ratings (i.e. factor structure), which differed from their explicit reporting of their CT responses (i.e. level of endorsement). The qualitative approach adopted in study 2 helped fathoming this discrepancy. Interviewees could distinguish two realms of interpersonal communication, an explicit/cognitive (verbal) and an implicit/emotional (non-verbal) one. Whilst able to justify only the first scientifically, participants considered the second more central to achieving positive outcomes, which takes us back to the concept of epistemic fallacy.

Simply put, the concept of epistemic fallacy expresses that concepts and theories are merely representations of the reality, and that they change when the world does not. This postulates that reality is not reducible to the ability to observe it, so that a difficulty to apprehend a given phenomenon should not preclude it from being an object of scientific investigation. In this sense, study 2 was a striking illustration of the potential damage incurred by a scientific model dominated by the epistemic fallacy. Indeed, remember that interviewees were reluctant to share their understanding of some core mechanisms of therapy because they feared coming across as non-scientific, ergo not professional, due to lacking a scientific corpus of reference.

**10.2.4 The current paradigm shift in psychotherapy**

However, contrary to their presentation in research interviews, clinicians trusted their implicit/emotional appraisal of the clinical situation more than their explicit/cognitive, which indicated that they were not caught in an epistemic fallacy in their practice. They were aware that implicit mechanisms that exceed the tasks scripted by manualised treatments, and are relational in essence, exercise a
therapeutic influence for patients. The empirical evidence of the predictive value of relationship factors for positive outcomes (Duncan et al., 2010; Lambert & Barley, 2001; Norcross & Lambert, 2014; Rosenzweig, 1936; Wampold & Imel, 2015c), thus merely reinforce what clinicians knew from experience. In fact, a closer look at the historical psychotherapy literature shows that theorists from a range of orientations have argued for the essential role of the relationship in treatment. Freud argued that the “friendly and affectionate aspects” of transference were “the vehicle of success in psycho-analysis exactly as it is in other methods of treatment” (S. Freud, 1958, p. 106). Rogers proposed the concept of unconditional positive regard as the essential and sufficient condition for change (Rogers, 1957). Finally for Beck, cognitive therapy was considered of no help without a friendly collaborative working relationship (A. T. Beck, 1979).

Yet, somehow, the field of psychotherapy research could seem sometimes to take the predictive value of relationship factors for granted, without probing this evidence further (Norcross & Lambert, 2014). An interviewee in study 2 described these processes as “a bit magical sometimes”, and most acknowledged not understanding the science behind it. Yet, should not we be asking, but how? How can a positive relationship with another human being, who is essentially a stranger, improve someone’s mental health? In the present case, how can it bring someone out of the darkest of places through to hope and desire for life again, sometimes within a few sessions? How can feeling cared for affect people’s inherent wish to live? How can we know so little still, about the mechanisms underpinning the therapeutic effect of the relationship? Cozolino (2017) proposes that a possible explanation is that historically, the brain and the mind have been studied essentially separately, in psychology and neurology respectively. He argues that, as a neurologist interested in the study of the mind, Freud stands out among other authors. Yet, Freud had to abort his original project for a scientific psychology, which aimed to investigate the neurobiological underpinning of mental processes, because the technology needed to test his hypotheses was far from available (Cozolino, 2017; S. Freud, 1895). Now however, advances in neuroimaging technologies open avenues to attempt bridging the gap between neurobiology and
psychology (Cappas, Andres-Hyman, & Davidson, 2005; Cozolino, 2017; A. N. Schore, 2012).

Over the past two decades, Schore has gathered evidence that similar interpersonal neurobiological mechanisms than those responsible for the maturation of right-brain structures in infants could be involved in psychotherapy. He argued that a body of evidence supports that the role of right-brain nonverbal emotional processes in psychotherapy dominates that of the left-brain verbal cognitive ones, and has induced a paradigm shift (A. N. Schore, 2012). In a similar vein, Cappas et al. have defended that neuroscience have the potential to bridge the gap between research and practice by reconciling medicine and psychology (Cappas et al., 2005). Effectively, some participants in study 2 relied on their knowledge in neuropsychology of attachment to justify their experience, while promoting consensus between theoretical orientations. Other interviewees had furthered their training by turning to new developments of CBT that put an emphasis on emotional processes, for example shifting from classical Beckian CBT to ACT or DBT (A. T. Beck, 1979; S. C. Hayes, 2004; Linehan, 1993). This project thus invited to consider that this paradigm shift, consisting essentially of giving more credit to the implicit/emotional dialectics at play in psychotherapy, could be of particular relevance to treating PRS. In fact, Linehan explained having to draw from psychodynamic orientations to develop the relational aspect of her treatment modality for BPD (Linehan, 1993, p. 21), which hinted that, in the field of clinical suicidology, a paradigm shift was already happening.

10.2.5 Hypothesis of an ‘absolute emotional pitch’

Finally, considering the gaps in our understanding of how the relationship can exercise a therapeutic influence, I draw on the combination of both quantitative and qualitative data to venture the working hypothesis of an “absolute emotional pitch”.

The absolute pitch (AP), or perfect pitch, is the ability to identify or produce a note or the pitch of a sound without any external reference point. AP is considered a rare
phenomenon that could concern between 1/1500 and 1/10000 people depending on the population considered, and no more than 15% of highly accomplished musicians (Baharloo, Johnston, Service, Gitschier, & Freimer, 1998; Takeuchi & Hulse, 1993). In contrast, relative pitch (RP) is the trained ability found in musicians, to identify or produce sound pitches in relation to other sounds, by identifying music intervals (Levitin & Rogers, 2005).

Drawing on the analogies with music and sound found in the data, I propose that aroha clinicians could possess an exceptional skill characterised by the outstanding ability to resonate and to become attuned to a wider range of emotion, faster and more accurately than the average population, regardless of their relationship to the person displaying that emotion. Let us name this hypothetical ability an “absolute emotional pitch” (AEP). Akin to the acoustic phenomenon, AEP could be a rare faculty that concerns only a minority of clinicians. We know that aroha clinicians belonged to a sub group of positively inclined clinicians representing less than 15% of a sample of clinicians willing to take part in clinical suicidology research. Also like the Absolute pitch (AP) in music (Zatorre, 2003), the absolute emotional pitch (AEP) could result from the complex combination of innate biological/cognitive dispositions and exposure to specific emotional environment at specific time of neural growth, i.e. in early childhood. The data suggested that clinicians noticed their empathic ability from a young age. Moreover, in clinicians’ own words, only parts of the skills they need with PRS were amenable to training, while others fell within the realm of art, or talent. Akin to musicians, empathic abilities could be trained in other clinicians, however only to reach a level of “relative emotional pitch” (REP), rather than an AEP.

This working hypothesis states that, thanks to an ability of AEP, aroha clinicians would perceive extreme dysregulated states to be within the normal range of emotion, and thus be able to become attune to them without feeling overwhelmed or threatened. Furthermore, from this state of emotional synchrony, aroha clinicians could tune their emotional tone, together with that of their patients, back to a state of regulated emotion, more easily self-sustainable for PRS. This regulated
emotional frequency could promote neural growth, or the rewiring of emotional regulatory structures in the right hemisphere of the brain, as proposed by the regulation theory (A. N. Schore, 2012). Effectively, clinicians in study 2 strove to achieve a state of interpersonal emotional synchrony, before somehow, bringing, their patients back to a state of emotional homeostasis. Clinicians had a sense of journeying emotionally, together with their patients, out of dark places and towards hope. As far as their experience went, clinicians were merely aware of tuning in their patients’ emotional experience, while constantly regulating their own responses in real time. In their clinical experience, this interpersonal regulation of emotion had a soothing effect on patients. Finally, they assumed that, over time, the repeated interpersonal experience of emotional regulation allowed patients to develop these skills for themselves.

Drawing a parallel between sound and emotion opens hypothetical avenues. Akin to sound, does emotion propagate in waves? Is there such thing as a measurable emotional frequency? Do aroha clinicians make use of an AEP skill to synchronise before tuning literally their patients’ emotional frequency to a more optimal level? With clinical training, have aroha clinicians turned a natural skill into a function resembling that of an “emotional tuner”? Is there such thing as a universal emotional tone or frequency that provides an optimal emotional environment promoting hormonal equilibrium and/or neuronal growth? A rapid brush upon the relevant literature suggests that there could be value in pursuing these ideas. Hippocampal theta-wave measured in hertz in rabbits have been associated with different emotional state (Yamamoto, 1998). In humans, frontal slow waves are associated with positive emotional states (Cuthbert, Schupp, Bradley, Birbaumer, & Lang, 2000; Diedrich, Naumann, Maier, Becker, & Bartussek, 1997). However, reviewing the literature on the topic is beyond the scope of this project.
10.3 Strengths & limitations of the methodology

I discussed the strengths and limitations of each study in chapter 6 and 9 respectively. The present section considers instead the ability and shortcomings of the mixed methods design in achieving the general aim of this research.

As discussed above, combining methods showed both the strengths and the limitations of the design concerning the notion of positive inclination. First, mixing methods confirmed that CT are complex phenomena that are inevitable but can be mastered. This means that, the occurrence and nature of CT is independent of the general sense of satisfaction clinicians experience in their work. Hence, liking clinical suicidology or feeling positively inclined to PRS does not mean that clinicians find the interaction necessarily enjoyable moment to moment. In this sense, exploring CT to PRS systematically with the TRQ was not as good a screening tool for positive inclination as was the like-statement. On one hand, mixing methods of investigation showed the limitation of the like-statement in capturing positive inclination. Few interviewees related to the term “like” and some indicated that their endorsement of it was mainly due to contingencies. Future work should consider selecting positively inclined clinicians by asking them if their find working with PRS “satisfying” and “meaningful” rather than if they “like it”. On the other hand, mixing methods of investigation also showed the strength of the like-statement. Whilst screening with the like-statement might have ruled out false negative, it did not create false positive cases. Indeed, all interviewees in study 2 found their practice with suicidal patients profoundly satisfying and meaningful. In this sense, implementing several rounds of screening for positive inclination through adopting a mixed methods design seems to have acted in favour of the general aim of the project. Reciprocally, using a quantitative approach moderated some of the biases inherent to qualitative research. For instance, study 2 suggested that clinicians relied predominantly on implicit intuitive thinking to navigate the clinical encounter. Yet, the importance conferred to implicit processes could merely be a reflection of my psychodynamic orientation. However, study 1 suggested that implicit processes are at play independently of researchers and participants’
influence. Indeed, without conceding the effect of implicit processes on the data, interpreting the EFA results in light of clinicians' low level of items endorsement is arduous. Quantitative and qualitative approaches ultimately complemented each other to establish the importance of implicit processes in therapy.

Combining approaches also raised a point of discussion around the diagnostic category of BPD. Not all suicidal people meet with professionals, and conversely, PRS might not be representative of all suicidal people. The overlap that exists in clinical practice between BPD patient and PRS has been well documented (Aviram, Brodsky, & Stanley, 2006; Bateman, Gunderson, & Mulder, 2015; P. Fonagy, Luyten, & Bateman, 2017; Kernberg, 2009; Linehan, 1993; Maltsberger, 2001). To prioritise clinicians' subjective appraisal of patients' presentation, I used the diagnostical nomenclature loosely, which constituted a limitation of the first study. Chapter 6 discussed that future research could benefit from a more rigorous use of the nomenclature to ensure homogeneity in the sample. On the other hand, I have argued that such design ensured that study 1, hence study 2, was carried out within a naturalistic samples of suicidal patients. Overall, this work questions the reliability and clinical relevance of BPD as a diagnostic category. Study 1 found that just over half of all PRS (N=267) did not meet criteria for BPD according to their clinicians. Study 2 showed that interviewees used the label BPD in a fluid manner too, which could indicate its lack of relevance to clinical practice. Linehan argued that the definition of BPD itself betrayed the stigma attached to it, which motivated her to develop DBT in the first place:

One of the main goals of my theoretical endeavors has been to develop a theory of BPD that is both scientifically sound and nonjudgmental and nonpejorative in tone. The idea here is that such a theory should lead to effective treatment techniques as well as to a compassionate attitude (Linehan, 1993, p. 18)

As well as proposing an Alternative Model for Personality Disorders, the DSM now encourages to consider mental health on a continuum, and diagnostic labels merely as the conceptual tools they are (American Psychiatric Association, 2013). Both
studies compounded to question whether BPD is a clinically relevant and helpful diagnostic category. The aroha model developed in study 2 invites to consider the essential features of BPD, including suicidal behaviours, as the mark of an impaired ability to regulate emotional states. If, as proposed, emotional regulation is indeed constructed interpersonally throughout the life span (A. N. Schore, 2003a), then BPD becomes a pathology of the relationship. Displaying troubled interpersonal patterns of relationship would not be the consequence of the pathology but the very mark of its aetiology, while dysregulated emotions including suicidality would be its consequences.

10.4 Implications

10.4.1 Potential for future research

I have provided indications for future research for each study separately, in chapters 6 and 9 respectively. As a whole, this project suggested that the core mechanism of psychotherapy with PRS is implicit/emotional in nature.

Consequently, in terms of basic research, future research could examine further the interpersonal processes involved in therapy with PRS. Working alongside aroha clinicians could be a precious help in trying to fathom these processes. Future work could seek to validate these findings further by assessing the prevalence of positively inclined clinicians in other samples, and seeking further feedback on the aroha model from clinicians who feel satisfied by their work with PRS. Seeking patients’ feedback would have immense value too. Personally, I envision a research that would draw from the interpersonal nature of psychotherapy instead. For instance, qualitative endeavours could interview dyads of clinicians and patients. Alternatively, the hypothesis of an absolute emotional pitch (AEP) could be developed further and tested in an experimental design involving clinician-patient dyads.

Applied research could combine findings from both studies to develop a training programme for clinicians. A short CT checklist (study 1) could be integrated as one
module of a training programme designed with the assistance of aroha clinicians (study 2).

10.4.2 Recommendations for clinical practice

I have considered the potential implication for clinical practice for each study individually (chapters 6 and 9). Considered together, study 1 and 2 provided evidence of the emotional nature of psychotherapy practice involving PRS.

The direct implication of these findings is to assert that, to help PRS, clinicians need to be CT literate, regardless of the type of therapy they wish to conduct. Moreover, given that PRS is not a delineated subgroup of patients, nor is suicidality a stable trait in people, clinicians need to be aware of the skills required to work with PRS regardless of their desired context of practice.

Clinicians also need to acknowledge that clinical suicidology requires advanced emotional skills that can only partially be taught and need time to develop, which should have 2 types of implications. First, training programmes of clinicians should integrate CT literacy training. Normalising CT as a conceptual tool should free clinicians from the guilt potentially associated with experiencing some types of emotional responses to patients. To prevent counter-therapeutic behaviours and learn to repair ruptures in the alliance, discussing CT in supervision and peer-vision groups should become common practice. Second, given the level of skills required with PRS, junior clinicians would benefit from a mentoring relationship that goes maybe beyond that expected normally in supervision. Indeed, this project suggested that clinicians need a type of support that matches the level of emotional involvement required to treat PRS. Finally, to ensure clinical safety, undergoing personal therapy should be a prerequisite to conducting therapy with PRS.
Chapter 11
General conclusion

Neither observation nor reason are authorities. Intellectual intuition and imagination are most important, but they are not reliable: they may show us things very clearly, and yet they may mislead us. They are indispensable as the main sources of our theories; but most of our theories are false anyway.\(^{22}\)

This project aimed to advance knowledge in clinical suicidology by studying the stance of clinicians who feel positively inclined, or “like” working with patients at risk for suicide (PRS). The mixed methods design used provided a rich understanding of clinicians’ positive inclination to PRS, while uncovering several possible paths for further research.

This work provided quantitative evidence on the nature of countertransference (CT) to PRS, while suggesting that less than 15% of clinicians could feel positively inclined to PRS. Additionally, the research developed qualitatively a model of clinicians’ positive inclination that is simultaneously a conceptualisation of the interpersonal dialectic involved in PRS’ improvement in therapy.

Both studies substantiated the emotional nature of treatment with PRS, hence establishing CT literacy as a prerequisite to achieving positive outcomes. There is no need to be a trained clinician to help a suicidal person, but all trained clinicians should either have the emotional skills required to help PRS, or the ability to recognize they lack them, without feeling judged for it.

Whilst confirming the critical role of the relationship in therapy, this project highlighted the important knowledge gap that persists in our understanding of how they operate. Qualitative and quantitative data suggested that the complex interpersonal dialectics located at the core of the clinical encounter with PRS are largely implicit. By nature, these processes are hard to observe and only partially accessible to the cognitive rational brain that orchestrates predominantly our scientific endeavours. Yet, practicing clinicians know that these mechanisms are not epiphenomena but rather, the main ingredients, if not the actual cause, of therapeutic influence. The future of clinical suicidology might depend on our ability to fathom of these processes.

The future direction I am contemplating builds on these findings while drawing an analogy between emotion and sound to formulate new working hypotheses. The hypothesis of an “absolute emotional pitch” (AEP), and its corollary, that of a “universal emotional tone or frequency” that could promote neural growth hence therapeutic change. In their current state, these propositions are speculative and metaphorical in nature. While perhaps far-fetched, they illustrate my contention that we need to combine disciplines in an atheoretical fashion to advance the field of clinical suicidology.

The time is ripe and the technology presumably available, to reconcile the study of the mind and that of the brain in order to move the field forward. I end this project with the sense that our obstinacy to keep them separate might make some of our endeavours resemble that of one attempting to observe radiation with a pair of binoculars. I concur with the view that this paradigm shift is already occurring in psychotherapy. The well-being of patients might depend on researchers, policy makers and clinicians’ willingness, ability and rapidity, to catch up.
References


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Appendices
Appendix I. Māori consultation for study 1

Tuesday, 01 March 2016
Dr Gabrielle Jenkin,
University of Otago Wellington - Public Health,
WSM&HS.

Te Rakai Koe Dr Gabrielle Jenkin,

NZ therapists’ emotional-cognitive responses to suicidal patients – A National Cross-sectional Short Survey.

The Ngāi Tahu Research Consultation Committee (the committee) met on Tuesday, 01 March 2016 to discuss your research proposition.

By way of introduction, this response from the Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states “Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago”. As such, this response is not “approval” or “mandate” for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGregor:

“Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that talk in a genuine and not cosmetic manner: Reaching a decision that may or may not alter the original proposal.”

The Committee considers the research to be of importance to Māori health.

The Committee notes and comments that ethnicity data is to be collected using the questions on self-identified ethnicity and descent contained in the latest census.

The Committee suggests including in the research team a researcher with expertise in analysing and interpreting data by ethnicity.

The Committee notes and comments the researchers on undertaking to disseminate the research findings to Māori health organisations.
We wish you every success in your research and the committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 01 March 2016 to 1 September 2017.

Nihau noa, ka

Mark Brunton
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Appendix II. Māori consultation for study 2

Tuesday, 04 July 2017.

Dr Gabrielle Jenkin,
Social Psychiatry and Population Mental Health Research Unit,
WSM&HS.

Tēnā Koe Dr Gabrielle Jenkin,

Clinicians’ positive inclination to patients at risk for suicide

The Ngāi Tahu Research Consultation Committee (the committee) met on Tuesday, 04 July 2017 to discuss your research proposition.

By way of introduction, this response from the Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states “Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago”. As such, this response is not “approval” or “mandate” for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee bases consultation on that defined by Justice McGechan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The Committee considers the research to be of importance to Māori health.

The Committee notes and commends that ethnicity data is to be collected using the questions on self-identified ethnicity and descent contained in the latest census.

The Committee notes suicide is particularly relevant to Māori youth and asks if the researchers have considered programmes such as Waka Hourua?

The Committee notes and commends the undertaking to disseminate research findings to Māori health organisations regarding this study.
We wish you every success in your research and the committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 04 July 2017 to 4 January 2019.

Nīhau noa, nā

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Appendix III. UOHEC decision letter for study 1

Dr G Jenkin
Dean’s Office (Wgnt)
University of Otago, Wellington
University of Otago Medical School
Division of Health Sciences

26 April 2016

Dear Dr Jenkin,
I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled “NZ therapists’ emotional-cognitive responses to suicidal patients - A National Survey”.

As a result of that consideration, the current status of your proposal is: Approved

For your future reference, the Ethics Committee’s reference code for this project is: 16/053.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:

While approving the application, the Committee would be grateful if you would respond to the following:

Recruitment
The Committee noted the reasons given for why there will be no upper limitation of the number of participants. The Committee asks, however, if you go well beyond what is needed for the project, is there a reasonable justification for continuing?

Please provide the Committee with copies of the updated documents, if changes have been necessary.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

The Human Ethics Committee asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page

http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html
Yours sincerely,

[Signature]

Mr Gary Witte
Manager, Academic Committees
Tel: 478 8256
Email: gary.witte@otago.ac.nz

c.c. Professor C D Collings Dean of University of Otago, Wellington Dean's Office (Wgmt)
Dear Dr Jenkin,

I am again writing to you concerning your proposal entitled "NZ clinicians’ emotional-cognitive responses to suicidal patients - A National Survey", Ethics Committee reference number 16/053.

Thank you for the email and hard copy of the letter received from the student researcher, Tess Soulie, on 1 July 2016. Thank you for your response providing a justification for not setting any upper limitation on the number of participants.

Thank you for notifying us of the following amendments which have been made:

- the term therapist has been changed to "clinician" throughout, including the title of the study;
- data collection will now commence in July/August;
- the inclusion criteria has been changed to allow clinicians to select the last patient they saw (whether it is a child, adolescent or adult - no personal information is asked about the patient);
- participants who complete the survey will be eligible to enter into a draw for a prize;
- professional associations will send an email to their members to encourage participation;
- thank you for providing a copy of the email to be used;
- the survey design tool has been changed to Qualtrics;
- the questionnaire has been renamed as the Clinicians’ Response Questionnaire;
- additional measures have been taken to ensure anonymity is preserved, by de-identifying responses;
- amendments have been made to the Survey following testing.
Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Yours sincerely,

[Signature]

Mr. Gary Witte  
Manager, Academic Committees  
Tel: 479 8258  
Email: gary.witte@otago.ac.nz

c.c. Professor C D. Collings  Dean of University of Otago, Wellington  Dean's Office (Wgnt)
Appendix V. UOHEC amendment 2 study 1

8 September 2016

Dr G Jenkin  
Dean’s Office (Wgnt)  
University of Otago, Wellington  
University of Otago Medical School  
Division of Health Sciences

Dear Dr Jenkin,

I am again writing to you concerning your proposal entitled “NZ clinicians’ emotional-cognitive responses to suicidal patients - A National Survey”. Ethics Committee reference number 16/053.

Thank you to Tess Soulie, student investigator on the above project, for her request for amendment of 7th September 2016.

To help increase recruitment into the study, Tess indicated that she would now like to e-mail professionals in charge of groups of clinicians, such as Directors of area Mental Health Services of District Health Boards and others in charge of institutes within the New Zealand Psychological Society.

The Committee accepts and approves the amendment requested.

Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Yours sincerely,

[Signature]

Mr Gary Witto  
Manager, Academic Committees  
Tel: 479 8256  
Email: gary.witto@otago.ac.nz

cc. Professor C D Collings  Dean of University of Otago, Wellington  Dean’s Office (Wgnt)
Appendix VI. UOHEC amendment 3 study 1

Dr G Jenkin  
Dean’s Office (Wgnt)  
University of Otago, Wellington  
University of Otago Medical School  
Division of Health Sciences

Dear Dr Jenkin,

I am again writing to you concerning your proposal entitled “NZ clinicians’ emotional-cognitive responses to suicidal patients - A National Survey”, Ethics Committee reference number 16/053.

Thank you to Tess Soulie for her request for amendment received today. Tess indicated that recruitment for the above study has not been as hoped and noted that an opportunity has become available to attend the New Zealand Psychological Society conference, being held from 1st September to 4th September 2016, to distribute flyers and potentially set up a stand about the study.

The Committee accepts and approves the amendment.

Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Yours sincerely,

[Signature]

Mr Gary Witte  
Manager, Academic Committees  
Tel: 479 8256  
Email: gary.witte@otago.ac.nz

cc. Professor C D Collings  Dean of University of Otago, Wellington  Dean’s Office (Wgnt)
Appendix VII. UOHEC initial decision study 2

Dr G Jenkin
Dean’s Office (Wgnt)
University of Otago, Wellington
University of Otago Medical School
Division of Health Sciences

23 June 2017

Dear Dr Jenkin,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled "Clinicians’ positive inclination to patients at risk for suicide".

As a result of that consideration, the current status of your proposal is:- Conditional Approval

For your future reference, the Ethics Committee’s reference code for this project is:- 17/094.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:-

Please address the following comments before proceeding with the research:

Patient confidentiality

Participants will be asked to describe their patients and, as such, the Committee seeks assurance that individual patients will not be identified in the final write up. The Committee is of the view that this issue could have been addressed in question 17, “potential problems and ethical considerations”.

Access to data (question 15 (e))

Please ensure that you also have access to the data and not just the student researcher, Tess Soulie.

Information Sheet

Please expand on the aim of the research, including the benefits and value of the project on the Information Sheet.
Before approval of the research to proceed can be granted, a written response must be received addressing the issues raised above. Please provide the Committee with updated documents, where changes have been necessary. The Committee expects that the above comments will be addressed before recruitment of participants begins. Please note that the Committee is always willing to enter into dialogue with applicants over the points made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood. Responses are reviewed outside the normal meeting cycle and only one copy is required. Please email your written response and revised documentation to Gary.Witte@otago.ac.nz or Jo.Farrondediez@otago.ac.nz. Your response will be reviewed and correspondence will be sent to you within 3-5 days of receipt.

Yours sincerely,

[Signature]

Mr Gary Witte
Manager, Academic Committees
Tel: 470 8258
Email: gary.witte@otago.ac.nz

c.c. Professor C D Collings  Dean, University of Otago, Wellington  Dean’s Office (Wgnt)
Appendix VIII. UOHEC approval study 2

Dr G Jenkin  
Dean’s Office (Wgnt)  
University of Otago, Wellington  
University of Otago Medical School  
Division of Health Sciences  

21 August 2017

Dear Dr Jenkin,

I am again writing to you concerning your proposal entitled “Clinicians’ positive inclination to patients at risk for suicide”. Ethics Committee reference number 17/094.

Thank you for your emails of 4th and 17th August 2017 with responses attached addressing the issues raised by the Committee.

The Committee thanks you for advising of the changes to be made to the study protocol and for noting that the interviews will no longer included face-to-face interviews but will be conducted remotely using video-calls only. You note that participants will be asked to scan, e-mail or post their signed consent form to the research team.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

The Human Ethics Committee asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page  
http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html
Appendix IX. Survey content study 1

NZ Clinicians’ Emotional-Cognitive Responses to Suicidal Patients – A National Survey

Thank you for your interest.
Please read the information below carefully before deciding whether or not to participate.

PROJECT AIM
This study aims to shed light on the nature, variety and strength of emotions NZ clinicians experience when working with suicidal patients/clients.

BACKGROUND
Working with suicidal people can be challenging. Suicidal people can stir up intense negative or positive feelings within clinicians. Clinicians’ awareness of such emotional-cognitive responses is associated with better outcomes in treatment and therapy.
We invite you to participate in this online survey in order to advance knowledge in the area of clinicians’ emotional-cognitive responses to suicidal patients/clients.

PARTICIPATION
To participate, you need to be a Psychiatrist, a Psychologist or a Psychotherapist; fully NZ registered, currently holding a certificate of practice, and currently conducting treatment or therapy with patients/clients.

STUDY CONTENT
The study consists of a validated questionnaire (79 statements to rate) plus additional questions.
The survey is entirely anonymous and usually takes between 10 and 15 minutes to complete.

CONSENT & RIGHTS
You will be asked to give consent before you start.
You will be able to leave the survey at any time (by closing the tab in your browser).
The survey needs to be complete to be included in the research.

DISSEMINATION OF FINDINGS
Any publication resulting from this study will only contain anonymised data.
LUCKY DRAW
After the survey is complete you will be able to enter a lucky draw to win an iPad Mini 4.

RESEARCHERS’ DETAILS
Tess Soulie is conducting this research as part of a PhD degree, under the supervision of Professor Sunny Collings, Dr Gabriele Jenkin and Dr Elliot Bell. You are invited to contact her or her supervisors should you need additional information about the present study.

Researcher - PhD Candidate
Tess Soulie - tess.soulie@postgrad.otago.ac.nz

Co-Supervisors
Dr Gabriele Jenkin - gabrielle.jenkin@otago.ac.nz
&
Dr Elliot Bell - elliot.bell@otago.ac.nz

Primary Supervisor
Professor Sunny Collings - deanseauow@otago.ac.nz

IMPORTANT NOTE
This study has been approved by the University of Otago Human Ethics Committee. If you have any concern about the ethical conduct of the research you may contact the Committee through the Human Committee Administrator (ph +643479 8256 or gary.wittes@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

INFORMED CONSENT
I have read and understood the information displayed and I consent to participate in the survey

[ ] No
[ ] Yes
Please note, for the purpose of the study, the terms patient and client are being used interchangeably.

What is your professional occupation?

- Psychiatrist
- Psychologist (general)
- Clinical Psychologist
- Counselling Psychologist
- Educational Psychologist
- Psychotherapist
- None of the above
You are a member of:

- NZCCP
- NZPsS
- Both NZCCP & NZPsS

Are you fully registered in NZ and currently hold a certificate of practice?

- Yes
- No

Do you have at least one suicidal patient, with whom you have worked for a minimum of 3 sessions, in the past 6 months?

For the purpose of the study, **Suicidal Patient** is defined as:
Someone who shows or has shown suicidal behaviours (including suicidal ideation), or has attempted suicide before

**AND**
Who seems to you at risk of suicide.

- Yes
- No

To ensure validity of data collected, please confirm that this is the first and only time you will take this survey

- I confirm that this is the first time I will take this survey
- I have taken this survey already
What is your gender?

Which ethnic group(s) do you belong to? Mark the space or spaces that apply to you

- New Zealand European
- Māori
- Samoan
- Cook Island Māori
- Tongan
- Nuean
- Chinese
- Indian
- Other (such as Dutch, Japanese, Tokelauan); please specify:

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What is your primary theoretical orientation?

- CBT
- Psychodynamic
- Eclectic
- Other, please specify:

How long have you been working in this occupation?

- Less than 5 years
- Between 5 and 10 years
- 11 years and over

On average, how many hours per week do you work face to face with patients?

- Less than 5 hours per week
- Between 5 and 10 hours per week
- Between 11 and 15 hours per week
- Over 15 hours per week
The work setting where you work with patients is:

- Public
- Private
- Both

Next is the Clinicians Response Questionnaire. It consists of 79 statements describing a broad range of possible emotional-cognitive responses which clinicians can experience towards their patients/clients while conducting treatment or therapy. We have tested the time needed to rate all statements, and it should take you 5 minutes approximately. Keep in mind that each item is important.

Please answer the questionnaire with respect to one suicidal patient. Select the one suicidal patient you saw most recently, with whom you have worked for a minimum of 3 sessions, in the past 6 months (check your diary if necessary). You will be asked to rate each statement as it applies to you most of the time while treating the suicidal patient just selected.

Note: For the purpose of this study, suicidal patient is defined as:
A person who shows or has shown suicidal behaviours (including suicidal ideation); or who has attempted suicide before

AND
Who seems to you to be at risk of suicide

Please remember that the questionnaire is anonymous and try to answer as honestly as possible.

When you are ready, click the "CONTINUE" button below to access the questionnaire.

CONTINUE
The questionnaire includes the following 79 statements:

1. I am very hopeful about the gains s/he is making or will likely make in treatment.
2. At times I dislike him/her.
3. I find it exciting working with him/her.
4. I feel compassion for him/her.
5. I wish I had never taken him/her on as a patient.
6. I feel dismissed or devalued.
7. If s/he were not my patient, I could imagine being friends with him/her.
8. I feel annoyed in sessions with him/her.
9. I don’t feel fully engaged in sessions with him/her.
10. I feel confused in sessions with him/her.
11. I don’t trust what s/he’s telling me.
12. I feel criticized by him/her.
13. I dread sessions with him/her.
15. I feel angry at him/her.
16. I feel bored in sessions with him/her.
17. I feel sexually attracted to him/her.
18. I feel depressed in sessions with him/her.
19. I look forward to sessions with him/her.
20. I feel envious of, or competitive with him/her.
21. I wish I could give him/her what others never could.
22. I feel frustrated in sessions with him/her.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>23.</td>
<td>S/he makes me feel good about myself.</td>
</tr>
<tr>
<td>24.</td>
<td>I feel guilty about my feelings toward him/her.</td>
</tr>
<tr>
<td>25.</td>
<td>My mind often wanders to things other than what s/he is talking about.</td>
</tr>
<tr>
<td>26.</td>
<td>I feel overwhelmed by his/her strong emotions.</td>
</tr>
<tr>
<td>27.</td>
<td>I get enraged at him/her.</td>
</tr>
<tr>
<td>28.</td>
<td>I feel guilty when s/he is distressed or deteriorates, as if I must be somehow responsible.</td>
</tr>
<tr>
<td>29.</td>
<td>S/he tends to stir up strong feelings in me.</td>
</tr>
<tr>
<td>30.</td>
<td>I feel anxious working with him/her.</td>
</tr>
<tr>
<td>31.</td>
<td>I feel I am failing to help him/her or I worry that I won't be able to help him/her.</td>
</tr>
<tr>
<td>32.</td>
<td>His/her sexual feelings toward me make me anxious or uncomfortable.</td>
</tr>
<tr>
<td>33.</td>
<td>I feel used or manipulated by him/her.</td>
</tr>
<tr>
<td>34.</td>
<td>I feel I am “walking on eggshells” around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out.</td>
</tr>
<tr>
<td>35.</td>
<td>S/he frightens me.</td>
</tr>
<tr>
<td>36.</td>
<td>I feel incompetent or inadequate working with him/her.</td>
</tr>
<tr>
<td>37.</td>
<td>I find myself being controlling with him/her.</td>
</tr>
<tr>
<td>38.</td>
<td>I feel interchangeable—that I could be anyone to him/her.</td>
</tr>
<tr>
<td>39.</td>
<td>I have to stop myself from saying or doing something aggressive or critical.</td>
</tr>
<tr>
<td>40.</td>
<td>I feel like I understand him/her.</td>
</tr>
<tr>
<td>41.</td>
<td>I tell him/her I'm angry at him/her.</td>
</tr>
<tr>
<td>42.</td>
<td>I feel like I want to protect him/her.</td>
</tr>
<tr>
<td>43.</td>
<td>I regret things I have said to him/her.</td>
</tr>
<tr>
<td>44.</td>
<td>I feel like I’m being mean or cruel to him/her.</td>
</tr>
<tr>
<td>45.</td>
<td>I have trouble relating to the feelings s/he expresses.</td>
</tr>
<tr>
<td>46.</td>
<td>I feel mistreated or abused by him/her.</td>
</tr>
<tr>
<td>47.</td>
<td>I feel nurturant toward him/her.</td>
</tr>
<tr>
<td>48.</td>
<td>I lose my temper with him/her.</td>
</tr>
<tr>
<td>49.</td>
<td>I feel sad in sessions with him/her.</td>
</tr>
<tr>
<td>50.</td>
<td>I tell him/her I love him/her.</td>
</tr>
<tr>
<td>51.</td>
<td>I feel overwhelmed by his/her needs.</td>
</tr>
<tr>
<td>52.</td>
<td>I feel hopeless working with him/her.</td>
</tr>
<tr>
<td>53.</td>
<td>I feel pleased or satisfied after sessions with him/her.</td>
</tr>
<tr>
<td>54.</td>
<td>I think s/he might do better with another therapist or in a different kind of therapy.</td>
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<tr>
<td>55.</td>
<td>I feel pushed to set very firm limits with him/her.</td>
</tr>
<tr>
<td>56.</td>
<td>I find myself being flirtatious with him/her.</td>
</tr>
<tr>
<td>57.</td>
<td>I feel resentful working with him/her.</td>
</tr>
<tr>
<td>58.</td>
<td>I think or fantasize about ending the treatment.</td>
</tr>
<tr>
<td>59.</td>
<td>I feel like my hands have been tied or that I have been put in an impossible bind.</td>
</tr>
<tr>
<td>60.</td>
<td>When checking my phone messages, I feel anxiety or dread that there will be one from him/her.</td>
</tr>
<tr>
<td>61.</td>
<td>I feel sexual tension in the room.</td>
</tr>
<tr>
<td>62.</td>
<td>I feel repulsed by him/her.</td>
</tr>
<tr>
<td>63.</td>
<td>I feel unappreciated by him/her.</td>
</tr>
<tr>
<td>64.</td>
<td>I have warm, almost parental feelings toward him/her.</td>
</tr>
<tr>
<td>65.</td>
<td>I like him/her very much.</td>
</tr>
<tr>
<td>66.</td>
<td>I worry about him/her after sessions more than other patients.</td>
</tr>
<tr>
<td>67.</td>
<td>I end sessions overtime with him/her more than with my other patients.</td>
</tr>
<tr>
<td>68.</td>
<td>I feel less successful helping him/her than other patients.</td>
</tr>
<tr>
<td>69.</td>
<td>I do things for him/her, or go the extra mile for him/her, in ways that I don’t do for other patients.</td>
</tr>
<tr>
<td>70.</td>
<td>I return his/her phone calls less promptly than I do with my other patients.</td>
</tr>
<tr>
<td>71.</td>
<td>I disclose my feelings with him/her more than with other patients.</td>
</tr>
<tr>
<td>72.</td>
<td>I call him/her between sessions more than my other patients.</td>
</tr>
<tr>
<td>73.</td>
<td>I find myself discussing him/her more with colleagues or supervisors than my other patients.</td>
</tr>
<tr>
<td>74.</td>
<td>S/he is one of my favourite patients.</td>
</tr>
<tr>
<td>75.</td>
<td>I watch the clock with him/her more than with my other patients.</td>
</tr>
<tr>
<td>76.</td>
<td>I self-disclose more about my personal life with him/her than with my other patients.</td>
</tr>
<tr>
<td>77.</td>
<td>More than with most patients, I feel like I’ve been pulled into things that I didn’t realize until after the session was over.</td>
</tr>
<tr>
<td>78.</td>
<td>I begin sessions late with him/her more than with my other patients.</td>
</tr>
<tr>
<td>79.</td>
<td>I talk about him/her with my spouse or significant other more than my other patients.</td>
</tr>
</tbody>
</table>
The suicidal patient selected is:

- A child
- An adolescent
- An adult

How long approximately did you or have you been working with this patient?

- Less than 6 months
- Between 6 months and a year
- More than a year
- More than 2 years

Overall or so far, how has the treatment/therapy been?

- Regular (constant)
- Erratic (on and off)

Are you currently still seeing this patient?

- Yes
- No
Referring to your clinical judgment, what describes best your patient in terms of type of suicidality?

- Chronic
- Acute
- Other, please specify: ___________

Do you consider that this patient has a Personality Disorder?

- Yes
- No

Using the words of your practice, how would you name or describe your patient's personality disorder?

___________

Now using the DSM-V nomenclature, please tick the box(es) that apply:
More than 1 answer can be selected

- Cluster A - Odd, Eccentric (Paranoid, Schizoid, Schizotypal)
- Cluster B - Dramatic, Emotional, Erratic (Borderline, Narcissistic, Histrionic, Antisocial)
- Cluster C - Anxious, Fearful (Avoidant, Dependent, Obsessive-Compulsive)
- Not Applicable
According to your clinical judgment, how is the treatment/therapy going with the patient selected?

- The therapy is going well
- The therapy is not going very well

Thank you for answers.
Now taking a step back, thinking about your work as a whole:

Over the past 5 years, have you participated in courses or training for the assessment and/or treatment of patients with suicidal behaviours (including suicidal ideation)?

- Yes
- No

Overall, you feel that your present level of competence enables you to care for suicidal patients.

- Very True
- True
- Somewhat True
- Not True
- Not True at All

Overall, you feel that you need further training to be able to help suicidal people appropriately.

- Very True
- True
- Somewhat True
- Not True
- Not True at All

Overall, you would say that you like working with suicidal patients.

- Very True
- True
- Somewhat True
- Not True
- Not True at All
Have any of your treatment/therapy patients died by suicide?

Yes

No

How many treatment/therapy patients have you lost to suicide?

1

Would you say that you have encountered suicidal issues in your personal life, either affecting a person close to you or you directly?

Yes

No

If you currently feel distressed or vulnerable, please ensure that you make use of your own supervision and of the professional help that is available to you.

If you are thinking about suicide yourself, you can call 0508 TAUTOKO (0508 82 98 65) for support.

TAUTOKO helpline operates 24 hours, 7 days, and is a service of Lifeline New Zealand.
WE NEED YOU!

The answers you provided indicate that you meet the recruitment criteria for the second phase of the PhD study (2017), which examines experiences of positive emotional-cognitive responses in the treatment of suicidal patients; an area that has received little coverage in the research literature.

If you agree to provide an email address, we will send information about the next study when it is available, possibly early 2017.

NOTE:
By providing your email address today, you are in no way bound to participate in the second phase, but merely consent to have information sent to you.

I agree to provide an email address so that information about the second phase of the study can be sent to me.

[Check box for YES or NO]

Please enter your email address in the text box below:

[Email address input field]

You finished answering all questions. To allow the answers you provided to be collected and analysed, please click the “SUBMIT SURVEY” button below

[CANCEL SURVEY] [SUBMIT SURVEY]
Table 4 – Factor Loadings for Exploratory Factor Analysis With Direct Oblimin Rotation of the TRQ with PRS (N = 267)

<table>
<thead>
<tr>
<th>Factors composition</th>
<th>Cross loadings</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor 1 – ENTRAPPED/REJECTING – 13 Items</strong></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I think s/he might do better with another therapist or in a different kind of therapy [54]</td>
<td>.67</td>
<td>-.01</td>
<td>.05</td>
<td>-.04</td>
<td>.01</td>
<td>-.10</td>
<td>.07</td>
</tr>
<tr>
<td>I feel less successful helping him/her than other patients [68]</td>
<td>.54</td>
<td>-.22</td>
<td>-.04</td>
<td>-.12</td>
<td>-.14</td>
<td>.08</td>
<td>-.02</td>
</tr>
<tr>
<td>I feel incompetent or inadequate working with him/her [36]</td>
<td>.51</td>
<td>-.24</td>
<td>.07</td>
<td>-.06</td>
<td>-.35</td>
<td>.05</td>
<td>.00</td>
</tr>
<tr>
<td>I feel anxious working with him/her [30]</td>
<td>.50</td>
<td>-.02</td>
<td>.05</td>
<td>.06</td>
<td>-.29</td>
<td>.22</td>
<td>-.16</td>
</tr>
<tr>
<td>I feel I am failing to help him/her or I worry that I won’t be able to help him/her [31]</td>
<td>.49</td>
<td>-.28</td>
<td>-.02</td>
<td>-.06</td>
<td>-.32</td>
<td>.07</td>
<td>.01</td>
</tr>
<tr>
<td>I feel frustrated in sessions with him/her [22]</td>
<td>.48</td>
<td>-.03</td>
<td>.01</td>
<td>.07</td>
<td>-.14</td>
<td>-.16</td>
<td>-.25</td>
</tr>
<tr>
<td>I feel annoyed in sessions with him/her [8]</td>
<td>.48</td>
<td>.11</td>
<td>.04</td>
<td>.07</td>
<td>-.02</td>
<td>-.22</td>
<td>-.40</td>
</tr>
<tr>
<td>I end sessions overtime with him/her more than with my other patients [67]</td>
<td>.47</td>
<td>.04</td>
<td>.02</td>
<td>-.29</td>
<td>.08</td>
<td>.33</td>
<td>.01</td>
</tr>
<tr>
<td>I dread sessions with him/her [13]</td>
<td>.46</td>
<td>-.23</td>
<td>-.06</td>
<td>-.01</td>
<td>-.09</td>
<td>.09</td>
<td>-.26</td>
</tr>
<tr>
<td>I think or fantasize about ending the treatment [58]</td>
<td>.43</td>
<td>.04</td>
<td>.11</td>
<td>-.02</td>
<td>.05</td>
<td>.08</td>
<td>-.42</td>
</tr>
<tr>
<td>I wish I had never taken him/her on as a patient [5]</td>
<td>.43</td>
<td>-.12</td>
<td>-.01</td>
<td>-.04</td>
<td>.04</td>
<td>-.00</td>
<td>-.25</td>
</tr>
<tr>
<td>I feel guilty about my feelings toward him/her [24]</td>
<td>.41</td>
<td>-.16</td>
<td>.08</td>
<td>-.21</td>
<td>-.02</td>
<td>.10</td>
<td>-.13</td>
</tr>
<tr>
<td>When checking my phone messages, I feel anxiety or dread that there will be one from him/her [60]</td>
<td>.35</td>
<td>-.08</td>
<td>.00</td>
<td>-.27</td>
<td>.04</td>
<td>.06</td>
<td>-.19</td>
</tr>
<tr>
<td><strong>Factor 2 – FULFILLED/ENGAGING – 9 Items</strong></td>
<td></td>
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<tr>
<td>I look forward to sessions with him/her [19]</td>
<td>-.05</td>
<td>.67</td>
<td>.13</td>
<td>-.03</td>
<td>.03</td>
<td>.07</td>
<td>.01</td>
</tr>
<tr>
<td>I feel pleased or satisfied after sessions with him/her [53]</td>
<td>-.18</td>
<td>.63</td>
<td>-.06</td>
<td>-.10</td>
<td>-.04</td>
<td>.02</td>
<td>.02</td>
</tr>
<tr>
<td>I am very hopeful about the gains s/he is making or will likely make in treatment [1]</td>
<td>-.11</td>
<td>.53</td>
<td>-.10</td>
<td>.02</td>
<td>-.03</td>
<td>.01</td>
<td>-.04</td>
</tr>
<tr>
<td>I feel like I understand him/her [40]</td>
<td>-.03</td>
<td>.52</td>
<td>-.08</td>
<td>-.09</td>
<td>-.07</td>
<td>.03</td>
<td>-.05</td>
</tr>
<tr>
<td>I find it exciting working with him/her [3]</td>
<td>.02</td>
<td>.49</td>
<td>.07</td>
<td>-.02</td>
<td>-.13</td>
<td>.09</td>
<td>.05</td>
</tr>
<tr>
<td>S/he is one of my favourite patients [74]</td>
<td>.04</td>
<td>.47</td>
<td>.18</td>
<td>-.10</td>
<td>-.22</td>
<td>.02</td>
<td>.21</td>
</tr>
<tr>
<td>I like him/her very much [65]</td>
<td>.01</td>
<td>.46</td>
<td>.12</td>
<td>-.08</td>
<td>-.28</td>
<td>.11</td>
<td>.14</td>
</tr>
<tr>
<td>I feel compassion for him/her [4]</td>
<td>.10</td>
<td>.37</td>
<td>-.02</td>
<td>.13</td>
<td>-.29</td>
<td>.21</td>
<td>.14</td>
</tr>
<tr>
<td>S/he makes me feel good about myself [23]</td>
<td>.00</td>
<td>.36</td>
<td>.10</td>
<td>-.22</td>
<td>-.11</td>
<td>.06</td>
<td>.03</td>
</tr>
<tr>
<td>Factor 3 – AROUSED/REACTING - 6 Items</td>
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<tr>
<td>I feel sexually attracted to him/her [17]</td>
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<td>.77</td>
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<td>I feel sexual tension in the room [61]</td>
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<td>I find myself being flirtatious with him/her [56]</td>
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<td>.69</td>
<td>-.06</td>
<td>-.01</td>
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<td>His/her sexual feelings toward me make me anxious or uncomfortable [32]</td>
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<td>.68</td>
<td>.02</td>
<td>.01</td>
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<td>I feel envious of, or competitive with him/her [20]</td>
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<td>.01</td>
<td>.51</td>
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<td>.02</td>
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<td>I have to stop myself from saying or doing something aggressive or critical [39]</td>
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<th>Factor 4 – INFORMAL/BOUNDARY CROSSING - 9 Items</th>
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<tr>
<td>I self-disclose more about my personal life with him/her than with my other patients [76]</td>
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<td>I disclose my feelings with him/her more than with other patients [71]</td>
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<td>.05</td>
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<td>-.14</td>
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<tr>
<td>I talk about him/her with my spouse or significant other more than my other patients [79]</td>
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<td>.04</td>
<td>.05</td>
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<td>-.00</td>
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<tr>
<td>I begin sessions late with him/her more than with my other patients [78]</td>
<td>-.02</td>
<td>-.13</td>
<td>.16</td>
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<td>.03</td>
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<tr>
<td>I return his/her phone calls less promptly than I do with my other patients [70]</td>
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<td>.01</td>
<td>.07</td>
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<td>.24</td>
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<tr>
<td>I lose my temper with him/her [48]</td>
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<td>-.16</td>
<td>-.34</td>
<td>-.41</td>
<td>.04</td>
<td>-.15</td>
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<tr>
<td>I call him/her between sessions more than my other patients [72]</td>
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<td>-.05</td>
<td>-.07</td>
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<td>-.08</td>
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<tr>
<td>I do things for him/her, or go the extra mile for him/her, in ways that I don’t do for other patients [69]</td>
<td>.05</td>
<td>.04</td>
<td>-.11</td>
<td>-.36</td>
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<tr>
<td>I tell him/her I love him/her [50]</td>
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<td>.05</td>
<td>.25</td>
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<th>Factor 5 – PROTECTIVE/OVERINVOLVEMENT - 9 Items</th>
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<tr>
<td>I have warm, almost parental feelings toward him/her [64]</td>
<td>-.18</td>
<td>.31</td>
<td>.05</td>
<td>-.12</td>
<td>-.62</td>
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<tr>
<td>I feel sad in sessions with him/her [49]</td>
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<td>.05</td>
<td>.13</td>
<td>.13</td>
<td>-.62</td>
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<tr>
<td>I feel like I want to protect him/her [42]</td>
<td>-.11</td>
<td>.18</td>
<td>-.03</td>
<td>-.03</td>
<td>-.60</td>
<td>.05</td>
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<tr>
<td>I feel nurturant toward him/her [47]</td>
<td>-.14</td>
<td>.37</td>
<td>-.08</td>
<td>-.04</td>
<td>-.58</td>
<td>.11</td>
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<tr>
<td>S/he tends to stir up strong feelings in me [29]</td>
<td>.22</td>
<td>.09</td>
<td>.07</td>
<td>.03</td>
<td>-.52</td>
<td>.05</td>
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<tr>
<td>I feel overwhelmed by his/her strong emotions [26]</td>
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<td>.26</td>
<td>.06</td>
<td>-.09</td>
<td>-.47</td>
<td>.12</td>
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<tr>
<td>I feel guilty when s/he is distressed or deteriorates, as if I must be somehow responsible [28]</td>
<td>.32</td>
<td>.20</td>
<td>.08</td>
<td>-.05</td>
<td>-.46</td>
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<tr>
<td>I wish I could give him/her what others never could [21]</td>
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<td>.08</td>
<td>.04</td>
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<td>-.45</td>
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<tr>
<td>I feel angry at people in his/her life [14]</td>
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<td>Factor 6 – AMBIVALENT/INCONSISTENT* - 5 Items</td>
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<tr>
<td>I feel bored in sessions with him/her [16]</td>
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<td>I worry about him/her after sessions more than other patients [66]</td>
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<td>I find myself discussing him/her more with colleagues or supervisors than my other patients [73]</td>
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<td>My mind often wanders to things other than what s/he is talking about [25]</td>
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<td>I don’t feel fully engaged in sessions with him/her [9]</td>
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<tr>
<th>Factor 7 – MISTREATED/CONTROLLING - 11 Items</th>
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<tr>
<td>I feel unappreciated by him/her [63]</td>
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<tr>
<td>I feel mistreated or abused by him/her [46]</td>
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<tr>
<td>I feel dismissed or devalued [6]</td>
</tr>
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<td>I feel pushed to set very firm limits with him/her [55]</td>
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<tr>
<td>At times I dislike him/her [2]</td>
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<td>I feel used or manipulated by him/her [33]</td>
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<td>I feel criticized by him/her [12]</td>
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<tr>
<td>I feel resentful working with him/her [57]</td>
</tr>
<tr>
<td>More than with most patients, I feel like I’ve been pulled into things that I didn’t realize until after the session was over [77]</td>
</tr>
<tr>
<td>I find myself being controlling with him/her [37]</td>
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<tr>
<td>I feel like my hands have been tied or that I have been put in an impossible bind [59]</td>
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<td>-.10</td>
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1 - Items loading < .4 were retained when they increased the internal consistency, loaded > .4 with PCA technique, and made sense clinically;
2 - 17 items from the original 79 items of the TRQ are not listed;
3 - Statements are showed with their original numbering (See Betan et al., 2005; Tanzilli et al., 2015);
*Refer to the result section for rationale behind maintaining Factor 6 in spite of a poor reliability score.
Appendix XI. Explicit biases upon entering study 2

I reflected on my preconceptions concerning clinicians’ positive inclination to PRS upon entering the qualitative phase of the project.

Some of my biases stemmed from conducting my masters research project in France. I have indicated that the study consisted of the in-depth interview of a therapist who had chosen to work in a suicide prevention centre (France). Others came from my own practice, my readings, and from conducting the first study of this research. Furthermore, my psychodynamic theoretical orientation influenced the way I considered clinicians’ positive inclination to PRS and the possible therapeutic consequences it might have.

I display below the content of this memo-writing put together before starting data collection for study 2:

I believe that clinicians like working with PRS because they do not focus on the suicidal risk as such. I expect positively inclined clinicians to associate suicide with life rather than with death. More precisely, I expect them to understand suicidality as a struggle to live rather than an actual effort to die.

I believed that positively inclined clinicians would interpret patients’ challenging behaviours as patients’ own struggles, rather than feeling targeted personally.

They think they understand people’s intense state of distress. They empathise with them and feel strong enough, and trained and skilled enough to intervene as appropriate.

Hence, clinicians do not doubt their capacity to help suicidal people and find rewarding to infuse them with hope, and help them choose life.

They might also like the challenge that trying to help a suicidal person represents, or the urgency. Although I do not really believe that. Instead, I actually believe that because they understand the situation, and realise what is at stake while feeling able
to help, that clinicians feel both inclined to help, and find rewarding to help. So I expect to find both a deep understanding of the suicidal state (heightened empathetic abilities), and appropriate personal resources as well as an willingness to engage, a positive regard, a caring attitude, love and hopefulness.

Drawing from the psychodynamic literature, I hypothesised that positively inclined clinicians foster a desire to live through adopting a maternal stance. I wondered if suicidality could stem from essential faults in the original maternal desire, real (abandonment, abuse, neglect), or fantasised. To put it in Lacanian terms, the other’s desire is necessary to life. We are essentially the product of the other’s desire, which could be symbolically defective in the case of PRS. Maybe that, for the portion of suicidal people drawn to treatment/therapy, a symbolic flaw in the mother’s desire is being repaired in the therapeutic relationship.

These patients might be testing clinicians’ perseverance and the unconditional nature of their desire to help, until they are able to trust them. I wonder about the possibility of developing a form of attachment where patients feel genuinely cared for in the therapeutic relationship, which help them somehow let go of suicidality as a coping strategy.

Ultimately, I hypothesise that, as Maltsberger proposed, patients need to be loved (Maltsberger, 2001). However, I doubted that ‘loving’ could be part of clinicians’ professional duty. Although Maltsberger described the type of love needed as resembling that of a good teacher for a student (Maltsberger, 2001, p. 161), it is love nonetheless. The therapeutic impasse according to me, could reside in the fact that you can ask professionals to hone their skills, be up to date with research and keep a record of their activity, but you cannot ask them to love.

I doubt that the ability to love can be learnt/taught. However, I believe you can educate clinicians to know what is needed and recognise when they cannot provide it. This should lead to seeking consultation or, in some cases, to early referral of patients to a competent colleague. Just like a heart surgeon would not operate on a brain, and vice versa. CT literacy would constitute a precious tool in that respect.
Appendix XII. Short descriptive survey study 2

CLINICIANS’ POSITIVE INCLINATION TOWARDS PATIENTS AT RISK FOR SUICIDE

Please complete the descriptive information below; by clicking directly on the box you want to tick (clicking a second time unticks the box)

1- What is your professional occupation?
   • Psychiatrist □
   • Psychologist (general) □
   • Clinical Psychologist □
   • Counselling Psychologist □
   • Educational Psychologist □
   • Psychotherapist □

2- What is your gender?
   Click here to enter text.

3- Which ethnic group(s) do you belong to?
   Mark the space or spaces that apply to you
   • New Zealand European □
   • Māori □
   • Samoan □
   • Cook Island Maori □
   • Tongan □
   • Niuean □
   • Chinese □
   • Indian □
   • Other (such as Dutch, Japanese, Tokelauan); please specify:
      ____________________________

4- What is your primary theoretical orientation?
   • CBT □
   • Psychodynamic □
   • Eclectic □
   • Other; please specify: ____________________
5- How long have you been working in this occupation?
   • Less than 5 years  □
   • Between 5 and 10 years  □
   • 11 years and over  □

6- On average, how many hours per week do you work face to face with patients?
   • Less than 5 hours per week  □
   • Between 5 and 10 hours per week  □
   • Between 11 and 15 hours per week  □
   • Over 15 hours per week  □

7- The work setting where you currently work with patients is:
   • Public  □
   • Private  □
   • Both  □

8- Do you consider that you have lost patients to suicide?
   • Yes  □
   • No  □

9- If yes, how many treatment/therapy patients have you lost to suicide?
   _______________________________
Appendix XIII. Illustration of the analytic process for study 2

The point of a qualitative exploratory method is to remain open to possibilities and learn from the data itself. I have argued that, as a method for approaching qualitative data, the grounded theory method (GTM) provides a methodological framework that allows for both the flexibility and the rigour I looked for from a critical realistic meta-theoretical framework. Further, the constructivist approach to GTM fostered confidence in providing a platform to acknowledge the role that I played as a researcher in constructing my findings. Yet, collecting and analysing qualitative data can be daunting. There are inherent limitations to how much prescription there can be to the task, and a certain amount of trust is required. Ultimately, as Glaser put it, you just have to do it. “In closing I admonish the reader again, trust grounded theory, it works! Just do it, use it and publish!” he wrote. (Glaser, 1998, p. 254).

In this appendix, I provide a more detailed description of the iterative data collection and analysis process. I then show that a characteristic of the data, to which I refer here as a “meta-category”, represented a first layer of findings that guided me towards the core category of the data, through a combination of mise-en-abyme and negative drawing.

**Results of the iterative data collection and analysis**

**Sequential interviewing & data saturation**

Effectively, I conducted four groups of interviews, to which I refer using letters A to D. I worked with the contingencies to constitute group similar in size, in order to analyse similar amount of data at one given time, but without compromising clinicians’ participation. This means that I favoured having uneven numbers of participants between groups, rather than postpone interviewing a clinician willing and available to participate.

I undertook initial coding on the first group of three interviews (group A). This led to a plethora of codes and potential categories (e.g. responsibility, philosophy, no
fear, challenge, vocation, connectedness, trust, hope), as shown on the diagram below (see Figure 1).
In line with the GTM, I did not spend much time trying to organise this first set of codes. Instead, I used memo-writing to reflect on them before collecting more data.

The second group of interviews (group B), included four participants. While coding and reflecting on the data of group B interviews, I reached a “aha moment”. I designed the diagram showed below to represent what appeared to me to be at the core of the clinical encounter (see Figure 2). Note that I used a different terminology at the time from the final aroha model. This sudden realisation, or “aha moment” initiated focused coding of all interviews, recursively. Consistent with the description that Charmaz provides of these moments, this conceptual epiphany prompted me to “study earlier data afresh” (Charmaz, 2006, p. 58).

![Diagram of initial codes after group A interviews](image)

![Diagram of "aha moment" group B interviews](image)
After seven interviews, the research questions seemed largely answered, in the specific context of the study. I collected and analysed the four subsequent interviews (group C) to confirm that I had reached data saturation. Group C interviews provided more instances of comparable experiences. These new instances allowed me to further my understanding of clinicians' positive inclination to PRS by refining categories and their relationships between them. Moreover, from group C interviews, I sought to increase the study trustworthiness by eliciting participants' feedback on preliminary findings.

After a clinician withdrew participation, the last group (Group D) consisted in fact of a single interview. I postponed it purposefully, in order to conduct it after I finished designing the model, to assess its trustworthiness. In hindsight, I could confirm that, consistent with previous research (Guest, Bunce, & Johnson, 2006), a form of data saturation regarding the research questions was reached after seven interviews. This means that after seven interviews, new data provided more instances of the same phenomenon, helping me refine the explanatory model, but did not yield substantial alteration of the main categories (See figure 3 for a visual representation of the data collection and analysis iterative procedure).
Figure 3 - Diagram of data collection and analysis iterative procedure

**MOVING BEYOND THE DATA**
Design of an explanatory model that articulates all emergent concepts in relation to answering the research questions

**ARCHA CONNECTION**
- Patient at risk
- Archetype
- Clinical
- Patient
- Caregiver
- Archetype

**INITIAL CODING**
Production of a multitude of codes describing the data, with no clear relationship between them

**FOCUSED CODING**
Led to refine categories' properties by examining their relation to one another, and develop them into concepts
Shift from analytic interpretation to theorization
Confirmation of data saturation

**“AHA MOMENT”**
Emergence of the core category “connection”, in relation to which the most significant codes became categories
Shift from description to analytic interpretation
Suspicion of data saturation
Theoretical sampling as a kind of purposive sampling

Theoretical sampling is not about recruiting a representative sample of a given population. Instead, it aims to further theory building (Charmaz, 2006). According to Jane Hood quoted by Charmaz, “Theoretical sampling really makes grounded theory special and is the major strength of grounded theory because theoretical sampling allows you to tighten what I call the corkscrew or the hermeneutics spiral so that you end up with a theory that perfectly matches your data” (Charmaz, 2006, p. 101).

In the present study, I did not seek to recruit a different type of participants from the one originally targeted, which is the common form of theoretical sampling. However, I used some form of theoretical sampling by amending the interview schedule consequent to analyses. For instance, I found peculiar that the first three participants recounted specific experiences of encounters with suicidal patients. It seems that they had encountered a seminal experience in relation to PRS. Moreover, it seemed that they were justifying the fact that they were indeed experts in clinical suicidology. Reflecting on this fact, I realised that the wording of the first question (“Can you tell me about your experience of working with suicidal patients”) could have prompted participants to recall specific experiences. Instead, I intended to explore how they experience, subjectively, working clinically with PRS. I amended the first question accordingly upon entering group B interviews, and asked instead “How do you experience working clinically with suicidal patients, or patients who might be at risk for suicide?”

Similarly, in analysing group B interviews and reflecting on the data through memo-writing, I questioned the leap I made previously from not endorsing the like-statement to disliking working with PRS. To remediate this, I prompted subsequent participants to reflect on the findings of study 1 themselves so I could gather their interpretation of these findings (i.e. on the proportion of clinicians who endorsed the like-statement).

Transversal meta-category: Missing the mark
In this section, I recollect the early feeling that the interviewees and I were somehow missing each other. It was a sense of a two-way mismatch, sometimes resulting in what felt like forced consensuses.

First, I report on how I perceived interviewees’ comments as a message that I was not on the right track. Then I recollect that I too felt, at times, that interviewees were missing my point. This sense of “missing the mark” percolated through Group A interviews, grew stronger in Group B to appear like a characteristic of the data. Finally, I recount how, by processes of negative drawing and mise-en-abyme, this characteristic, or meta-category, ultimately led me to the core category of these data.

This part of the analytical journey shows that the core-category was indeed a co-construction between participants and I. My propositions are illustrate with excerpts from clinicians’ narratives.

*The interviewer misses the mark*

In several occasions, about various aspects and in different ways, interviewees implied that I was missing the mark. I present these feedbacks in three different themes: the questions asked, the terms used, and the point made.

I received immediately the feedback from interviewees that the questions designed were difficult or confusing. Participants were informed that the prompts were very broad, and that I encouraged them to associate freely with what came to mind. I explained, in introduction of the interview, that the way they would answer would provide a valuable insight into their views and perspectives. I was interested in finding out what was important to them. I also chose this methodology to work with, and to some extent, around, my biases.

Despite providing them with this information, participants seemed to struggle with the unstructured nature of the questions. Nolan for instance commented about the questions multiple times through the interview. He seemed to find the first prompts quite confusing and difficult to answer.
Nolan attributed his trouble answering to the question itself. Similarly, Oceane acknowledged that she found the question difficult to answer, before blaming the question itself too.

These difficulties elicited frustration in interviewees, hence in myself. Hassie, who sounded rather exasperated during the first part of the interview, addressed the matter directly:
Tess: Um interesting... so... ok so... that’s how you would say you experience working with patients at risk for suicide... [Pause]

[No answer]

How would you say you experience it personally, if that makes sense as a question? How is...

Hassie [Psychiatrist]: Oh, I guess so, if you want me to talk about [sounds a bit exasperated/annoyed]. I, uh, I mean it's such a broad question now... you want me to talk about anxiety and things?!

Most of the time however, clinicians' critique conveyed some insight about what had been missed according to them. This was the case in Landon's following comment:

Not the right questions

Landon [Psychotherapist]: I think the problem with your question is that you're asking me as a single person question when they are two people participating.

The interviewer is not using the right terms

Clinicians’ most striking critique was about the terminology used in the study. At first, I found quite ironic that participants volunteered to take part in the study about “clinicians who like working with suicidal patients”, to immediately tell me, in substance, that neither the term “suicidal patients” nor “like” sat right with them. At first, I felt unfairly critiqued and tended to react defensively. I responded to some comments by confronting interviewees about their own contradictions, like with Adelia in the following excerpt.

Not the right terms
Tess: You ticked 'yes I like', or 'overall I would say that yes I like or like very much'. Can you elaborate on that, the fact that you like it?

Adelia [Psychotherapist]: Well, it's really the fact that I ticked that box because I did think [words missing] how can one “like”, how can one “like” that. So I can’t say...

Tess: And yet you ticked the box...

Adelia: Yes, so I ticked the box but I ticked the box with that question in my mind. I can’t say I “like” it because I um, I like the feeling of um, [clears throat] being of help, in having people be glad to be alive.

At first, I was too worried about the validity of the study and potential problem of its design to listen attentively. I found unhelpful that clinicians would feel frustrated by the questions or the terms used in the interview, given that I encouraged them overtly to question them in the first place.

Through this process of try and error, I soon realised that, by pointed out what did not sit right with them, clinicians were in fact telling me their truth. This is where my clinical stance oriented by psychoanalysis influenced me. From that point on, I considered these instances as an opportunity to probe their representations and thus, to further my understating of their subjective experience of the clinical encounter.

Not the right terms
Some participants found that the term ‘suicidal patient’ failed to reflect the reality of their practice. Nolan highlighted that people with a range of difficulties and interpersonal dynamics could be at risk for suicide. In this context, it did not make sense to him to refer to such variety of situations as one category.

Landon [Psychotherapist]: That’s not, no. That’s not really the right question. Do I like working with people who present with trauma? Yes. I do. Or people that present with fear that they cannot understand, and try desperately not to feel, yes. I enjoy working with those people. Yes I do.

“Suicidal patient” is not the right term

Some participants found that the term ‘suicidal patient’ failed to reflect the reality of their practice. Nolan highlighted that people with a range of difficulties and interpersonal dynamics could be at risk for suicide. In this context, it did not make sense to him to refer to such variety of situations as one category.

Not the right terms

Nolan [Clinical psychologist]: [...] suicidal clients isn’t one category. What’s going on? Are we talking about very depressed clients, are we talking about personality disorder [...].

For Landon, suicide is outside of the scope of clinical practice. Suicide is merely one option contemplated to dam an intense distress. As a clinician, Landon works with the distress, not with the suicide.

Not the right term

Landon [Psychotherapist]: [...] Because the suicidal patient is kind of... How do we describe them? You know. What is such a thing as a suicidal patient? [Chuckles].

Moreover, being suicidal or contemplating suicide is not a constant trait so that people can stop being, or become suicidal during the course of therapy. Renee
explained that suicidality can emerge during the course of therapy, or stop being a way for someone to deal with distress at some point in treatment. Hence, it does not make much sense, as far as psychotherapy goes, to label someone as suicidal.

Not the right terms

**Renee [Psychotherapists]:** Right I think I don’t really see...I don’t really sort of describe clients who are suicidal, as suicidal patients. Often when they come to see me, I wouldn't know that they may be suicidal during the course of therapy. So I really love my work and I think that when people are… suicidal um… it’s like, that’s part of the work, but I wouldn't ever want to, you know, label them as being suicidal.

“Liking” *is not the right term*

The second key term involved in the study was “to like”. I chose this term purposefully to seek a spontaneous positive inclination towards patients at risk for suicide. I sought a more personal inclination rather than a feeling of being professionally trained, or competent, to help people at risk. To participate in the study, clinicians had to confirm that ‘overall they liked’ working with suicidal patients. Yet, the term ‘to like’ or ‘to enjoy’ appeared to not sit right with most interviewees.

Not the right terms

**Oceane [Clinical psychologist]:** I don’t really like that word enjoyable but um, cause it’s sort of, you know, you could say, yes I enjoy about chocolate, we’re talking about something different [chuckles] um… but, satisfying I suppose, satisfying and meaningful.

Not the right terms

**Nolan [Clinical psychologist]:** […] it’s not ‘liking’, ‘everyday want to do that work’, but it’s [sigh] wanting to be with humans [...].
Not the right terms

**Donna [Psychotherapist]**: I don't know... I don't know whether 'like', I mean I saw that in your initial brief and I thought is it 'like'? Or is it just...um I don't, I don't differentiate, or exclude [pause] is it, is it actually 'like'? Um... [...].

Others like Landon or Bernice stood by the term, while specifying under which conditions they related to it. Bernice first declared that the term 'like' did not sit right with her, before claiming it in response to clinicians who did not endorse the like-statement.

Not the right terms

**Bernice [Clinical psychologist]**: Um, I guess it means... I know, it's such a, it does, it feels somehow awkward saying 'I like it', but I guess a lot of people don't like it, so I like learning new ways to help young people, because it sucks that some of them are so miserable that they think their only option is for them to take their lives[...]

By refining what he actually likes about his practice, Landon provided insight into his perspective on the nature of the therapeutic encounter with PRS.

Not the right terms

**Landon [Psychotherapist]**: That's not, no. That's not really the right question. Do I like working with people who present with trauma? Yes. I do. Or people that present with fear that they cannot understand, and try desperately not to feel? Yes. I enjoy working with those people. Yes I do.

**The interviewer is missing the point**

Some participants seemed to doubt whether I realised the complexity of the matter, or so it seemed to me.
They would sometimes infer that I was missing the point, based on the terms I used. For instance when Hassie cut me off, sounding frustrated:

**Missing the point**

_Nolan [Clinical psychologist]:_ So it’s a very broad question cause you’re asking me about a whole bunch of different types of clients and a whole bunch of different types of services.

They would sometimes infer that I was missing the point, based on the terms I used. For instance when Hassie cut me off, sounding frustrated:

**Missing the point**

_Tess:_ So you’re putting everything in place to make sure people are safe but ultimately... [No!][Hassie interrupts me]

_Hassie [Psychiatrist]:_ No! No! You can’t! You cannot put everything in place to make sure people are safe, they might die [...].

Similarly, Landon felt that I was missing the point when I reflected back to him his statement that he was not aware of the emotional content of the interaction until six years prior:

**Missing the point**

_Tess:_ I mean I have trouble thinking that you were not aware about what was going on before...

_Landon [Psychotherapist]:_ I was aware but much, much, much, but in a much less physical body way. And I’m also explaining to you that it’s very difficult to impart this to other clinicians, this experience. And yet you are investigating why only a small number of clinicians enjoy being with suicidal patients [yes] and I’m saying that I think this might be a key that I’m explaining to you, why there is only a few of us enjoying being with suicidal patients [...]

Nolan agreed unconvincingly when I tried to summarise why he liked the job:
Missing the point

**Tess:** So that’s the reward, that what’s rewarding, being able to see that change? [Yeah]. And that makes it worth it… for you…?

**Nolan [Clinical psychologist]:** Yeah. Somehow, the way you say it sounds too simple but I think it’s right [yeah].

**Interviewees miss the mark**

Reciprocally, I was first taken aback that interviewees seemed to struggle to follow instructions. I did not expect mental health clinicians to have any trouble being self-reflective about their practice. I assumed that elaborating freely on their experience and emotional involvement in the clinical encounter would come to them naturally. Coming from a stance where I was interviewing experienced professionals, I was surprised to find that clinicians appeared in some ways, with respect to the purpose of the study, to miss the mark also.

Next, I present the statements that conveyed that sense in three themes. The fact that interviewees appeared to be on their own agenda, that they seemed to use the interviews to further their reflections, and that they found these matters to be hard to articulate.

**Interviewees are on their own agenda**

Early on in the analysis, I wrote a memo about feeling that interviewees where on their own agenda. It seemed to me that they wanted to get a message across rather than answering my questions. Consequently, I felt like the questions were almost eluded at times, to favour conveying their own message. I wrote:

On their own agenda [memo]
I guess I felt that some of them were on their own agenda:

- [one] participant was about to retire and seemed to want to convey something before doing so maybe

- [one] found [the study] important and thought we could do better at teaching clinicians and connect with people

- [One] had been suicidal herself in former years and wanted to talk about that

Adelia started by explaining that she took liberty in interpreting the instructions of the first phase of the project (study 1). Not only did she want to talk about the first phase of the project when I prompted her about the second, but she wanted to talk about her suicidality when I asked specifically about her experience of her patients’ suicidality.

On their own agenda

**Tess:** Would you please tell me about your experience of working with suicidal patients?

**Adelia [Psychiatrist]:** Sure! [Chuckles] My… umm my first response to your initial phase [...] was that I was my own suicidal patient. [...] So I can’t remember exactly how I answered it because I almost do things freely and just as it comes up, but the one I had in mind was myself.

As I progressed through collecting and analysing data, it became clear that each participant had their own reason for participating, and for some, a message to get across. Natalia wanted to help and believed that more could be done. Landon started by mentioning that he had ‘prepared’ for the interview thinking of specific cases.

Just as I learned from clinicians’ critique of the terminology used, I quickly moved from feeling anxious that clinicians’ motivations would jeopardise the study, to
realising that once again, in bending the instructions their way, clinicians were telling me something of their truth.

Most clinicians had a seminal experience with suicide that they wanted to share. This was a case or a situation that marked them profoundly and shaped their representations of suicidality and of the nature and limitations of clinical work with PRS.

Through the interview process, I became more flexible. I let interviewees communicate what they wanted or needed to, in their own way, rather than impose my views on what ‘elaborating freely’ should sound like. We each had a goal in undertaking this research. Theirs necessarily differed from mine. I had to be open to that. Again, my clinical background helped me regain confidence that I should merely try my best to understand them first. This was the best way to go in order to construct an understanding that would have important face value.

Hence, when Donna mentioned a situation she wanted to talk about, I encouraged her to do so.

On their own agenda

**Donna [Psychotherapist]:** [...] And there is another, there is a story which will of no doubt unfold about this, somewhere down the track, when you’ll ask me more specific questions. I’m not sure.

**Tess:** No you can go now! If there’s something you know you want to mention, go!

Additionally, I amended the interview schedule accordingly, to allow time for participants to reflect on the interview process and think of any message they would have wanted to communicate. I also added a question to explore why they volunteered their participation to the study.

On their own agenda
Interviewees are furthering their reflections on the topic

The interviews provided clinicians with an opportunity to further their reflexions on the clinical encounter with patients at risk. I had imagined that clinicians would have reflected on their practice with PRS regularly before, in supervision for instance, or in reviewing cases within their team. Most participants were moreover supervisors themselves. While this was certainly the case, I also found that the interview enabled clinicians to further their reflection on the topic.

Again, what surprised and worried me to start with, turned quickly into something positive. I was glad that the study could have a self-reflexive function. I felt privileged also that they would explore their thoughts with me.

Furthering reflexions

Eliza [Psychotherapist]: No no, I really like your question. Let me, let me just, clarify that in my own mind.

Furthering reflexion

Adelia [Psychotherapist]: Sort of, I wouldn’t, I couldn’t have put it in these words, but I think about that just now, umm... [Pause].

The interview gave clinicians an opportunity to think about their practice in a different way. Some participants even anticipated that the interview process would be of value to them.
Furthering reflexion

**Donna [psychotherapist]:** [...] I think it’s been really enjoyable. It’s been really useful to me to think about... Things from the perspective that you are coming at things. I’m going ‘oh how about this’? I have to think really hard about the question that you’re asking. It’s been quite useful and quite interesting really!

**Interviewees find hard to articulate their thoughts**

Finally, the most striking fact was that, in trying to articulate the processes involved, interviewees found themselves unable to, or struggling to do so. Natalia was the first participant to note how tricky it was to put words on these processes. Her reflection caught my attention for she was otherwise remarkably articulate. She was able to elaborate on various aspects of the therapeutic encounter in depth, and was undoubtedly CT literate. Yet, she was surprised herself by how hard she found to put words on these processes.

**Difficulty to articulate**

**Natalia [Clinical psychologist]:** Absolutely, yeah, and to feel it, and to be... and rather than feeling it umm, in a way that they feel it all the time, for that feeling to be different, or ...ummm, it’s hard isn’t, it’s hard to put words on these processes.

Still, I did not think much of it at the time, and in hindsight, I probably first attributed it to her CBT orientation, which I thought might be less encouraging of exploring interpersonal dialectics as much as dynamic orientations. It is not until the interview with Hassie that the inability to articulate struck me. I wrote a memo about it:

**Difficulty to articulate [memo]**
I found [Hassie] not being able to articulate things clearly at all. She was repeating the same common terms such as “interesting and challenging” without being able to elaborate further. Moreover, she seemed quite annoyed by my questions, until I pointed out that she sounded annoyed.

I was amazed that a psychiatrist who works and, I have no doubt, works well, with highly troubled adolescents, did not seem to have thought through these processes. She could not articulate how she felt, or how she experienced her practice. She seemed to find hard or inappropriate (?), or to be surprised that I would ask about these mechanisms at all.

Maybe because it was particularly intense in that instance, coding Hassie’s interview called to mind that I had heard similar reflections from other participants, in various forms, quite a few times already. I was noticing that these experienced clinicians all found quite hard to articulate what was happening, or more accurately, to elaborate further about what was happening, beyond what they had obviously accepted as an acceptable way of describing it.

**From emergence of a core category to design of an explanatory model**

Hence, two intertwined processes led me to a core category of the data.

**‘Mise-en-abyme’**

First, rather organically, through a phenomenological “mise-en-abyme”. A mise-en-abyme, also referred to as the Droste effect, is a technique used in the arts, which consists of placing the image of a work at the centre of the work itself, in a manner that suggests a recursive occurrence to the infinite. More broadly, it is used to describe the insertion of any type of artwork into itself (e.g. a filmmaking within a film, a picture within a picture).
As the description of the meta-category shows, only when I stopped worrying about what I expected, did I start being able to hear what the participants were actually saying. I therefore experienced in vivo, within the research process, what clinicians talked about as being the essence of the therapeutic encounter. That is, the necessity to be willing to engage, as well as the necessity to be aware of one’s own biases and CT to be able to become attuned to the other. The actual ability to hear and understand people arises from the attunement to another person. Without this, the person can be forever missed.

**Negative drawing**

Then only, in hindsight, I was able to understand that some insight about the nature of the data resided in the feeling that interviewees and I were missing one another. They were on their own agenda, why would they not be, but I was on my own one
too. What I first disregarded as being outside of the scope of the findings kept grappling with my perception of the data until forming a sort of transversal meta-category. This feeling of a mismatch was actually a characteristic of the data. Akin to negative drawing, or photographic films, this multi-dimensional way of ‘missing’ made the nature of the clinical encounter to PRS apparent, by shading the negative space around it.

Towards a conceptual working model

This meta-category guided me to the core category in this data, which consists of clinicians’ experience of a deep connection with their patients. This deep connection appeared to be located at the core of the clinical encounter. This core category or category alpha emerged as being central in the sense that it was holding other aspects of the data together. It transcends individual accounts, professions, theoretical orientations and work settings.

In this sense, I relate to the GTM terminology that categories are “emergent”. In my experience of using GTM, it was as if my brain was computing information at an implicit level, and linked dots without my explicit willingness to do so. Hence, it felt as if a core category essentially appeared to me, emerged from the data, rather than the product of my active construction of it. The construction came after, in the conscious examination of the relationship between categories, and subsequent shaping of a conceptual working model of clinicians’ positive inclination to PRS where all categories fit together. Thus the different categories identified (see table 1 below) correspond to the different elements of the aroha model.
**Table 1 - Overview of categories and sub-categories pertaining to positively inclined clinician’s encounter with PRS**

<table>
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<th>Overarching Categories</th>
<th>Categories</th>
<th>Sub-categories</th>
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<td>Implicit Interpersonal</td>
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<td>(core category)</td>
<td>Phenomenological aspects</td>
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<td></td>
<td>Epistemological aspects</td>
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<td><strong>Clinicians’ part</strong></td>
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<td>of the interaction</td>
<td></td>
<td>Let the encounter be about the other</td>
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<td></td>
<td></td>
<td>Willing to form an attachment</td>
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<td></td>
<td>Genuine care and hope</td>
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<td></td>
<td>Emotional literacy</td>
<td>To accept the risk To foster the genuine care required</td>
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<tr>
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<td></td>
<td>To navigate professional boundaries</td>
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<tr>
<td></td>
<td>Implicit/explicit dialectic</td>
<td>Mastery of procedural aspects Sitting with emotionality in situation Theoretical framework as compass</td>
</tr>
<tr>
<td><strong>Patients’ part</strong></td>
<td>Ambivalence towards engagement</td>
<td>Hope behind ambivalence Drive to make change</td>
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<tr>
<td>of the interaction</td>
<td>Suicidal ideation &amp; behaviours</td>
<td>Attempt to escape unbearable state Not the focus of treatment Underlying history of trauma</td>
</tr>
<tr>
<td></td>
<td>Emotional dysregulation</td>
<td>History of neglect or abuse Attachment issues Inability to regulate emotional states</td>
</tr>
<tr>
<td></td>
<td>Implicit/explicit dialectic</td>
<td>Emotional synchrony Vicarious navigation of emotion Collaborative weaving of narrative</td>
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<td>Possible obstacles</td>
<td>Distal Proximal</td>
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