Psychologists’ perspectives on the process of collaboration using the Collaborative Assessment and Management of Suicidality (CAMS): An Interpretative Phenomenological Analysis.

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Abstract

Introduction: Whilst evidence grows for the effectiveness of suicide-specific interventions such as the Collaborative Assessment and Management of Suicide (CAMS), much less is known about the clinicians’ experience of the collaborative process. This study aimed to give voice to the lived experience of psychologists using the CAMS framework with suicidal clients.

Method: A qualitative design was utilised involving the completion of semi-structured interviews with participants. Semi-structured interviews were conducted with ten psychologists who currently or had previously worked in a Suicide Assessment and Treatment Service (SATS) where the CAMS approach is utilised. Interviews were audio recorded and transcribed verbatim for analysis.

Results: An Interpretative Phenomenological Analysis (IPA) approach was used and revealed a number of superordinate and subordinate themes in the interview narratives. The superordinate themes included ‘Finding Safety’, ‘Regulation of the Self’, ‘Connecting’, and ‘Systemic Challenges’.

Discussion: This study highlights important elements of the collaboration process of the CAMS approach. The findings of this study are discussed in the context of previous literature. Implications for clinical practice and future research are discussed with particular emphasis on supportive avenues for clinicians working with suicidal clients.
Declaration

I declare that this thesis is entirely my own work, other than the counsel of my supervisors, is an accurate reflection of work, and has not been submitted as part of another degree at the University of Limerick or any other academic institution.

_________________________  _______________________
Bríd Fogarty                Date
Acknowledgements

I would like to thank my supervisor, Dr Sharon Houghton, for the support and guidance she provided throughout this work. Your support and feedback proved an ongoing source of reassurance and encouragement. Thanks to my field supervisor Dr Eoin Galavan for steering me in the right directions and being a source of expert guidance. Thanks also to Dr Barry Coughlan for his advice on the early stages of this study’s inception.

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Last but by no means least, I would like to thank Lucio for his unflagging love and support and for keeping me going at times when I didn’t think I’d ever finish this. Thank you for your constant patience, reassuring words, thoughtfulness and understanding throughout this whole process.
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Chapter One: Introduction

"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient. . . . The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal."

Francis W. Peabody (in Michel et al. (2002))

Suicide is an extremely contentious subject which taps into our deepest human emotions and our most basic fears. Historically, suicide has ignited infinite social, cultural, religious, moral and philosophical tensions (Jobes, 2000). This was particularly true of Ireland where suicide was considered deeply shameful and immoral behaviour. In fact, until at least the 1970’s, Catholics who died by suicide could not be buried on consecrated ground and attempted suicide was a criminal offence. By the mid-nineties, when the act of suicide was finally decriminalised (Criminal Law [Suicide] Act, 1993), the Church had also relaxed their stance on burial rites, the Irish National Task Force on Suicide was established (1995), and public stigma began to shift towards a better understanding of peoples’ mental health and psychosocial needs. The recent destigmatisation has opened the public conversation towards support, understanding and prevention. Beginning in 2003, Ireland along with other countries, began to observe World Suicide Day, with the aim of raising awareness, openness, and understanding regarding the causes of suicidality. There are now several organisations in Ireland working to educate the public about suicide and preventative strategies, and the commensurate study of suicide has developed considerably in the past 30 years, both in Ireland and throughout the world.

Globally, at least 800,000 people die by suicide each year and approximately twenty times more attempt suicide annually (WHO, 2017). Suicide was the reported cause of 1.4 per cent of all deaths in 2016, making it the eighteenth leading cause of death worldwide (WHO, 2017). In Ireland, the suicide statistics collated by the Central Statistics Office (CSO) annually and typically published two years later, demonstrate that despite the concerted efforts of the last decade, suicide remains a considerable issue in Ireland. Provisional figures from 2017 (HSE, 2018) indicate that there were 392 suicides reported in Ireland in 2017. This aligns with a modest decline in reported
suicides in recent years, with 425 deaths by suicide reported in 2015 and 486 deaths in 2014 (HSE, 2018). However, it is imperative to note that these are considered minimum figures as many deaths are not reported or officially recognised as suicides.

In addition, the numerous individuals who attempt to die by suicide or engage in suicidal behaviour each year must be considered. It is estimated that suicidal attempts occur at a ratio of 1:20 for every completed suicide (WHO, 2017), and reported that the majority (almost 60%) of those who experience suicidal thoughts and behaviours do not seek intervention from services, predominantly due to a desire to address the issue more personally (O'Connor & Nock, 2014).

Approximately 45 per cent of people who complete suicide consult their GP one month prior to death without disclosing suicidal ideation or intent (Isometsa, Heikkinen, Marttunen, & Henriksson, 1995). In Mental Health care, it is reported that almost one quarter of people who have died by suicide engaged with mental health services in the 12 months before their death (Appleby et al., 1999). In their examination of 153 Irish post-mortem reports of people who died by probable suicide between January 2006 and May 2012 Kielty et al. (2015) found that approximately 40 per cent had had prior contact with mental health services. Perhaps more interestingly, analysis of the associated toxicology reports noted that less than one-third of those who had been prescribed with psychopharmacological medication by mental health services were not taking their medication at the time of death. This suggests a high rate of non-compliance with medication intervention (Kielty et al., 2015).

While those identified as at risk of dying by suicide are often admitted to residential psychiatric hospital facilities, it is estimated that approximately five per cent of all suicides occur by people admitted to psychiatric inpatient services (Walsh, Sara, Ryan, & Large, 2015). Jobes (2016) highlights that there is little research evidence that hospitalisation is an effective response to suicidality. In fact, Large and Ryan (2014) argue that hospitalisation may be a risk factor for suicide. It is clear that interaction experiences with services are crucial in terms of the care and support offered to clients presenting with suicidality in order to support them to cope. Despite the high rates of contact with services prior to death by suicide in the U.S., Jobes, Gregorian, and Colborn (2018a) maintain that mental health services are significantly underprepared to provide effective intervention for people presenting with suicidality; to the point
where suicide was commanding a “Sentinel Event” in health care in the U.S in February 2016. Indeed, suicide is also an urgent priority in Europe and is identified as one of five priority areas in the European Pact for Mental Health and Well-Being (European Pact for Mental Health and Well-Being, 2011). Here in Ireland, the national strategy “Connecting for Life (CfL)” to reduce suicide 2015-2020 outlines a vision of “an Ireland where fewer lives are lost through suicide” (HSE, 2018, p. xiii).

Given the prevalence rates and estimations for engagement with services, it is to be anticipated that psychologists frequently encounter suicidality within their caseloads. Dexter-Mazza and Freeman (2003) reported that 99 per cent of psychologists in training have engaged in clinical work with a client reporting suicidality; 25 per cent of psychologists in training have worked with a client who has attempted suicide; and 11 per cent have experienced the death of a client by suicide whilst still in training (Kleespies, Smith, & Becker, 1990). For mental health clinicians, a survey study suggests that 22 to 29 per cent of clinicians have also experienced a client’s death by suicide (Pope & Tabachnick, 1993). Jobes et al. (2018a, p. 249) describes suicide as the “fatality of mental health care” and places the onus on researchers and mental health clinicians to do everything possible to improve professional ability to understand, assess, and provide effective care for clients who present as suicidal.

1.1 Thesis Structure
A comprehensive critical review of the extant literature in relation to suicidality is presented in Chapter 2 which particularly focuses on the psychotherapeutic relational component of suicide. Chapter 3 outlines the qualitative methodology of this study, including a description of participants, data collection, and analyses. The findings of this study as outlined in Chapter 4 are categorised by superordinate and subordinate themes. Chapter 5 considers the findings of this study in the context of existing literature, clinical implications, and guidance for future research. Full chapter summaries are provided below.

1.1.1 Chapter Two: Literature Review
This literature review synthesises existing suicidality literature, including theories of suicidality, therapeutic interventions, and the research findings of the therapeutic alliance and suicide. It also identifies where the current research sits with regard to the literature and explains the rationale for the current study.
1.1.2 Chapter Three: Methodology
This chapter presents the qualitative approach and research design adopted in the present study and elucidates this as the most appropriate method to address the present research question. The use of Interpretative Phenomenological Analysis (IPA) is discussed in the context of the present study. The process of participant recruitment, data collection, and data analysis is also described and ethical issues, together with issues of reliability and validity are addressed.

1.1.3 Chapter Four: Findings
This chapter presents synthesised findings from the IPA analysis of the 10 participant narratives. Four superordinate themes are presented: namely, Finding Safety; Regulation of the Self; Connecting; and Systemic Challenges. Nine subordinate themes are identified within the four superordinate themes. Relevant extracts from the participant narratives are presented to illustrate the themes, along with the researcher’s interpretative commentary. Reflections made during the process of analysing the results are also presented.

1.1.4 Chapter Five: Discussion
Chapter 5 grounds the findings from Chapter 4 in the context of existing literature. Additional consideration is given to the strengths and limitations of the study, practical applications of the findings in clinical settings, and guidance for future research. Finally, a number of conclusions are outlined, summarising the author’s suggestions regarding the implications of this study and recommendations for practice and future research.
Chapter Two: Literature Review

The field of anthropology has comprehensively established that humans are a relational species (Murdock, 1941). As such, we have a natural tendency to live in societies, establish one-to-one relationships with others, and shape attachments with social groups which provide a sense of belonging. Jobes (2000) suggests that in accepting the fundamental, evolutionary relational aspect of our being, we can begin to understand that suicidality exists in a relational world. He posits that suicidality is fundamentally a relational phenomenon: thus important relationships can be both preventative and causal. In working with suicidality in clinical practice, relational aspects of suicide are especially poignant (Jobes, 2000). This review of the literature explores the various concerns which suicidality poses in effective clinical practice.

2.1 Literature Search Strategy

2.1.1 Scoping the Literature

To determine the efficacy of reviewing the extant literature in this area, an initial scoping search was performed in January 2018 to overview of the range and depth of prior research. To this end, databases including PsychInfo, the Cochrane Library and PsychArticles were utilised. This exercise did not reveal any review papers that offered a systematic or rigorous analysis of the research relating to clinician experiences of working with people who are suicidal.

2.1.2 Literature Search

The literature reviewed here was found by searching electronic databases for relevant articles. These databases included: CINAHL Complete; MEDLINE (EBSCO); PsychInfo; Academic Search Complete; PubMed; ScienceDirect; Web of Science, PsychARTICLES; Social Science Premium Collection; Cochrane Library; and Google Scholar. Due to practical time constraints, only the first 100 search results of Google Scholar were screened. However, this did not produce any records which had not already been identified in the database searches. Various arrangements of the following search terms were utilised: suicide; suicidality, suicidal risk; suicidal intent; suicidal expression; suicidal ideation; qualitative research; qualitative; qualitative study; interviews; psychologists; clinicians; and mental health practitioners.
2.2 Theories of Suicide

Significant research regarding suicide has focused on risk factors that are predictive of suicidality (Chan et al., 2016). However, there is growing consensus that the utility of isolated risk factors is limited. Mulder, Newton-Howes, and Coid (2016) go so far as to suggest that risk categorisation evidence may actually be harmful in terms of exacerbating the clinical understanding of suicide. It is established that people who die by suicide present with several interacting risk factors rather than one singular risk factor (Van Orden et al., 2010). Suicide is essentially a conscious, intentional decision to end one’s life. Therefore, it is argued that the onus rests on mental health professionals to fully understand suicide and provide evidence-based intervention (O'Connor & Nock, 2014).

Moving beyond identifying risk and protective factors, there has been extensive research involved in trying to understand the phenomenon of suicide which draws from the fields of sociology, psychiatry, psychology, philosophy, neurobiology and genetics. In consequence, the numerous theoretical models which represent these viewpoints share the aim of explaining and predicting suicidality. As critically examining each model is beyond the scope of this review, an overview of those prominent theories is provided in Table 2.1 below:
### Prominent theoretical frameworks for understanding suicide

<table>
<thead>
<tr>
<th>Theory</th>
<th>Author</th>
<th>Basic principles</th>
</tr>
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<tbody>
<tr>
<td>Le Suicide</td>
<td>Durkheim (1897)</td>
<td>Coming from a sociological view, Durkheim theorised that suicide is a societal condition and that enhanced societal controls would reduce rates of suicide. Durkheim’s theory is supported by research identifying societal factors as suicidal risks, such as marital status and political oppression (Tartaro &amp; Lester, 2005)</td>
</tr>
<tr>
<td>Diathesis stress hopelessness model of suicide</td>
<td>Schotte and Clum (1987)</td>
<td>From a biological perspective, Schotte and Clum propose that hereditary vulnerabilities interact with life stressors. They suggest that deficits in impersonal and interpersonal problem solving, means a person experiences increased stress and hopelessness. They suggest that this social problem solving vulnerability points to the relationship between stress and suicidal risk.</td>
</tr>
<tr>
<td><strong>Escape Theory</strong></td>
<td>Baumeister (1990)</td>
<td>Baumeister proposes a causal mechanism of suicide. This involves a series of phases which lead to the person seeking death as an escape mechanism from unbearable experiences of the self (unacceptable, comparative with society, painful self-awareness and negative affect). This model has influenced the understanding of suicide and been significant in the development of further theories. However, empirical support for the model is mixed (Dean &amp; Range, 1999; Dean, Range, &amp; Goggin, 1996).</td>
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<tr>
<td><strong>‘Psychache’ and the Cubic Model</strong></td>
<td>Shneidman (1993)</td>
<td>Shneidman pioneered the first psychological theory of suicide, proposing the conflation of three factors: psychological pain (psychache), presses and perturbation. Shneidman’s cubic model suggests that the synergy of these psychological factors at maximum levels leads to an attempt to die by suicide, regardless of the variants of their personal experiences that</td>
</tr>
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</table>
brought them to that point (Shneidman, 1987). The keystone to Shneidman conceptualisation of suicide was psychache, which he believed was the principle cause of suicidality. There is significant and growing empirical support for psychache as a significant predictor of suicidality (Orbach, Mikulincer, Gilboa-Schechtman, & Sirot, 2003; Patterson & Holden, 2012; Troister, Davis, Lowndes, & Holden, 2013; Troister & Holden, 2012).

**Attachment Theory**

Kaplan and Worth (1993)

Attachment literature recognises that a person’s attachment pattern may contribute to a persons’ vulnerability to suicide, particularly those with an insecure attachment pattern (Mandal & Zalewska, 2012). Whilst there is support for this theoretical understanding, it fails to account for persons with healthy attachment styles who die by suicide.

**Hopelessness Theory**

Abramson *et al.* (2000)

Abramson and colleagues posit that negative life events experienced by a person, result in
hopelessness and facilitate a vulnerability to a negative cognitive response process. It is hypothesised that this negative thought pattern increases the risk of suicidal ideation and intent. There is empirical support for the role of hopelessness in suicidal behaviour (Abramson et al., 1998) but it is suggested that hopelessness alone is not a sufficient causal factor of suicide (Holden, Mehta, Cunningham, & McLeod, 2001).

**The Interpersonal Theory of Suicide**

Joiner (2005) proposes an integration of known suicidal risk factors, including psychiatric diagnosis, previous attempts to die by suicide and social isolation. Key to Joiner’s theory of suicide is that a combination of high levels of ‘thwarted belongingness’ and ‘perceived burdensomeness’ that leads to a suicidal desire. Joiner posits that suicidal desire leads to suicidal behaviour when the inherent fear regarding suicidal behaviour is overcome and
the ‘capability’ for suicidal behaviour has been achieved. There is strong empirical support for this model, both in terms of the interaction of causal factors (Van Orden, Witte, Gordon, Bender, & Joiner Jr, 2008) and for the requirement of capability (Joiner Jr et al., 2009).

**Fluid Vulnerability Theory**  
Rudd (2006)

Adapting Beck’s modal theory of psychopathology (Beck, 1996), Rudd offers that suicidal behaviour is consequential to the activation of a ‘suicidal mode’. The ‘suicidal mode’ involves cognitive, behavioural, emotional and physiological systems. As yet, there is limited empirical support for this model (Bryan, Johnson, David Rudd, & Joiner Jr, 2008)

**Cognitive Model**  
Wenzel and Beck (2008)

Taking known predicative factors associated with suicidality, Wenzel and Beck conceptualised these within a framework established from Beck’s general cognitive
theory of psychopathology (Beck, 1991). There are three main concepts: dispositional vulnerability factors, cognitive processes (psychiatric) and cognitive process (suicidal). Causal processes proposed by the model (impulsivity, problem-solving deficits, etc.) have not received empirical support. However, there is encouraging support for cognitive processes proposed by the model, particularly in relation to the role of hopelessness (Beck, Brown, Berchick, Stewart, & Steer, 2006) and attentional biases towards suicide-relevant stimuli (Cha, Najmi, Park, Finn, & Nock, 2010)

| Integrated Motivational-Volitional Model of Suicidal Behaviour | O'Connor (2011) | O’Connor proposes a model integrating existing models (diathesis-stress, interpersonal) that frames the development of suicidal ideation, behaviour and the process of shifting from the former to the latter. The process, according to O’Connor, involves |
three phases: pre-motivational, motivational and volitional. The model proposes factors that distinguish between suicidal ideation and suicidal enactors. Although a new model, there are several studies demonstrating strong support for the model with adults and adolescents (O'Connor, O'Carroll, Ryan, & Smyth, 2012; O'Connor, Rasmussen, & Hawton, 2012).

<table>
<thead>
<tr>
<th>Genetics</th>
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<tr>
<td>Biological and genetic elements of suicide have been identified in twin studies (Voracek &amp; Loibl, 2007) and biological relative studies (Tomassini, Juel, Holm, Skytthe, &amp; Christensen, 2003). Joiner’s Interpersonal Theory of Suicide acknowledges the role of neurobiology and genetics in suicide (Joiner, 2005). Research in this area is ongoing.</td>
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**Table 2.1: Prominent theoretical frameworks for understanding suicide, presented in chronological order**
While early theories were established in isolation, recent theories have built upon earlier contributions and formulated more integrative frameworks. Initiated by Shneidman (1987), it is clear from the subsequent psychological models developed in the past 31 years, that there is a shift towards understanding the underlying mechanisms and dynamics implicated in suicidal behaviour. This progression in the literature yields a greater understanding of the ‘why’ of suicide, and also paves the way for focusing on therapeutic interventions (O’Connor & Nock, 2014). Brown, Wenzel, and Rudd (2011) suggest that, in and of themselves, theoretical frameworks of suicidality provide a mechanism for advancing a shared understanding of the experience of suicidality between the client and clinician.

The prominent theories of suicidality, examined in the table above, all point to the relational component of suicidality (Aherne, Coughlan, & Surgenor, 2018). For instance, Durkheim (1897) sociological model of suicide suggested that “excessive individuation” or a sense of not belonging or being integrated into society increases the likelihood of a person dying by suicide. The eighth of the ten commonalities for suicide which Shneidman (1977) proposes, states that “the common action in suicide is egression”. In this context egression denotes the action of departing from the relational world (Jobes, 2000). Attachment theory described the protective role of secure attachment patterns in terms of suicidality, whereby the affective bond someone has with significant others facilitates acceptance of the self and others; and equally, how insecure patterns are related to suicidality (Ürün, Yildirim, & ERKOÇ, 2015). Indeed, relational aspects of suicide are at the core of Joiner (2005) Interpersonal Theory of Suicide, whereby the combination of the two interpersonal concepts of thwarted belongingness and perceived burdensomeness (in addition to the hopelessness of such positions) generates suicidal desire (Van Orden et al., 2010). More recently, Aherne et al. (2018) proposed a framework to illustrate the role of “connectedness” in suicide, as understood by treating psychotherapists. The role of relationships and relational interactions is clear in the theoretical understanding of suicide. In fact, (Jobes, 2000, p. 8) contends that “suicidality is essentially a relational phenomenon”. This study therefore aims to focus on the uniquely relational aspect of suicidality captured in the theories presented here, by exploring the experience of collaboration for clinicians when working with suicidal clients.
2.3 Psychotherapeutic Interventions for Suicidal Behaviours
As scientist-practitioners, psychologists not only require an understanding of the theoretical psychological models involved, but also the application of evidence-based therapeutic interventions. Clients presenting with suicidal thoughts or behaviour typically find themselves referred to Mental Health teams. However, it is increasingly evident that interventions which centre on the psychiatric diagnosis rather than suicidality as the fundamental difficulty have been found persistently ineffective in reducing suicidal behaviours (Beasley Jr et al., 2007; Cuijpers et al., 2013).

Research regarding suicide-specific interventions is ongoing and large gaps remain in the literature regarding which interventions are most effective with which populations. Molock et al. (2014) purports that methodological issues may be partially accountable for the lack of momentum in this regard since research that centres on suicide intervention and prevention is especially challenging due to the low base-rate of death by suicide. Moreover, Molock and colleagues (2014) acknowledge that the underlying mechanisms for the phenomenon of suicide are not well understood, thereby making it difficult to target the interventions and detect effects. Suicidal ideation is often used as a proxy outcome measure in research (Smith, Cukrowicz, Poindexter, Hobson, & Cohen, 2010): this constitutes an erroneous assumption. Whilst suicidal ideation is recognised as a significant risk factor for suicidal behaviour (Ribeiro et al., 2016), most suicidal ideators never attempt suicide (May & Klonsky, 2016).

While the slow progress of research regarding effective psychotherapeutic interventions is understandable in the context of methodological issues then, it has detrimental consequences in clinical practice. For example, it is established that clinicians continue to deploy longstanding interventions which have proven to be ineffective. These include strategies such as no-suicide contracts (Lewis, 2007; Rudd, Mandrusiak, & Joiner Jr, 2006) or focusing the intervention on peripheral or associated symptoms (such as depression) without diligent ongoing assessment of suicidality (Kene, Yee, & Gimmestad, 2018; Rudd, Cukrowicz, & Bryan, 2008).

Given the methodological challenges, it is therefore unsurprising that very few psychotherapeutic inventions have demonstrated a repeated RCT evidence-base (Brown & Jager-Hyman, 2014). Such evidence-based interventions include dialectical behaviour therapy (DBT); cognitive therapy for suicide prevention (CT-SP); brief cognitive behaviour therapy (B-CBT); and the Collaborative Assessment and
Management of Suicidality (CAMS) (Jobes, Piehl, & Chalker, 2018b). In reality, a wide range of issues stymie the formal establishment of suicide-prevention approaches efficacy. These include the number of participants required in order to generate statistical power and dependence on suicidal ideation as a proxy measure. Jobes et al. (2018b) argue that no one orientation can ever entirely capture the complexity of suicidality; and there is no one ‘best practice’ intervention approach, and indeed, over the past two decades empirical support for DBT, CT-SP, B-CBT and the CAMS has increased year on year.

In 2000, a number of clinical suicidologists convened in Aeschi, Switzerland, to address their concerns regarding contemporary clinical approaches to the suicidal client (Jobes, 2016). From this working group forum a shared perspective referred to as the “Aeschi approach” emerged, containing six guiding principles for clinical intervention with suicidal clients (Michel, 2011) as outlined Table 2.2. Since 2000, the Aeschi approach has influenced a number of emerging evidence-based approaches (Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016; Jobes, 2016; Jobes et al., 2018b). As such, there are a number of common elements to psychotherapeutic interventions, including the phenomenological approach to understanding the client’s experience of suicidality, and specialised skill development to meet the needs of the suicidal client. In addition, there is a shared focus on the therapeutic alliance, collaborative approach, and the psychotherapeutic principles of validation, empathy, and relatedness (Jobes, 2016; Jobes & Ballard, 2011; Schechter & Goldblatt, 2011).

<table>
<thead>
<tr>
<th>The Aeschi Working Group: six guiding principles</th>
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<tr>
<td><strong>1.</strong> The goal for the clinician must be to reach, together with the patient, a shared understanding of the patient’s suicidality.</td>
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<td><strong>2.</strong> The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.</td>
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<td><strong>3.</strong> The interviewer’s attitude should be non-judgemental and supportive.</td>
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<tr>
<td><strong>4.</strong> A suicidal crisis is not just determined by the present, it has a history.</td>
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<tr>
<td><strong>5.</strong> New models are needed to conceptualise suicidal behaviour that provide a frame for the patient and clinician to reach a shared understanding of the patient’s suicidality.</td>
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6. The ultimate goal should be to engage the patient in a therapeutic relationship, even in a first assessment interview.

**Table 2.2: Guidelines for Clinicians created by the Aeschi Working Group**

*(Michel, 2011, pp. 9-10)*

It may conceivably be that the therapeutic alliance and other shared factors of the psychotherapeutic intervention have become established as the predictor of efficacy rather than the particular model utilised (Horvath & Symonds, 1991). As the CAMS is one such model of suicide prevention which has shown significant promise in terms of efficacy, the present study sought to examine the model. In the next section, the literature surrounding the CAMS model specifically will be examined.

2.3.1 **Collaborative Assessment and Management of Suicidality (CAMS)**

The Collaborative Assessment and Management of Suicidality (CAMS) was initially developed by David Jobes (2016) as a suicide-specific therapeutic framework for working with clients who present as suicidal. To this end, it adopts the stance of “suicidality as the central clinical problem, independent of diagnosis” (Jobes & Drozd, 2004, p. 74), and exclusively focuses on the idiosyncratic experience of suicidality as a coping mechanism whilst unapologetically aiming to enhance the client’s reasons for living.

A part of this philosophy of care is to provide the intervention within in a community setting rather than hospitalisation, thus there is an initial emphasis on safety and self-harm risks (Jobes, 2006). Procedurally, the clinician, sitting beside, and in collaboration with the client, is guided by the Suicide Status Form (SSF) for assessment, generation of treatment plan, ongoing tracking of suicidal risk, and ensuring focus is maintained on difficulties related to the client’s experience of suicidality (Jobes, 2016). The SSF contains Likert rating scales and open-ended questions which explore the client’s experience of psychological pain, stress, agitation, hopelessness, self-hatred, and overall risk of suicide (Jobes, 2016). Jobes and colleagues (2018a) stress that the CAMS is conceptualised as a “philosophy of care” (p. 244) that orientates the clinician towards understanding the underlying “drivers” of client suicidality. In this way, any subsequent therapeutic intervention is open to the clinical techniques, therapeutic orientations, intervention strategies, and
theoretical approaches which the clinician introduces in response to individual client needs (Jobes, 2016). Each subsequent CAMS session begins with a completion of the SSF and sessions continue until the suicidality resolves. Resolution is operationally defined as three consecutive sessions of no reported suicidality.

The CAMS approach symbolises a radical shift in terms of the deliberate and ongoing collaborative approach with clients in the context of suicidality (Galavan & Repper, 2017). Supporting the therapeutic alliance is the clinician’s position that suicidality is an understandable (although maladaptive) resolution which serves as a functional coping mechanism for the client. On such a basis, Jobes asserts that the clinician is better placed to explore alternative, adaptive coping strategies which meet the client needs (Jobes, 2015). Jobes (2011) recalls that his early career experiences of administering the Rorschach Inkblot Test ignited his interest in the assessment dynamic. This interest carries through to the CAMS, where, fundamental to the CAMS approach, is a phenomenological aspect that encourages the clinician to understand the client’s suicidality (Jobes, 2016). There is a strong focus on the development of the therapeutic alliance and utilising this relationship as the intervention mechanism (Jobes, 2011). Jobes maintains that the therapeutic alliance is supported by purposefully engaging the client as an active participant in the assessment process and in supporting them to co-author treatment plans (Jobes, 2011). Galavan (2017) noted that the philosophy of this framework attempts to avoid the latent coercive interactions that can infect clinician-suicidal client interactions wherein the suicidal client is conceptualised as “threat and trouble”, to be controlled or avoided in order to circumvent blame or legal consequences. Jobes maintains that the SSF supports the clinician-client dyad in their shared understanding and co-authored intervention plan for the identified suicidal drivers (Jobes et al., 2018a).

As previously mentioned, CAMS is one of few suicidality interventions which has a strong empirical evidence base, including correlational studies (Arkov, Rosenbaum, Christiansen, Jónsson, & Münchow, 2008; Jobes, Jacoby, Cimbolic, & Hustead, 1997; Jobes, Kahn-Greene, Greene, & Goeke-Morey, 2009; Nielsen, Alberdi, & Rosenbaum, 2011).

Nielsen et al. (2011) demonstrated the effectiveness of CAMS in a clinical context at The Centre of Excellence in Suicide Prevention in Denmark. However, their results
should be interpreted with caution owing to several vulnerabilities in the study design; most notably the sparse detail relating to the methodology and lack of transparency in terms of how certain outcomes were achieved. For example, it is reported that 74 per cent of the participants indicated that the CAMS intervention had meant that they no longer felt suicidal, but it is unclear how this information was collected without bias. Support for CAMS is also demonstrated with studies of open trial (Ellis, Green, Allen, Jobes, & Nadorff, 2012), non-randomised control case-control (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005), controlled comparisons (Ellis, Rufino, & Allen, 2017; Ellis, Rufino, Allen, Fowler, & Jobes, 2015) and randomized control trials (Andreasson et al., 2016; Comtois et al., 2011; Jobes et al., 2017). Andreasson et al. (2016) found the CAMS intervention to be as effective as a brief DBT intervention for clients with a diagnosis of Borderline Personality Disorder (BPD) over a period of 28 weeks. Likewise, Comtois et al. (2011) found that CAMS clients demonstrated greater recovery in terms of suicidal ideation, symptom distress, and increased hope at one year compared to clients who received enhanced care as usual (E-CAU). Although a randomised design was used, it is noted that the clients in the CAMS condition received a greater number of intervention sessions which may have influenced the results outside of the explicit intervention. Surprisingly, Jobes et al. (2017) found that soldiers responded to both CAMS intervention and E-CAU in much the same way. Whilst CAMS clients were far less likely to express suicidal ideation after three months, this was not sustained at further time points. Clearly, while the rigor of randomised control trial research is to be applauded and the support for the framework is encouraging, further consideration of the study limitations must be considered. Indeed, further randomised trials are in progress (Jobes et al., 2018a).

While evidence mounts for the efficacy of the CAMS, much less is known about the clinician’s experience of this novel approach. Jobes et al. (2018b) proposes the CAMS as a potential remedy to the clinical challenges that arise in the therapeutic assessment and intervention of suicidality. However, there is a paucity in qualitative research with regard to the CAMS and as such, little is understood about the clinician’s experience of the CAMS or if it differs from other literature regarding psychotherapeutic work with suicidal clients.
2.4 Therapeutic Alliance

It is resoundingly clear in mental health literature that the therapeutic alliance is fundamental to successful care provision. In a meta-analysis of 300 studies, Flückiger, Del Re, Wampold, and Horvath (2018) found a robustly positive correlation between alliance and psychotherapeutic intervention outcome across treatment approaches, patient characteristics, clinician perspectives, outcome measures, and countries. Establishing the therapeutic alliance with suicidal clients is especially important, as the prospect of dying by suicide often sets clinician and client against one another (Jobes, 2011). Irrespective of theoretical orientation, the therapeutic alliance remains the most studied aspect of psychotherapy intervention (Flückiger et al., 2018). In research, the alliance is often preceded by ‘working’, ‘helping’ or ‘therapeutic’ (Flückiger et al., 2018). For ease of clarity, this review considers the terms interchangeable and references to ‘therapeutic alliance’ are only used in this review.

The therapeutic alliance refers to the shared, holistic, and collaborative aspects of the clinician-client relationship. Horvath and Luborsky (1993) report that discourse regarding the therapeutic alliance can be traced back to Freud’s initial conceptualisation of the psychanalytical process of transference and the significance of the client’s conscious relationship with the therapist (Freud, 1912/1958). Since then, the concept has evolved over time to one of a common, pan-theoretical process which contributes to the effectiveness of various therapeutic approaches. Whilst Freud (1912/1958) is credited with the conceptualisation, Zetzel (1956) first coined the term ‘therapeutic alliance’; defining it as a positive transference between the clinician and the client. The concept has progressed from its psychoanalytical roots in the past 63 years. Luborsky (1976) and Bordin (1979) are both credited for their pan-theoretical positioning of the alliance, however their conceptualisation of the therapeutic alliance differs considerably. Luborsky (1976) proposed a theoretical development of the alliance. He suggested that the alliance advances across two phases, taking into account the inherent dynamic characteristics of the relationship. Luborsky identified two forms of alliance, the first (occurring usually at the beginning of therapy) is formed based on the client’s perception of the therapist as a support (Ardito & Rabellino, 2011). The second type (occurring later in the therapy work), is characterised by the collaborative dyad that develops between the client and therapist in an effort to address the client’s presenting problems. The latter involves a shift to a shared responsibility positioning in order for the therapeutic process and goals to be
Bordin proposed a pragmatic formulation of the therapeutic alliance, underlining the collaborative relationship between the client and clinician in order to overcome the client’s presenting problem. He proposes three key elements to the collaborative relationship: agreement on the goals of therapy, agreement on the tasks to achieve the therapy goals, and the development of the bond between the clinician and the client (Ardito & Rabellino, 2011). There are at least thirty measures of alliance, not counting the varying versions of these measures (Horvat, Del Re, Flückiger, & Symonds, 2011). The diversity between the measures speaks to the vast array of recognised methods of assessing the collaborative aspects of the therapeutic relationship (Flückiger et al., 2018).

2.4.1 Therapeutic Alliance and Therapy Outcomes

In the literature, it is clear there is not an agreed upon concept of the therapeutic alliance or indeed measurements of the construct. However, there is a strong predictive relationship between the therapeutic alliance and general psychotherapy outcomes, regardless of measurement variability, perspective evaluations or the type of therapy. "The quality of the alliance matters" (Horvath et al., 2011, p. 13). Meta-analysis studies have consistently reported a robust effect size (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Flückiger et al., 2018), proposing that the therapeutic alliance may account for approximately 8–9% of the variance in client outcomes. A ubiquitous relationship between the therapeutic alliance and outcome has been reported (Flückiger et al., 2018; Martin, Garske, & Davis, 2000), supporting the concept that the alliance is intrinsically therapeutic. Of interest, meta-analysis studies have found that a significant portion of the alliance-outcome correlation is impacted by the clinician (Baldwin, Wampold, & Imel, 2007; Del Re et al., 2012; Flückiger et al., 2018). For clinical practice, this is quite a significant finding, indicating that clinicians vary in their capacity to form a quality alliance, that subsequently impacts on therapy outcomes.

2.4.2 Therapeutic Alliance with Suicidal Clients

The therapeutic alliance is widely accepted as the cornerstone to effective work with clients who are suicidal (Bostik & Everall, 2007; Jobes, 2011; Leenaars, 2006; Michel, 2011; Michel et al., 2002; Schechter, Goldblatt, & Maltsberger, 2013). Marsha Linehan (2018) underlines the significance of validation and non-judgemental acceptance when forming a quality alliance with suicidal clients. Therapeutic empathy
with the suicidal wish or “the death wish” is considered necessary in order to form a genuine connection and quality therapeutic alliance with the suicidal client (Orbach, 2001, p. 166). It is suggested that the therapeutic alliance could be the mechanism that preserves the suicidal client’s connection to being alive (Rizvi, 2011). In the literature, there is debate regarding the role of the therapeutic alliance with suicidal clients. It is suggested that a strong therapeutic alliance encourages open disclosure of suicidal thoughts and behaviours (Shea, 1999), whilst others argue that it underpins effective intervention approaches (Jobes, 2016; Michel, 2011). Another consideration is that the inherent ambivalent positioning of suicidal clients means that withdrawal from therapy is not uncommon (Van Heeringen et al., 1995) and a strong therapeutic alliance may function to maintain engagement in the therapeutic work (Dyck, Joyce, & Azim, 1984). Indeed, Dahlsgaard, Beck, and Brown (1998) report that clients who completed suicide attended fewer therapy sessions and dropped out of therapy more frequently.

It could be reasoned that research regarding general psychotherapy is applicable when working with suicidal clients, given that there is a noticeable lack of research exploring the therapeutic alliance with clients who are suicidal. From the few published studies, there exists discordant conclusions. In a robust study by Perry, Bond, and Presniak (2013), the authors looked at the therapeutic processes associated with improvement in suicidality using audiotaped therapy sessions and independent raters of the process. The study reported a non-significant relationship between outcome and measures of therapeutic alliance. However, the authors suggest that the therapeutic alliance may be more nuanced and have complex role that was not captured in the study.

Client perceptions of a collaborative therapeutic relationship is associated with improvement of suicidal ideation. In a study by Ilgen et al. (2009) which examined the impact of mood states of veterans with bipolar disorder and their perceptions of the therapeutic relationship on suicidal ideation. It was found that the extent to which the relationship was perceived as collaborative was correlated with reduction of suicidal ideation. It must be noted that the measure of suicidal ideation was a single item on a depression inventory that failed to capture the complexity of suicidal thoughts, reducing them to a dichotomy of endorsement or not. Bedics, Atkins, Harned, and Linehan (2015) reported stronger support for the role of the therapeutic alliance in their study examining aspects of the therapeutic alliance in Dialectical Behavioural
Therapy (DBT) with clients presenting with Borderline Personality Disorder (BPD). Of interest, this study used suicidal behaviour as an outcome measure, rather than the proxy measure of suicidal ideation used by Ilgen et al. (2009). This study found that the alliance, rated by the clinician, was indicative of decreased attempts to die by suicide. However, the analysis used in this study did not allow for conclusions regarding causation, and it may be that reduced suicidal behaviours facilitated a stronger therapeutic alliance. Contradicting the findings of these studies, and of particular interest to this study, Ellis et al. (2012) reported an absence of relationship between alliance measures and outcome when using the CAMS framework. The authors acknowledged that the negative correlation trend suggested the need for further more nuanced examination.

2.4.3 Challenges to the Therapeutic Alliance with Suicidal Clients

Jobes (2000) contends that suicidality is a relational phenomenon in that relationships can paradoxically be risk and protective factors. For clinical work with clients who are suicidal, this is particularly relevant. There is a scarcity in the suicide literature regarding the clinician in the process of therapeutic work involving suicidality. Soderlund (1999) reflected that that the “scarcity of research on how therapists deal with the suicide of a patient smacks of a collective avoidance” (p1). However, there does seem to be a general consensus that therapeutic work with clients expressing suicidal intent can have an adverse impact on the clinician and how they work with clients expressing suicidality (Pearlman & Saakvitne, 1995; Reeves, 2010; Reeves & Mintz, 2001).

The collaborative relationship with a suicidal client, who in different ways is preoccupied with suicidality, poses a range of inherent and unique challenges (Jobes et al., 2018b; Weinberg et al., 2011). From their review of the literature, Weinberg et al. (2011) proposed fifteen alliance-interfering factors and five alliance-facilitating factors. These are outlined in Table 1.3. Some of the alliance interfering and potentially destructive factors include the wish to die, projection of suicidal intent, pervasive shame, painful life experience, disturbed attachment and chronic hopelessness. Suicidal clients often present in therapy with experiences of intense shame about their suicidal thoughts and behaviours, which inhibits their ability to talk about these with the clinician (Jobes et al., 2018b). As a result, intense transference and countertransference responses can be triggered. For clarity, transference in the
reactivation of the client’s prior experiences in the therapeutic relationship, these may include memories or unconscious needs in relation to significant attachment figures. Countertransference involves the clinician’s unconscious response to the client and the client’s transference; these reactions are grounded in the clinician’s own tensions (Leenaars, 1994). Transference and countertransference responses of distrust, self-blame and hopelessness can be triggered between the clinician and the suicidal client (Jobes et al., 2018b; Leenaars, 1994). In this way, the presence of suicidal risk can fundamentally impact on the clinician’s interaction with the suicidal client (Jobes & Ballard, 2011).

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<thead>
<tr>
<th>Alliance-Facilitating Factors</th>
<th>Alliance-Interfering and Potentially Destructive Factors</th>
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<tbody>
<tr>
<td>1. Hope to get better</td>
<td>1. Negative or Critical Self-Experience</td>
</tr>
<tr>
<td>2. Explicit agreement to work on decreasing suicidal risk</td>
<td>2. Projection of Critical Ego ideal</td>
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<tr>
<td>3. Strong attachment to the therapist</td>
<td>3. Projection of Suicidal Intent</td>
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<tr>
<td>4. Wish to Live</td>
<td>4. Wish to Die</td>
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<tr>
<td>5. Fear of Death</td>
<td>5. Envy of the Therapist</td>
</tr>
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<td></td>
<td>6. Malignant Narcissism</td>
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<td>7. Self-Centredness</td>
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<td>8. Self-Sufficiency</td>
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<td>9. Shame</td>
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<td>10. Provocation</td>
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<td>11. Execution Alliance</td>
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<td>12. Impaired Evocative Memory</td>
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<td>13. Disturbed Attachment</td>
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<td></td>
<td>14. Chronic Hopelessness</td>
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<td></td>
<td>15. Painful Life Experiences</td>
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*Table 2.3: Factors that impact on the therapeutic alliance with suicidal clients (Weinberg et al., 2011, pp. 295-299)*
The therapeutic alliance is dependent on empathic engagement with the client. Orbach (2001) cautioned that working with clients expressing suicidal intent exerts the most intense power on the therapeutic dyad and on the ability to work effectively. Clinicians can feel overwhelmed by the client’s fear of exploring the unknown which results in an inclination to withdraw. Likewise, Winter, Bradshaw, Bunn, and Wellsted (2013) identified that ambivalence projected towards the clinician can impede their effectiveness in the dyad. Firestone (2014) argues that passive anger encompassed the most common emotion provoked in clinicians whilst working with clients expressing suicidality. The strength of the client’s emotions such as shame or hopelessness can make the alliance challenging to maintain (Schechter & Goldblatt, 2011). In an influential paper in the field of suicidology, Maltsberger and Buie (1974) proposed a countertransference theory unique to suicidal clients. They suggested that the clinician who is not accepting of suicide will likely experience aversion, malice and anger towards the client because of their suicidality and their ambivalence towards intervention (Milch, 1990). These feelings obstruct the clinician’s ability to empathise with the client, which ultimately undermines the therapeutic process (Orbach, 2001; Richards, 2000). This gives rise to potential for rupture to the alliance. In the same way, a suicide attempt during therapy is considered potentially harmful for the therapeutic alliance (Ramsay & Newman, 2005). It is reported that both the client and clinician can feel parallel feelings of guilt, shame and anger (Cureton & Clemens, 2015). Awareness of the countertransference process in therefore intrinsic to repairing the therapeutic alliance in these instances (Cureton & Clemens, 2015). On the other hand, Ramsay and Newman (2005) suggest that a suicide attempt during therapy provides the opportunity for repair and could potentially even strengthen the therapeutic alliance between the clinician and client.

The role of clinicians’ personal attitude towards suicide has been investigated in terms of working with clients expressing suicidality (Bernstein, 2001; Lussier, 2004; Roose, 2001). Rycroft (2004) underlined the necessity for clinicians to be in tune with their personal beliefs and attitudes towards suicide and how these may influence therapeutic engagement with clients. (Bernstein, 2001) proposes that clinician attitudes could play an egocentric role, stemming from the deleterious impact another’s death could have on the clinician, while Roose (2001) maintains that strong emotions of fear and shame relating to failure can hamper clinician competence when working with clients.
expressing suicidality. This is echoed by (Hendin, Haas, Malsberger, Szanto, & Rabinowicz, 2004) who posited that personal clinician anxieties can lead to ineffectiveness or coercive interactions. In short, the experiences of losing a client to death by suicide can precipitate the risk of the clinician adopting a more directive approach or a protective stance (Gurrister & Kane, 1978).

Working with suicidal clients can trigger intense feelings of anxiety and anger for the clinician (Dressler, Prusoff, Mark, & Shapiro, 1975), impacting on the development of a quality therapeutic alliance. The client’s ability to die by suicide invariably introduces struggles of control, power and vulnerability into the therapeutic dyad (Jobes & Ballard, 2011). The clinician can experience immense pressure to prevent the client from completing suicide, which runs the risk of creating an adversarial rather than collaborative relationship (Jobes & Ballard, 2011). The fear of making mistakes or being blamed can result in defensive clinical practice, such as admitting a person to inpatient care, becoming coercive or controlling in the therapeutic relationship, limiting the exploration of the client’s phenomenology of suicidality or taking limited clinical risks that may benefit the client (Jobes, 2016). In this way, the possibility for working collaboratively is diminished significantly as the client’s stance in the dyad is pushed out of focus in order to manage the clinician’s anxieties.

Pervasive fears that a client will die by suicide while under clinician care is strongly noted across the literature (Jobes, Rudd, Overholser, & Joiner Jr, 2008; Rudd, Joiner Jr, Jobes, & King, 1999; Simon, 2002). In an early paper, Henn (1978) observed that it is often presumed that the death of a client by suicide implies the mental health professionals involved “made a mistake” in some way. Indeed, there are societal and legal expectations that the clinician, as the instrument of care, must prevent the client from completing suicide by all means necessary (Jobes & Ballard, 2011). In the US, fears of malpractice litigation are widespread (Jobes et al., 2008) and here in Ireland, there is growing concerns regarding legal implications following the death of a client by suicide (Gaffney et al., 2009). In Ireland, formal investigations following the death of client are a source of anxiety for clinicians regarding fear of blame, or being second guessed as a competent clinician (Gaffney et al., 2009; Jobes et al., 2018b). There is typically an organisational investigation following the death of a client by suicide in which all clinical notes, reports, and correspondences are reviewed and the professionals involved are interviewed in order to assess whether there were gaps in
the care provided. Whilst the investigations are clearly necessary, this can inadvertently result in a risk-aversive approach to managing suicidal risk (Galavan & Repper, 2017). Such fears can dominate and compromise the collaborative alliance, and induce defensive, risk adverse practices for clinicians (Jobes, 2016).

The clinician’s sense of responsibility was also prominent in the literature as a factor that can impact on therapeutic alliance. Jobes et al. (2000) argue that aspects of blame and interpersonal responsibility are imbedded in every suicide. The degree to which the clinician feels responsible for the client impacts on the therapeutic alliance, the efficacy of the intervention, and personal impact on the clinician (Whitfield, 2011). Orbach (2001) theorised that the sense of responsibility for another person’s life is the defining factor that distinguishes clinical work with clients expressing suicidality from other therapeutic work. Orbach argued that this placed huge demands on the clinician’s ability to be containing, whilst holding an individual’s wish to die, and not become “overwhelmed and incapacitated by anxiety” (p.166). Ellis (2004) also considered the sense of responsibility clinicians held in relation to the clinical work being successful with suicidal clients, proposing that the clinician’s anxiety results in a fundamental need to assert control over the client’s actions which inevitably results in resistance and damage to any possibility of a collaborative working alliance.

As outlined above, the challenges for clinicians in establishing a strong therapeutic alliance with clients expressing suicidal intent are manifold in the literature. In order to work effectively with suicidality, it is clear that such challenges must be met and overcome. Michel et al. (2002) suggests that some clinical approaches inadvertently exasperate the resistance experienced by clients by failing to recognise these concerns. One approach that seeks to address these fundamental challenges is the Collaborative Assessment and Management of Suicidality (CAMS) (Jobes, 2016)

2.5 Research Objective
The literature as a whole arguably focuses on the demanding emotive experiences felt by clinicians when working with suicidal clients. These are rooted in several causes: namely, the clinician’s perceptions regarding suicide; the immense sense of responsibility for another person’s life; the fear of making a mistake or legal proceeding instigated against them; countertransference; and personal and/or professional distress. The key concept which emerges is one of a continuous challenge
to establish effective collaboration within the therapeutic alliance. The complexities of collaboration is a predominant element of the literature that warrants more detailed exploration. Achieving this requires the clinician to demonstrate an increased ability to endure or counter client ambivalence, enhanced reflectiveness on behalf of the clinician, and the ability to attune to the client by non-judgementally accepting the client’s ‘suicidal wish’. While the challenges to collaborative work with suicidal clients have been well documented in the research, a number of significant areas of enquiry remain in terms of how clinicians experience the collaboration process.

2.6 Research Question
The present study proposes to address the dearth of literature on clinician experiences of using the CAMS. As discussed, the existing literature is focused on understanding suicidality, elucidating the experience from client’s perspectives, and the clinician’s experience post-client suicide. There is a therefore a need to deconstruct and explore the collaboration process in greater detail. The present study aims to shed further light on the various aspects of the CAMS collaboration process as outlined above. To this end, the broad research question developed as a means of remaining open to all aspects of the CAMS clinician experience is as follows:

“What are CAMS clinicians’ experiences of collaboration?”

Chapter Three: Methodology

3.1 Chapter Introduction
This chapter offers a comprehensive account of the research methods utilised in this study and the underpinning rationale for decisions made in the process. The following sections outline participant information, the procedure of this study, data management and ethical considerations. A step-by-step guide to the qualitative analysis undertaken in this study is also provided.

3.2 Rationale for Qualitative Approach
Qualitative methodology was chosen as an appropriate means of investigation for this study as the focus of the research question was on gaining insights into experiences, namely the lived experiences of CAMS clinicians working with clients who are suicidal. Following an in-depth review of the literature, a significant dearth in qualitative research in suicidality generally was identified (Hjelmeland & Knizek,
2010), particularly in terms of literature examining clinician experiences. This also influenced the decision to use a qualitative approach. Previous literature on CAMS has primarily utilised quantitative methodology to demonstrate conceptual clarity of its efficacy (Jobes, 2012; Jobes, 2016). Using a qualitative approach for exploring clinician experiences of this framework may support the development of rich or ‘thick’ data (Geertz, 1973, cited in Grix (2010) that can provide further insights into clinicians’ in-depth, holistic experiences of CAMS. Such subjective lived experiences related to the CAMS process may be difficult to access using quantitative approaches.

Qualitative research approaches are based on the assumption that an objective reality or universal truth does not exist (Lyons, 2007), but instead that reality is constructed by every individual (Howitt, 2011). From an epistemological standpoint, qualitative research is concerned with exploring and capturing the elements that provide meaning for an individual; that is, how a person makes sense of their world, their lived experiences or the meaning they attribute to a phenomenon (Willig, 2013). Qualitative research therefore centres on the quality of experiences rather than on causal relationships (Grix, 2010). In addition, qualitative approaches provide the mechanism for encapsulating the richness of phenomena of the study whilst also illustrating the individual’s particular perspectives in the shared study findings (Flick, 2014).

Taking a different epistemological perspective, quantitative research largely centres on falsification theory; that is, hypothesis-testing of a theory with the aim of eliminating unfounded claims and seeking to move closer to the truth (Pietkiewicz & Smith, 2014). Whilst quantitative research is valuable for addressing some research questions, its focus on incidence rates, volumes or the magnitudes of correlations between factors requires the contraction of experiences to numerical values in order to perform statistical analysis (Pietkiewicz & Smith, 2014). In contrast, qualitative approaches aim to collect data of subjective human experiences in real-life settings and to scientifically explore the insights elicited.

3.3 Interpretative Phenomenological Analysis (IPA)
IPA is a qualitative research approach in psychology that is committed to exploring how people generate meaning about a phenomenon they have experienced (Smith et al., 2009) through a process of detailed reflective analysis (Peat, Rodriguez, & Smith, 2019). IPA is informed by concepts and considerations from philosophy that are
rooted in three principals: phenomenology, hermeneutics and idiography. This provides a useful framework for researchers’ understandings of how individuals make sense of their personal and social worlds (Smith et al., 2009).

3.3.1 Phenomenology
Phenomenology aims to understand the complexity of lived experience as a process, including the developing perspectives and meanings that are individual to a person’s embodied and situated relationship to the world (Smith et al., 2009). IPA is phenomenological in that it is concerned with philosopher Edmund Husserl’s idea of returning “to the things themselves” (Smith et al., 2009, p. 1). Progressing Husserl’s work beyond descriptive and transcendental concerns, prominent figures in phenomenological philosophy Heidegger, Merleau-Ponty and Sartre each enhanced the view of the person as embedded in a lived world. Drawing on the work of these philosophers, IPA is concerned with the subjective exploration of experience as well as the perception of experience (Smith et al., 2009), especially processes of perception, thought, memory, emotion, bodily awareness and action (Smith, 2013). Utilising an IPA approach facilitates the expression of another’s interpretation of their experience in the world, meaning that to analyse this, the researcher must immerse themselves in the participant’s account via an in-depth process of interpretation (Pietkiewicz & Smith, 2014).

3.3.2 Hermeneutics
Informing IPA, Heidegger’s hermeneutic phenomenology refers to the theory of interpretation whereby the researcher holds an active role in exploring how a phenomenon appears as well as the participants’ meaning making around their experiences (Smith et al., 2009). Please see Image 1 from Peat et al. (2019, p. 9) for a visual representation of hermeneutic cycle. IPA is interpretative process between the researcher and the participant. Insight to the lived experience of the participant is dependent on, and made complex by, the researcher’s own background, belief system and conceptions about their world (Smith & Osborn, 2008). Therefore, a two-stage interpretation process or double hermeneutic occurs, since firstly the participant applies meaning to their experiences in the world and secondly, the researcher attempts to make sense of the participant’s meaning making (Smith & Osborn, 2008). IPA requires the researcher to engage in this dynamic and iterative process, whilst
maintaining awareness of their own subjective and experiential interactions with the research activity and minimising the impact of these (Smith et al., 2009).

![Figure 1: The hermeneutic circle congruent with Interpretative Phenomenological Analysis (IPA).](image)

**Figure 3.1: From Peat et al. (2019, p. 9)**

3.3.3 Idiography

IPA’s idiographic commitment refers to the focus on ‘the particular’, the single case (Smith et al., 2009, p. 29). IPA aims to achieve a sense of detail or depth in the analysis of each single-case perspective of the participant before making collective statements (Pletkiewicz & Smith, 2014). This requires the researcher to conduct a detailed and close analysis of the experience of one participant in isolation, before commencing the analysis of the next participant (Smith, 2004). Finally, comparisons of findings from each participant reveal common themes. Exploring the experiential phenomenon in this way protects the context in which the participant experienced it.

3.3.4 Rationale for Using IPA

Whilst a number of different qualitative methods were considered for this study, Interpretative Phenomenological Analysis (IPA), grounded in the philosophical and theoretical basis of Smith et al. (2009), was chosen as the research approach for a
number of reasons. To begin with, a key component of the research question was explicitly the experience *in itself* of the clinicians and the interpretations they draw from their experiences utilising the CAMS framework with clients who were suicidal (Smith et al., 2009). The essence of the study was to ‘give voice’ to the participant’s concerns and ‘make sense’ or contextualise the individual’s experiences and interpretations (Larkin, Watts, & Clifton, 2006, p. 106).

Qualitative methods such as grounded theory, thematic analysis and narrative analysis are possible approaches, but their focus is more appropriate for different research questions. For example, while a grounded theory approach could offer insight and develop a theory that explains the basic social processes of the CAMS experience, this was not the aim of the research question for this study. This study was interested in exploring the lived experience of clinicians using the CAMS framework rather than generating a theory which might explain how those experiences had developed. As this study was aiming to understand, as far as possible, what it was like to stand in the shoes of psychologists who use the CAMS approach with people who are suicidal, as well as to capture meaning through an interpretative process, IPA was considered the appropriate approach.

### 3.4 Semi-Structured Interviews

This study utilised an IPA research approach, which is primarily concerned with obtaining rich, detailed and first-person descriptions of experiences (Pietkiewicz & Smith, 2014). Semi-structured, in-depth, one-to-one interviews are the most commonly practiced method of achieving such participant descriptions (Smith et al., 2009), although alternative data collection approaches can also be employed, such as focus groups, letters or chat dialogues (Pietkiewicz & Smith, 2014), diaries (Boserman, 2009) and email (Murray & Rhodes, 2005). The use of semi-structured interviews was considered the most appropriate for this study. The interactive nature and idiographic format of semi-structured interviews means they are easily contained and that they allow for a rapport to be established while offering space for the participant to reflect, talk and be heard (Smith et al., 2009). These interviews also allow for unique or unexpected concerns to surface, which the IPA researcher can explore in more detail with additional prompts.
3.5 Sampling

3.5.1 Method of Sampling
This study utilised a purposive homogenous approach for recruiting participants. This meant a conscious choice of participants to establish a defined sample for whom the research phenomenon is relevant and holds individual significance (Pietkiewicz & Smith, 2014). Criteria for eligibility were that participants must be psychologists who had completed the CAMS training and had applied this approach to working with clients expressing suicidality.

3.5.2 Sample Size
In total, 10 psychologists expressed interest in participating and were interviewed for this study. In keeping with IPA’s idiographic focus, Smith and colleagues (2009) outline the value of having a smaller sample size to fully capture individual accounts, taking into consideration the complexity and richness of the participant’s descriptions, the commitment to case-by-case analysis and pragmatic constraints of the researcher. Indeed, they caution against the challenges of meeting IPA conditions with a sample that is ‘too large’ for professional doctorate research. Smith and colleagues (2009, p. 51) suggest four to 10 interviews as sufficient. For clinical psychology doctoral programmes in the UK, (Turpin et al., 1997) submit that six to eight participants is appropriate for IPA research.

3.6 Participants

3.6.1 Recruitment
Participants were recruited from the Health Service Executive (HSE) East area of the Republic of Ireland. All participants currently or had previously worked in a Suicide Assessment and Treatment Service (SATS) where the CAMS approach is utilised. The study information sheet (see Appendix 1) was circulated by e-mail (see Appendix 2) to a pool of psychologists who had completed the CAMS training and who currently or had previously worked in the specialised suicide service using the CAMS approach. In total, 10 psychologists expressed interest in participating in the study. All met the inclusion criteria for the research study and were invited to participate in an interview. Participants were recruited to the study between August 2018 and December 2018.

3.6.2 Sample Characteristics
All the participants in this study were clinical psychologists who had at least five months of experience of working in the suicidal specific service. Participants were
eight females and two males. During the interviews, participants indicated they had been working with clients who presented as suicidal (with various populations) for time spans varying from two to 12 years (M=6). Participants also estimated the amount of clients they had worked with who had been suicidal. This ranged from five to 40 clients per participant (M=25.78). Further descriptive information of the participants is provided on the next page. When considering homogeneity, the range of experience is not ideal. However, a pragmatic approach was taken owing to time constraints with regard to participant recruitment.

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Clinical Psychologist Grade when working in the SAT service</th>
<th>Length of time estimated working with clients who are suicidal</th>
<th>Approximated number of clients worked with clients who presented as suicidal</th>
<th>Experience of client suicidality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aiden</td>
<td>Senior</td>
<td>10-12 years</td>
<td>24-36 clients</td>
<td>Completed suicide</td>
</tr>
<tr>
<td>Bronagh</td>
<td>Staff grade</td>
<td>6-7 years</td>
<td>30-40 clients</td>
<td>Completed suicide</td>
</tr>
<tr>
<td>Ciara</td>
<td>Staff grade</td>
<td>4 years</td>
<td>10-15 clients</td>
<td>Attempted suicide</td>
</tr>
<tr>
<td>Deirdre</td>
<td>Senior</td>
<td>7 years</td>
<td>50 clients</td>
<td>Attempted suicide</td>
</tr>
<tr>
<td>Eimear</td>
<td>Staff grade</td>
<td>10 years</td>
<td>11 clients</td>
<td>Attempted suicide</td>
</tr>
<tr>
<td>Fiona</td>
<td>Trainee</td>
<td>2 years</td>
<td>20-30 clients</td>
<td>Suicidal ideation</td>
</tr>
<tr>
<td>Grainne</td>
<td>Staff grade</td>
<td>2-3 years</td>
<td>5 clients</td>
<td>Completed suicide</td>
</tr>
<tr>
<td>Hannah</td>
<td>Staff grade</td>
<td>4 years</td>
<td>20-30 clients</td>
<td>Attempted suicide</td>
</tr>
<tr>
<td>Isabella</td>
<td>Staff grade</td>
<td>5 years</td>
<td>15 clients</td>
<td>Attempted suicide</td>
</tr>
<tr>
<td>John</td>
<td>Senior</td>
<td>8 years</td>
<td>Unable to estimate</td>
<td>Attempted suicide</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>---------</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>

**Table 3.1: Participant descriptive information**

### 3.6.3 Additional Information about Suicide Assessment and Treatment Service (SATS)

The specialised suicide service is largely run by clinical psychologists as well as a limited number of other MDT professionals, all of whom are connected to community mental health teams across the catchment area. Each psychologist commits approximately two hourly slots weekly, using the CAMS approach, to working one to one with clients expressing suicidality.

### 3.7 Procedure

#### 3.7.1 Data Collection

Prospective participants who received the information sheet by email were encouraged to contact the lead researcher by email to organise a suitable time and date to conduct the interview. During this email exchange, participants were provided with a copy of the consent form (see Appendix 3) to read through prior to the interview.

Nine interviews were conducted in the work places of the respective clinicians as this was indicated as being the most convenient for them. These included five community-based adult mental health services and three primary care centres. One interview was conducted in a quiet room in an offsite educational facility at the request of a participant who experienced high demand for space in their workplace.

Interviews followed a broad structure of developing rapport with the participant, answering any questions they had about the study, clarifying how confidentiality and anonymity would be maintained, clarifying the purpose of the consent form, advising the participants to read and sign two copies of the consent form (one for the researcher and one for the participant) and explaining how the interview would be structured. Participants were reminded that they were not under any obligation to participate and were free to withdraw from the study at any point. At this time, permission was requested to begin audio-recording the interview. Interviews were recoded using an Olympus Digital Voice Recorder VN-731PC. In addition, a backup recording was made using the ‘Voice Memo’ app on the Apple iPhone 5S.
On conclusion of the interview, participants were offered the opportunity to review their transcript in the following weeks. This was proposed in order to conserve research ethics, and to empower the participants by offering them control of what was included in the study (Mero-Jaffe, 2011). Only one participant indicated interest in reviewing the transcript. This was subsequently transferred by password-protected Microsoft Word document in email to the participant, who did not provide feedback on the transcript.

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Interview Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aiden</td>
<td>59 minutes 50 seconds</td>
</tr>
<tr>
<td>Bronagh</td>
<td>62 minutes 23 seconds</td>
</tr>
<tr>
<td>Ciara</td>
<td>65 minutes 43 seconds</td>
</tr>
<tr>
<td>Deirdre</td>
<td>49 minutes 42 seconds</td>
</tr>
<tr>
<td>Eimear</td>
<td>72 minutes 10 seconds</td>
</tr>
<tr>
<td>Fiona</td>
<td>61 minutes 27 seconds</td>
</tr>
<tr>
<td>Grainne</td>
<td>59 minutes 16 seconds</td>
</tr>
<tr>
<td>Hannah</td>
<td>35 minutes 31 seconds</td>
</tr>
<tr>
<td>Isabella</td>
<td>51 minutes 22 seconds</td>
</tr>
<tr>
<td>John</td>
<td>77 minutes 52 seconds</td>
</tr>
</tbody>
</table>

Table 3.2: Duration of interviews

Interview recordings were uploaded to the lead researcher’s encrypted laptop immediately following the interview and deleted from the two devices. Using Groove Music player software, interviews were transcribed verbatim by the researcher into a Microsoft Word Document. A list of the recording times is included on Table 3.2. Interview times ranged from 35 minutes 31 seconds to 77 minutes 52 seconds (M=59.53 minutes; SD=11.95).

Reflective field notes were kept by the researcher after each interview and throughout the data collection process (See Appendix 7 for extracts). These focused on subjective thoughts and emotive responses to content and interview experiences, such as first impressions, reflections and initial interpretations of the participant’s account. These were referred to during analysis and supported the analysis process.
3.7.2 Interview Schedule

Since this study comprised of a series of semi-structured interviews with clinicians using the CAMS framework with clients who are suicidal, an interview schedule (Appendix 4) was designed by the researcher prior to data collection. The process of developing the schedule was a dynamic, iterative one that involved exploration of previous literature, reflection on the broader research question of clinicians’ experiences of using the CAMS framework and utilisation of research supervision. The questions were developed in line with the principles outlined in Smith et al. (2009). A pilot interview with a trainee clinical psychologist was conducted prior to participant interviews. This facilitated tuning of the interview schedule with respect to the order of the items, conversational flow and pacing. The researcher utilised an exploratory, conversational tone throughout the interviews, where the schedule was not followed rigidly, but rather used to guide the participant’s reflective process. This allowed the researcher to follow the participant’s exploration of topics and to ask probing questions to garner richer information about the participant’s experience.

3.8 Data Analysis

Each interview recording was transcribed by the researcher into a Microsoft Word document. Transcript text was then copied into the table format described by Smith and colleagues (2009). The table featured three columns: a wide right margin for descriptive, linguistic and conceptual comments, a finer margin to the right for emergent themes and a centre column that held the transcribed interview. This was then printed and the analysis process was conducted by hand. Commenting included descriptive (red pen), linguistic (green pen) and conceptual notes (blue pen), as outlined by Gee (2011). An example of this configuration and analysis format can be seen in Appendix 5.

The IPA analytic process is defined by a dynamic, iterative and inductive cycle that moves between the particular and the shared in addition to the individual and the whole (Smith et al., 2009). Analysis occurred over an extended period of time. Significant efforts were made to become familiar with the data; interview recordings were listened to multiple times in order to become familiar with the participant’s idiom and ‘voice’. In addition, interview transcripts were read and re-read, and the process was reflected upon. The analytic steps outlined in Smith et al. (2009) were followed. This is charted below in Figure 3.2.
Figure 3.2: IPA Analytic Process – Adapted from Smith et al. (2009)
3.9 Research Trustworthiness and Credibility Considerations
Establishing integrity of results is an essential component of any research. Consistent with Smith and colleagues (2009), Lucy Yardley’s (2000) four broad principles for validity in qualitative research were applied in this study. These are ‘sensitivity to context’, ‘commitment and rigour’, ‘transparency and coherence’ and ‘impact and importance’ (Yardley, 2000).

3.9.1 Sensitivity to Context
The researcher demonstrated sensitivity to context during all stages of the research process. This was achieved by engaging with relevant literature, becoming familiar with the central tenants of the IPA approach and recognising that the phenomenological foundations and idiographic nature of IPA offered a useful mechanism for gaining insight into clinicians’ experience of the CAMS framework. Data collection was conducted via semi-structured interviews which built on the researcher’s clinical skills of putting others at ease and providing space for those others to expand and explore concerns. During analysis, efforts were made by the researcher to ensure immersive, in-depth, idiographic analysis of each participant’s account. In the write-up, interpretative arguments were contextualised by numerous verbatim extracts, preserving the participant’s voice in the study.

3.9.2 Commitment and Rigour
As outlined throughout this chapter, the researcher adhered to the guidance offered in Smith and colleagues’ (2009) influential text with regard to designing this IPA study, collecting and analysing data, and writing up. In addition, the researcher attended a number of events hosted by IPA Ireland during all stages of the research process. The researcher’s commitment to the research was also shown during the semi-structured interviews, where a conversational and encouraging approach to questioning was adopted in order to remain responsive to each participant’s emerging account. Rigor was observed by the researcher allowing sufficient time to genuinely become immersed in the data and so ensure completeness of analysis. A reasonably homogeneous sample was recruited.

3.9.3 Transparency and Coherence
This is largely demonstrated through detailed descriptions of each stage of the research process provided, in addition to the extracts of analysis provided in the appendices. Engagement with an independent audit trail, as proposed by Smith et al. (2009),
provided a transparent mechanism for the researcher to reflect on how valid were the analytic claims drawn from the source data. A critical peer reviewed the audit trail for a sample of interviews to ensure validity. In addition, the main thesis supervisor reviewed samples of initial noting and development of emergent themes for an interview. Engagement with the reflexive process augmented the transparency of this study’s findings in terms of bracketing preconceptions and documenting personal responses. The study has remained consistent with the underlying principles of the IPA approach.

3.9.4 Impact and Importance
The researcher believes this study provides comprehensive insight into clinicians’ experiences of using the CAMS approach with clients who present with suicidality. Given the dearth of existing research in this area, it is hoped that the findings of this study will contribute to the knowledge and offer useful information for clinical practice. Given the rates of suicidality presenting to services in Ireland and the current novelty of the CAMS approach, it is hoped that this research can provide a starting point for creating awareness of the experiences, from the perspective of the clinician, in engaging with the CAMS framework.

3.10 Reflexivity
Reflexivity is a fundamental component of IPA research which runs throughout the entire research process. Researchers are individuals with social positions and personal experiences as well as political and professional beliefs (Berger, 2015). IPA is focused on exploring the participant’s experience, meaning-making, perceptions and views. Paired with the participant’s exploration of their experience is the researcher’s reflective process of interpretation in the research process. Smith and colleagues (2009) term this the double hermeneutic, in which the researcher aims to understand the participant’s interpretation by empathising with their interpretation and also asking questions of it (Vicary, Young, & Hicks, 2016). Reflexivity can therefore be seen as a mechanism for strengthening the rigor of the study by observing the tension between attachment and detachment of the researcher and the participant (Berger, 2015).

3.10.1 Researcher’s Positioning
The researcher is a white, Irish, middle-class female, aged 31 years. She is a psychologist in clinical training who has prior experience of working with people who
have contemplated and/or attempted suicide. Whilst familiarity with the complexity of working with people who are suicidal was considered beneficial for enhancing the researcher’s understanding of the participants’ interpretations’ of their lived experiences, the researcher was particularly mindful of continuously checking that these experiences did not project into the study, meaning a more objective lens was used to engage and make sense of participants’ experiences. This was achieved by engaging in reflection on the differences and commonalities between the researcher and the participants’ experiences, as suggested by (Lietz, Langer, & Furman, 2006).

It was considered that pre-existing norms in relation to mentoring may impact on the dyad between a qualified clinical psychologist and a psychologist in clinical training during interviews. The researcher was mindful of her own thoughts, emotions and triggers before and after interviews in relation to approaching questions and content as well as engaging with the participant. In addition, the researcher remained naïve to the CAMS framework in practice.

The researcher’s own interest in the topic had been stimulated by an experience of peer supervision with clinical psychologists during her adult mental health placement, in which a recent experience of a client’s death by suicide was shared. The researcher was struck by the complexity of the personal and professional impact of this as well as the enormous resilience of the clinicians, since suicidality presented so frequently on their caseload. This initial interest was further reinforced following an introduction to a senior CAMS-care consultant who provided a causal summary of the CAMS approach to suicidality. This approach resonated with the researcher’s own valuing of collaborative clinical work, such as the use of collaborative formulation. The researcher’s interest was also propelled by an increasing national media coverage of suicidality rates in Ireland as well as questions regarding the failures of the Irish Mental Health system’s approaches to suicidality. The conflating of these influences developed the researcher’s interest in conducting research with clinicians in order to disseminate findings in relation to their experiences. In order to ensure that this IPA study diminished the possible effects of these interests, research trustworthiness and credibility processes were considered crucial to ensure the study was valid.
3.11 Ethical Considerations

Ethical approval for this study was obtained from the local Hospital Research Ethics Board (see Appendix 6). The following sections outline the ethical considerations that were relevant to the study.

3.11.1 Initial Contact

A research collaboration was established with the service’s Clinical Lead. This person is also a consultant with the CAMS-Care company, providing formal training in the use of the CAMS approach, in which many of the potential participants were likely to have engaged. When ethical approval was confirmed, email addresses of potential participants were given to the researcher. Contact details were drawn from a list of clinicians in the service who had agreed to be contacted for research purposes following the CAMS training.

Initial contact was made by the researcher in order to counter any implicit pressure that may be perceived by potential participants when receiving recruitment information from the Clinical Lead of the service. A recruitment email with an information sheet attached was circulated detailing the purpose of the study and what participation would entail, should they wish to partake in the study. At each point of contact, participants were reminded they are not under any obligation to participate in the study and were reminded of their right to withdraw at any point. Additionally, participants were reminded that their identities and responses would be anonymised.

3.11.2 Vulnerability of Participants as Staff/Employees

The Clinical Lead committed to refrain from discussing this research study with potential participants. During the verbal debrief, participants were made aware that alternative clinical supervisors were available to them should they subsequently wish to discuss a clinical case that arose over the course of the interview while remaining anonymous in their participation.

The scheduling of interviews at the service centre remained between the researcher and the participant; however, it was acknowledged that the service centre was a shared environment. As such, efforts were made to offer appointments off-site where possible (such as at the current place of employment for clinicians and at local third-level educational facilities).
It was explained to participants that transcripts would anonymised to safeguard their confidentiality as well as that of their clients, colleagues, workplace and supervisors. It was made clear that interview recordings and full transcripts would be held by the lead researcher only and would not be available to other researchers of the study, except the sharing of some transcripts with Dr Sharon Houghton (academic supervisor) to help with inter-rater reliability.

3.11.3 Data Storage and Management

Following each interview, digital files of the recordings were uploaded to the lead researcher’s encrypted laptop and deleted from the devices. Following analysis, the audio digital files were deleted from the laptop. Identifying information about participants, others or services was removed from the transcripts, using ID codes where appropriate. Transcripts were reviewed solely by the researcher with the exception of sharing of selected transcripts within the academic supervisory dyad.

Data linking the ID code to participant remains stored in a password-protected file. Study findings were reported anonymously so that participants and clients are not identifiable. Verbatim quotes are included in reporting; any personally identifiable information has been removed from these quotes to ensure anonymity. Transcripts will be stored by the academic supervisor on an encrypted memory stick in a locked filing cabinet at the University of Limerick for a period not exceeding seven years, in accordance with UL data management policy.

3.11.4 Potential Distress

The interviews for this study entailed discussion of therapy work with clients who have expressed suicidal intent, or who have possibly attempted or even completed suicide. This is an emotive topic, and it was understood that it may have been difficult for participants to narrate some of their experiences. Participants all had experience of working in a specific suicide assessment and intervention service, and supervision processes were in place as a professional requirement. Even so, participants were made aware of the sensitive nature of the interview in advance. On conclusion of the interview, participants were provided with a verbal debrief in which the sensitive nature of the discussion was named and participants were encouraged to seek support if they felt it might be beneficial.
The researcher was aware from the outset that spending a considerable amount of time immersed in the topic of suicide would potentially be a difficult process. As such, she engaged in regular personal therapy sessions throughout the research process.

**Reflective Box: The Research Process**

In general, I felt the research process was quite smooth in terms of timely and sufficient participant engagement. Whilst I was familiar with the theoretical underpinnings and quantitative research literature pertaining to CAMS, I had yet to complete the CAMS training or see it in clinical practice. So for me, the interviews genuinely sparked interest in hearing clinicians’ experiences of CAMS. I found the interviews fascinating and enjoyable, especially appreciating the variety of individual experiences and new insights expressed by each participant. The semi-structured nature of the interviews felt like a good fit in terms of drawing on familiar therapy skills. I liked having the flexibility to explore novel views in a comfortable way; this helped me remain curious and open to the topics participants expressed. This reassured me that the concerns of the participant and the experiences they considered important were being represented in the data. It also reassured me that appropriate depth was obtained from the interviews.

There were struggles of course. I found analysis quite challenging at first, which is likely due to a lack of previous experience with qualitative methodology. I found I was awkward about identifying themes and uncomfortable about applying my layer of interpretation. Initially I was over-cautious in interpretation and sought reassurance frequently from ‘the book’ (Smith, Flowers, & Larkin, 2009). This resulted in an incredibly time-consuming analysis stage. However, once I found my stride with the analysis, I found the process much more rewarding. Having grasped an intimate knowledge of the data, I felt immensely responsible for representing the participants’ voices in the findings of the study in a manner that was authentic, grounded and valuable.

**3.12 Conclusion**

This chapter detailed the rationale for research approach and design. It has outlined the research procedure and analytical process of this study. In addition, it discussed ethical considerations, research trustworthiness and credibility considerations and the role of researcher reflexivity.
Chapter Four: Findings

4.1 Chapter Introduction
Following months of immersion in the data, which entailed transcribing, listening to audio recording, reading, re-reading, analysing and collating, a number of key themes emerged from the data. This chapter will present the findings of the study and provide an interpretation of the lived experience of using the CAMS framework from a number of different perspectives. As such, the chapter presents the superordinate and subordinate themes which emerged from the 10 interviews, a summary of the related findings and an interpretation of the data for each theme. These themes will be conceptualised as overlapping experiences and the superordinate themes will be schematically represented as shown in Figure 4.2.

Quotations from the participant’s narratives will be provided throughout to allow the reader to ‘hear’ the voice of the participant, while analytical comments aim to provide an account of the researcher’s interpretation of each theme. Direct quotes will be italicised and Figure 4.1 outlines the notation used in the quotation extracts. The chapter also contains reflective memo boxes at various points throughout the chapter to provide the reader with insight into aspects of the researcher’s reflective process.

... a marked pause in the narration

[...] non-relevant material omitted

Figure 4.1: Transcript notation used in the extracts

4.2 Overview of Superordinate Themes
The superordinate themes which emerged from the participant’s narratives are schematically presented in Figure 4.2. ‘Finding Safety’ relates to participants’ experiences of seeking security in the structure of the CAMS framework and/or relationally with peers and colleagues, while ‘Regulation of the self’ focuses on clinician’s experiences of complex emotions in the therapeutic work and also of developing reflective awareness of their internal process. ‘Connecting’ concerns the development and importance of the therapeutic alliance and the experience of a genuine bond. Finally, ‘Systemic Challenges’ elicits participants’ perspectives of overcoming the challenges of using the CAMS framework within the therapeutic
relationship. In addition, the impact of the team and organisational challenges of working with a suicidal person are also explored.

Figure 4.2: Schematic Representation of Research Findings
Table 4.1 presents superordinate themes and associated subordinate themes which emerged from the participant narratives:

<table>
<thead>
<tr>
<th>Superordinate Theme</th>
<th>Subordinate Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding Safety</td>
<td>“I’m doing my best” (Following the CAMS)</td>
</tr>
<tr>
<td></td>
<td>Feeling supported</td>
</tr>
<tr>
<td>Regulation of the Self</td>
<td>“Checking into yourself” (Attuning to the Self)</td>
</tr>
<tr>
<td></td>
<td>“It’s worrying, It’s scary” (Difficult Emotions)</td>
</tr>
<tr>
<td>Connecting</td>
<td>“Into the Person’s World”</td>
</tr>
<tr>
<td></td>
<td>Establishing a Shared Way of Working</td>
</tr>
<tr>
<td>Systemic Challenges</td>
<td>Tension and Battles with the medical model</td>
</tr>
<tr>
<td></td>
<td>Finding My Voice</td>
</tr>
<tr>
<td></td>
<td>Challenges of the CAMS</td>
</tr>
</tbody>
</table>

**Table 4.1 Summary of superordinate and subordinate themes**

4.3 Finding Safety
This theme embraces the participants’ description of seeking and finding their own bases of safety and the associated freedoms this affords in terms of working with clients who are suicidal. This theme encompasses two inter-related sub-themes which will be explored in turn.

4.3.1 “I’m doing my best” (Following the CAMS)
With the exception of John, who did not mention this as part of his experience, grounding personal anxiety in the structure and processes of the CAMS framework was a feature of almost all the participant narratives. For Isabella, her worries in
relation to completing all her responsibilities in the session are contained within the structure of the Suicide Status Form (SSF):

“You have it there in front of you. You’re doing it. So it takes the onus off you having to remember all the bits and pieces because it’s there in a form in front of you. And allows you to maybe connect more with the person because your fear is reduced - because you know you’ve got that covered. Those lists are covered in that form.”

(Isabella, p. 19)

It is evident that Isabella finds containment to her inner sense of chaos in the configuration and prioritization of the SSF, as “the form becomes the list” (Isabella, p. 19). Her use of the generic pronoun “you” could be serving as an insulator from the intensity of the fear associated with these past experiences. Earlier in the interview, Isabella had similarly revealed that she finds the organised process of the CAMS containing for anticipatory anxiety before sessions with clients, when wondering what will emerge in the session:

“Right: whatever happens in this session, I know at least half an hour or twenty minutes or five minutes will be this […] I’m doing what I should be doing in this. I’m doing my best.”

(Isabella, p. 8)

For Bronagh, containment stemmed from reassurance that as a clinician, she had drawn on a framework grounded in up-to-date evidence base:

“…you feel like you’re doing the best you can […] like I was doing a reasonable job based on this and am….and like that helps you with the anxiety because you’re kind of thinking like there’s nothing else I can do that I know about or that is reasonable within this.”

(Bronagh, p. 81)

For Bronagh, it may be her perception of the CAMS as “very thorough and everything exists within the frame of the CAMS” (Bronagh, p. 5) that allays her worries of being ‘enough’ and tolerating the inherent uncertainty encompassed in the work. Being able to rationalise her approach to herself and to others appeared to be supportive for Bronagh.
Eimear also derived a sense of safety from knowing “I did my best” (Eimear, p. 35) in trying to understand and create meaning the experience of the suicidality with her client:

“I will hold that, um, feeling of ‘have I done all I could do for the person?’ . . . I feel for myself it’s a little bit less. It’s probably still there, but it’s less because I feel safer with the CAMS model. I definitely do. And I can never say what’s going to happen two minutes after someone leaves me but, um, in that moment I have done all of this and I have tried to….and I suppose it’s even more than the risk bit; it’s the risk bit, but also I would be confident in talking to anyone around you, know, like I did my best in trying to understand and make sense of that for my client or with my client in terms of the CAMS.”

(Eimear, p. 33-35)

Her questioning of her experience with the person epitomises the worry and felt sense of responsibility to connect with and meet the needs of this person. Like Bronagh, Eimear speaks to the distressing uncertainty when the session is over and the ongoing worries for the person. Eimear’s sense of safety appears to be rooted in connecting with and being effective with her client, as opposed to just managing a risk.

Like the others, Hannah finds reassurances in using the CAMS as “we’re doing our best, we’re…it’s all we can do at the end of the day” (Hannah, p.24). Her narrative elucidates a sense of active competency in the work and focusing on the establishing a possible way forward for the person:

“What I like about CAMS that it keeps you grounded in ‘well, I’m doing what I can in using an evidenced-based treatment; I’m asking the questions; I’m getting an idea of their history; I’m getting an idea of what’s driving it. I’m looking at what you know - what reasons they have for staying alive...very much focusing on that rather than the ‘death piece’.”

(Hannah, p. 6)

For Hannah, there is a sense of confidence in this formulaic process that grounds her in holding hope for the person and navigating a way forward with the person. Hannah uses the striking repetition of “I’m” throughout this extract, giving a clear felt sense of focus and awareness of her personal role in the process. Hannah’s quotation here
ends with an interesting description of suicidality as ‘the death piece’, perhaps signifying her awareness of the finality of suicide. At the same time, ‘piece’ suggests an aspect or element of the presentation, and that Hannah might be holding the possibility of the suicidal act with some ambivalence. In completing the assessment, Ciara spoke about the experience of being confident to ask questions which evoked fear, being comprehensive in the assessment of suicidality, and finding safety in the thoroughness of the process:

“...but as well, that that you are, I suppose, looking at all the aspects of suicide; that you are asking the difficult questions - but being able to do so in a way that’s, am, bringing the person on board. It just it feels...I don’t know. It feels safer generally.”

(Ciara, p.10)

In the same way, Fiona found security in the comprehensive nature of the tool:

“It’s really thorough. Am, and like, I always think even if you do the CAMS badly, it’s still a really good risk assessment. Am, and yeah, and I think probably the thoroughness is the bit that, like, comforts me and the treatment plan that, am, you’re doing.”

(Fiona, p. 32)

Fiona reveals her felt sense of vulnerability in working with clients who are suicidal captured in her sense-making “even if you do the CAMS badly”. This is interpreted as fear she holds for herself and the use of the generic ‘you’ pronoun is employed to create distance with this unsettling experience of vulnerability. Like Fiona and Ciara, Aiden focused on the security which is gained from structured design of the assessment:

“It systematically walks you through making a rating so again rather than the arbitrary way that that we might make a rating, this kind of brings, um...brings you static risk factors, historical risk factors, current risk factors, current risk factors, current psychological risk factors, um, together in way that, um, helps you make a call on the risk...I do feel that by following the structure you have, am, a very tight way to have thought of relevant variables.”

(Aiden, p. 59)
Aiden’s experience of introduction to the CAMS model appears to have been a transformative learning experience and he highlights his experience of psychological models of suicidality being largely unknown in clinical practice:

“Not in any of the four degrees that I have done. Not in any of the many supervisors that I’ve had. Not in any article that I’d ever looked up for myself had I ever come across this. It sounds really ridiculous to me at this point...and it was a very vivid learning moment that I remember...you know they say, “the penny drops”? This was more like the bank vault dropped!”[laughs] I was in a training session about CAMS and about half an hour into it I went “Oh, my god! Oh yes! Why did I never think of this? Why have I never looked this up? I never knew to. I never knew to look up psychological models of suicide.”

(Aiden, p. 27)

There is evident relief and exhilaration in this extract from Aiden’s description of his learning experience. “Oh, my god! Oh, yes!” gives us an animated image of excitement. Aiden provides an incredibly vivid metaphor of “this was more like the bank vault dropped”. Here the penny is converted to a bank vault in order to convey the enormity of his experience. There is a clear sense of dawning realisation of the existence of psychological models of suicide. There is also palpable bewilderment that such models were not already known to him given his extensive professional experience and significant academic achievements.

Grainne afforded similar containment from understanding a model of suicidality that she could utilise to understand a client’s distress:

“What CAMS gave me was a model for formulating suicidality - and as its own separate thing, you know as ...am, that needs its own formulation. Am, and yeah, I just kind of de...not demystify, but kind of brought suicidality down into a very workable level.”

(Grainne, p. 31)

The extract captures the grounding Grainne experienced from having the CAMS framework to process the complexities of suicidality in a way that gave her the opportunity to utilise formulation skills to create understanding with her clients. Her use of academic language “formulating suicidality” is striking here in her discussion
of such an emotive topic; perhaps this is her typical language use, or it functions as a shield from difficult emotions.

Conversely, Deirdre’s experience of the CAMS differed from the other participants. While the others find relief in the structured process of the CAMS, Deirdre expressed concern that the CAMS framework serves to meet the clinician’s emotional and intellectual needs, at the expense of the clients:

“These kind of assessment based models, I think they certainly have their place in safety planning and so on, but I just wonder is it more for the clinician? To reduce their anxiety so they can actually tolerate working with this client group without being overwhelmed or flooded by their own anxiety, rather than being so much for the client.”

(Deirdre, p. 80)

She further ponders whether the structure stymies her own creativity or flexibility to connect on a deeper emotional and relational level with the client. With the use of “their”, Deirdre distances herself from the uncontained emotional distress the, presumably other, clinicians hold in working with people presenting with overwhelming pain leading them to consider suicidality. As we go through the various themes, it will become clearer that for Deirdre the CAMS “didn’t fit all that well with me” [Deirdre, p. 11]. However, Deirdre admitted that she found the conceptualisation of suicidality beneficial and something she would like to develop further through formulation:

“To me, I would…the understanding of the suicidality is really good. Am…but I would like to then to expand on that and just develop more of a sort of sense of what my formulation would be; what’s going on…you know, a more of kind of collaborative thought formulation of what is…what is the meaning of this.”

(Deirdre, p. 90)

To provide context, “the understanding of suicidality” that Deirdre refers to here is the overview of the theoretical models of suicide synthesised in the CAMS training and also in the CAMS manual. However, Deirdre goes on to confirm that she prefers to use this theoretical information to inform a collaborative and detailed formulation of
the client’s presentation; thus implying this is of more value to her than the CAMS assessment.

**Reflection Box**

I was particularly taken with the concept of CAMS providing reassurance and safety through dissemination of research in an accessible manner and the structured format of the framework. When initially planning this study, the concept of documentation as providing assurance for the clinician against possible litigation was a highlighted benefit of the framework. In interviews I was struck that this was raised once or twice but not significantly enough to form an accumulative theme. Instead, the resounding message was one of “I’m doing the best I can for my client” and I was personally struck by this conscientiousness of the participants in prioritising their clients in this, whilst at the same time, they described the deep-seated anxiety and responsibility that accompanies this work.

**4.3.2 Feeling supported**

With the exception of Isabella, feeling supported by peers and colleagues was a compelling theme for nearly all participants’ in terms of feeling grounded, contained, and in enhancing resilience for working with persons expressing suicidality. Aiden described the high value he places on the reflective space held in his psychology team:

“There is a great openness to talking about it. The system is quite reflective within the psychology team so I have somewhere that I can take any vulnerability that, am, that I might experience. Am, and I do, and, am, other people do. And, am, we learn from each other.”

(Aiden, p. 29)

Here Aiden places value on the opportunity to share vulnerabilities encountered in his work with his peers and to have that responded to reciprocally. It is likely this provides an experience of validation and competence for Aiden. He talks about “having somewhere” that gives a sense of security, responsiveness, and acceptance of his vulnerabilities. Meanwhile, Hannah conveys the support she feels from colleagues who invest interest and time in getting involved in the CAMS work:

“When you’ve the professionals who do believe that and wanting to work in the same way as you, it’s very uplifting and it kind of keeps the enthusiasm going.”

(Hannah, p. 15)
Here Hannah is clearly relishing the opportunity to share the experiences of working with people who are suicidal, which likely facilitates an experience of feeling understood and support being available. In addition to the professional motivation of feeling competent, Bronagh and Ciara referred to the support they have felt from the psychiatry team lead in their respective teams:

“...working on the mental health team, you have that ability to ring a psychiatrist and go ’I’m really worried about this person.’”

(Bronagh, p. 25)

“I think once, am, a psychiatrist knows that you’re working with CAMS generally, they’ll check in around that you know if any decisions are being made.”

(Ciara, p. 38)

From his experience of team support, John reported how the support he feels from his team impacts on his sense of safety and confidence:

“Where I feel that other team members are open and receptive to planning collaboratively together, am, both as a team and with the person, - am, that kind of reduces that sense of anxiety. It means that it is shared, ah, shared sense of responsibility and I can more easily park it at the end of the day.”

(John, p. 12)

The diffusion of perceived responsibility is clearly a powerful experience for John and he indicates a greater ability to maintain an appropriate work/life balance. John’s metaphor of “park it” is also revealing, as it suggests the experience of anxiety and responsibility is constant for him and leaving it aside temporarily at the end of the day is what his aim is. This speaks to the pervasiveness of his sense of responsibility and also the immense value of team support for John. Grainne similarly values the opportunity to engage in the CAMS framework in a team that typically adheres to a medical model conceptualisation of mental health difficulties:

“...but I think it was very much supported and encouraged that, you know, that if you’re working with somebody and then identify suicidal risk of any kind you switch to CAMS even if just for a few weeks.”
Fiona also described her hopes for this way of team working in the future:

“Ideally, if the team’s perspective on suicidality was, you know, ‘let’s listen to the person about it - am, which the CAMS does - that would be the helpful one. Yeah. And managed by everyone also.”

While this speaks to the valued sense of support she hopes to experience in a team sharing a unified conceptualisation of suicidality, it denotes the current absence of this experience for Fiona. Here, Fiona nods to the potential for all team members to share the responsibility of the work, which again likely points to a current dearth in this area. Deirdre spoke about to a past experience of a client working with a number of team members and the support she felt from that experience:

“...known to quite a number of members of the multidisciplinary team which was good as well, in that it wasn’t just one person, am, ah, carrying all of it...”

Like John, Deirdre described the security she experienced from a diffused sense of responsibility and the opportunity to share the experience with colleagues. “All of it” is indicative of the momentous weight of the responsibility felt by the clinicians. Equally “carrying” speaks to the fortitude and strength required to bear the burden of responsibility.

Eimear echoes the value of collaborative team working in her current service, which she finds helps to reduce the individual sense of responsibility:

“I think here we work very well as a team so I feel less isolated here...if anything is of...as we deem it, high risk in any way, ...you know, no one is left here on their own holding anyone....if you feel that you’re not enough, or you know. Or even just to be able to share or to air things a little bit, there is always someone around to join you with that case and we allow that for each discipline does that.”

(Eimear, p. 52)
Eimear’s acknowledgment of “feeling not enough” speaks to some level of team openness and acceptance that difficult personal emotions can be triggered by the work. This culture likely provides Eimear with a secure base in which to not only seek comfort when dealing with difficulties in client work but also to enhance her own confidence, competence, and resilience.

4.4 Regulation of the Self
This superordinate theme encompasses values held by all the participants within their narrative of being curious and attuned to their personal and emotional inner narratives when working with clients who are suicidal. This theme consists of the two interacting subthemes of “Checking into yourself” (Attuning to the Self) and “It’s worrying. It’s scary” (Difficult Emotions).

4.4.1 “Checking into yourself” (Attuning to the Self)
This subtheme captures all the participant’s experiences of thinking about and reflecting on their own internal processes. Aiden describes a greater focus on self-reflection in acclimatising to the CAMS framework in the context of shared team reflectiveness:

“In terms of my development of skill around CAMS and the collaborative piece which is, which is a slight shift in how I normally practice - not a huge shift but a slight shift - but it has been the reflective space that is held within our psychology team, am, and.....I suppose, the psychological safety to explore and to be curious and to be uncertain and to talk about my resistance.”

(Aiden, p. 67)

Here Aiden attributes his experience of engaging in reflective practice as a mechanism for enhancing the ability to engage collaboratively in the CAMS process. Of interest is that Aiden’s description of his reflective experience in the team appears to mirror the process facilitated in the CAMS. It is likely the felt experience of the process not only shapes skill in this area but also enhances his value of the experience. Moreover, he refers to having the space to explore the meaning of his experiences with responsive colleagues, which in parallel is what Aiden is providing for his clients. With his clients Aiden speaks about “It’s very much the slowing down, giving space, giving time, empathizing” (Aiden, p. 7).
Ciara also narrates an awareness of caseload influences on her ability to engage in client work:

“I’m mindful of the rest of my caseload and, am, waiting lists and all of that [...] I suppose also aware of my own personal pulls and that - so when I start the work with somebody and, am, build that relationship. It’s really hard for me to, I suppose, am, then, sort of say, ‘this is all I can do; you’ll have to go back to the waiting list.’”

(Ciara, p. 28)

Here Ciara reflects on the personal impact when she has completed a discrete CAMS assessment and intervention. While the suicidality has resolved for the client, work on a number of therapeutic goals remain, which, owing to caseload demands, is interrupted for a significant period. Balancing the needs of clients on the psychology waitlist and needs of the client work she is engaged with is an ongoing tension for Ciara. Hannah is also mindful of caseload constraints on her ability to fully engage in the therapeutic process;

“...you have to....be aware of what you’re bringing into the room and your own emotional state at that point and, am, sometimes that can be a challenge, depending [...] on your workload and making sure that you’re not overly burnt out.”

(Hannah, p. 30)

For Hannah, maintaining an awareness of the emotional demands of her overall caseload and her available resources before entering the therapy is important. “Overly burnt out” is an interesting turn of phrase since it infers that there is a correct or acceptable level of burnout. It perhaps speaks to her familiarity with the experience, either personally or through a colleague. Indeed, Hannah acknowledges the challenge of logistically maintaining her personal resources and also speaks of the key self-care activities she practices to promote her resilience and the ability to notice her emotional reactions such as, “spending time with my husband, my friends, my family, am doing meaningful things [...] making time for myself personally, yeah...detaching” (Hannah, p. 9). Her use of the word “detaching” is indicative of a protective process of emotionally distancing from her work in order to allay an inner sense of being
overwhelmed. In the same way, Eimear describes her attunement to her internal process at the beginning of therapeutic sessions:

“Checking in to yourself and, you know, ‘How does this feel? Is this...?’ And then figuring out a way around that with any work for me. None of the work can start until that is... that’s okay, that it feels safe.”

(Eimear, p. 48)

Here Eimear is engaging in an emotional scan of the self before entering the therapy process. Her phrasing of “that’s okay, it feels safe” is also indicative of the danger of being unaware of your internal process in the work. The tenor of Eimear’s language here is perceived as a glimpse into her inner narration. The familiarity with which she speaks about her grounding process gives us a sense that this is something she does with great frequency. Bronagh reports similar frequent checking of her emotional triggers:

“You’re like ‘What the hell is going on here?’ [...] if you’re really anxious going in to a client or really anxious about a client...that’s something like a big alarm bell [...] but you’re noticing if you’re feeling really anxious about a client. That’s a big deal. It means that you’ve got....there’s something going on that you need to bring to supervision.”

(Bronagh, p. 82)

Bronagh is clear in her enunciation of sometimes feeling unsafe in her own process that she notices and actively addresses. Whilst Eimear and Bronagh are talking about the same process, Bronagh’s tone here is much more of alarm. Her use of “‘what the hell” conveys the infrequency of this experience. Meanwhile Fiona considers the function of her behavioural activity, such as detailed note writing, “so like trying to ring her [the clinical team lead], document that you’re trying to ring her. Lots of documentation!” (Fiona, p. 61). She goes on to posit such focused documentation as potential avoidance mechanisms of underlying difficult emotional processes since “you can kind of distract from the internal self-blame or feeling or fear or terror“ (Fiona, p. 64). Terror is a poignant description here that conveys a sense of acute fear, dread, and panic that Fiona seeks to contain by reaching out to colleagues and documenting her work.
Meanwhile, Grainne is more attuned to the philosophical and ethical questions that arise in working with people with suicidality and also the potential impacts this dialogue can have on client work:

“I do believe that people have the right to take their own life, you know...it’s something I’m kind of dancing with it a bit in terms of where I do stand and how much I do really believe that, you know? And how much I will go, ‘oh no, actually we really need to hospitalize you now.’”

(Grainne, p. 16)

Here, Grainne demonstrates her struggle with the philosophical right to self-determination while simultaneously adhering to the professional concept of duty of care. Though she initially asserts her beliefs forcefully, her description of these thoughts as a dance conveys a sense of the constant ambivalence and flux in her viewpoints. Equally, her question “how much I will go?” gives us a sense of ambiguity in her philosophical thoughts about suicide.

Isabella described adrenaline-driven experiences of the past and her residual awareness of them in her current practice:

“It’s awful work. It’s really hard but there is a little bit of a ‘we’re on the war zone - we’re soldiers’ and there’s almost like a badge you get, you know?...Again you have to be mindful of all of these emotions that are popping up when you’re working with people - that they’re not running the show. But they’re definitely there.”

(Isabella, p. 40)

Isabella honestly delineates the biological feedback of adrenaline and feelings of heroism in engaging with risk based work. Here, she acknowledges and accepts their presence but is thoughtful about managing these sensations. The image of the war zone is affecting here, illustrating the life and death nature of the work, but also the heightened fear system that drives that image. John echoes similar experiences of shifting into a rescuing role and the impact of this on his relationship with the client:

“...is very easy to shift into the rescuing mode or the doing mode and immediately that puts the person into, am, all sorts of opposite roles; maybe
not opposite roles but a role that undermines their own agency. Am, such as a passive helpless, am, mode or potentially a more resistant you know. Or…. dismissive mode...also it’s not helpful for me, as it creates a greater sense of pressure, you know. That sense that I need to rescue you and to do for that person and, am, you know if...over time, if I’m working with that person who I can’t control how they act, am, that would create or set me up for failure and set me up for tension, stress, and inevitably burnout, I think.”

(John, p. 27)

Here John is reflective on the potential for this to happen for him and the harmful dynamics it can introduce to his relationships. It is clear from this and other extracts from John’s narrative that being mindful of didactic tendencies in his interactions is something he reflects on continuously. It speaks to a candid honesty and critical reflection of his skills and personal triggers in this work. Deirdre expressed a similar deep awareness of her internal processes and her consciousness of the potential impact on the collaborative working space:

“If you’re triggered […] whatever it is that you’re experiencing emotionally to the extent that that’s your own stuff, and, am, if you’re not aware of that, that interferes with empathy then. That interferes with collaborative working because you know you’re not responding to the person with empathy anymore, or you are kind of responding to your own emotional state which is heightened.”

(Deirdre, p. 30)

Deidre demonstrates awareness of her own triggers in therapeutic work and understands that her personal resistance is indicative of barriers to the therapeutic process. “If you’re not aware of that” conveys her understanding that while this is critical to the therapeutic work, her cognizance can be overlooked at times.

4.4.2 “It’s worrying. It’s scary” (Difficult Emotions)

While there is a strong super-ordinate theme of findings safety in the participant’s narratives, difficult emotions remain part of the narratives throughout and merit commentary. For Grainne, the tension of cognitively holding the reality of suicide completion jars with her felt sense of anxiety:
"In theory I can accept that it might not work and they might, am, they still might take their own life, but the reality is a very hard thing to actually accept. So it’s difficult."

(Grainne, p. 6)

Grainne captures the essence of her relational and human experience of working with clients who are suicidal and the innate worry that she feels in this work. She speaks to the instinctive challenge of accepting another person’s suicidal wish, whilst theoretically understanding it. This cognitive and emotional dichotomy is also expressed by Eimear:

“‘I’ve done that’ but it’s still...still sitting uneasy, or I’m not, you know, feeling 100% about their safety or something that is more felt than on an intellectual level.”

(Eimear, p. 52)

Aiden further illustrates the intensity of the responsibility in the moment, again held in tension with the cognitive understanding that others feel this responsibility in tandem:

“It’s worrying. It’s scary. Psychologically it’s hard to deal with. Am, it feels like a lot of pressure and responsibility on, am, our shoulders. Am, and when you’re one to one in a room with somebody it feels like it’s on your shoulders, even though other members of the team may feel it’s on their shoulders.”

(Aiden, p. 16)

An image of striking fear, isolation, burden, and disconnectedness from the clinical team permeates this extract. For Aiden, this is an intense experience of responsibility for the life of another person. Earlier his conscientious engagement in supportive processes (reflectiveness, theoretical knowledge, skill enhancement) was conveyed, and thus this momentary experience is considered indicative of the powerful force of client distress on the self. Bronagh recounts similar experiences of intense anxiety in relation to the uncertainty and perceived sense of responsibility:
“The anxiety that you feel that, you know…..are they going to be okay between sessions? Are they going to kill themselves? That’s the worst thing, holding the anxiety - am…the worst.”

(Bronagh, p. 20)

Bronagh’s repetition of the word ‘worst’ here educes an understanding of overwhelming worry. She describes “holding” the anxiety, which proposes an image of bearing a heavy burden. John further develops this point, outlining the immediacy of the risk felt in the room and the felt impact on the body:

“There is a sense at which the, am, the immediacy of the risk can enter into the room, you know, am. The sense that you’re working on a cliff-edge, you know, and that this is the sense of importance of the outcome. ...The sense of importance of that person engaging, am, is high, and so that, of course, comes with a sense of anxiety and physical tension in my body at times too.”

(John, p. 14)

John’s striking image of the cliff-edge emphasises a sense of constant threat where one’s every move is significant. He speaks about his awareness of potential outcomes and the pressure to engage his client in the, presumably, life-saving intervention. This analogy gives rise to a progressive sense of responsibility to intervene and the responsibility to be successful in that endeavour. Fiona describes similar experiences of vulnerability and grappling with her sense of responsibility as it arises in the room:

“It’s a really vulnerable…it’s a really vulnerable place to be in. It’s a really vulnerable to…it’s really vulnerable to work with people who are suicidal, am, because I think it confronts, you know, your own limitations am [...]And also, I suppose, the more you try to keep somebody safe the more responsible you ultimately feel.”

(Fiona, p. 37)

Fiona’s reiteration of the word ‘vulnerable’ reinforces the intensity to her susceptibility to personal pain and distress. This extract illustrates how Fiona understands the self is deeply embedded in this process and thus the potential for harm to the self is ever present. Fiona also captures the delicate balancing of responsibility
in the therapeutic relationship. Deirdre further expands on this by outlining the anxieties of potential heavy outcomes that can engage the clinician:

“I think the problem in working with suicidal clients is that sometimes maybe other things or other concerns can get in the way, sometimes that can be your own anxieties around are you doing enough? Or you know your own anxieties around if the worst comes to the worst and this person does take their life and, you know, so I suppose in some ways that can interfere I think in maybe...in your...in your kind of ability to be with the client.”

(Deirdre, p. 7)

Deirdre identifies suicidal clients as a discrete cohort here, acknowledging the clinical challenges of working with this population. Anxiety about being “enough” is a challenge for Deirdre. This questioning of being enough speaks to a deep seated vulnerability and questioning of worth, which is likely distressing and overwhelming emotion for her to bear. Similarly, Isabella exposes the frightening nature of the intensity of the emotional experience of the client and the subsequent impact on her at certain times:

“In the room, yeah, that intense distress can be overwhelming. Am, and sometimes it can be hard to empathize with it because actually it can be...yeah, it can feel really scary sometimes.”

(Isabella, p. 24)

The use of the word ‘scary’ captures the defencelessness felt by Isabella in the room. Here we see Isabelle shift from formal psychology language to describe her experience as “scary” which really resonates with childlike vulnerability. Whilst Isabella speaks about the barrier to connecting with her client owing to the anxiety, Hannah describes potential to internalize the responsibility as a perceived fault with her practice:

“You know, you might fall into a trap of feeling a bit self-critical, but obviously when your emotions are up yourself.”

(Hannah, p. 27)
Ciara also discusses feeling suddenly de-skilled when the anticipated progressive decline in suicidal ideation fails to occur in the work, and again, this inward projection of blame is articulated:

“…where the suicidality doesn’t shift, that can be a bit disarming for you as the therapist. It’s like, well, we’re working on the things you’ve identified and your risk is still really high.”

(Ciara, p. 19)

These excerpts underscore the intensity of the felt sense of personal and professional responsibility in the narratives, with the worst case scenario consciously held by all participants.

4.5 Connecting
This superordinate theme refers to the participant’s experience of connectedness and collaborative working with their client when using the CAMS framework. It inheres the two subordinate themes of “Into the Person’s World” and “Establishing A Shared Way of Working”.

4.5.1 Into the Person’s world
Each of the participant’s spoke of the experience of connecting authentically with their clients and empathising with their suicidality. It is clear from the narratives that the theoretical models synthesised by the CAMS framework facilitates this connection process. Ciara found the conceptual understanding of suicidality useful in understanding the process of how somebody becomes suicidal:

“…so you know, I suppose, seeing suicidality as…their solution to, you know, whatever is going on in their lives and really trying to make sense of how they’ve come to this - being the solution.....feels...more kind of respectful of the person rather than, I suppose, you know, sitting at a distance and, am, in some ways kind of seeing the person as the problem if that makes sense? ”

(Ciara, p. 7)

Here Ciara is drawing comparison with her previous approach to clients who presented with suicidality and the disconnectedness she felt from the client’s suicidal experience in the past. “Respectful” here conveys a strong sense of value for the person in terms
of their emotional distress and life experiences. Several other participants, including Grainne, voice a similar experience of understanding the person’s journey to their current presentation as facilitative in connecting with them empathically:

“...you get down to the, am, to the drivers, and you can validate and empathize with those and really understand how much pain someone is in, and then it kind of becomes easier.”

(Grainne, p. 29)

Once again, Grainne attributes this ability to explore the drivers of suicidality to the conceptual underpinnings of the CAMS framework. John also talks about uncovering the underpinnings of the person’s suicidality and meeting their needs through alternative mechanisms.

“I’d be using, am, kind of problem solving with the client as well around what the drivers of suicide are and...am, with the client I’m thinking of....other ways of coping other than suicide to, am, address their needs.”

(John, p. 5)

Similarly to Ciara and Grainne, John is empathising and connecting with the maladaptive coping function suicidality provides to a person in distress. Eimear further elaborates on the individualised meaning making for the client that she has experienced in completing the assessment:

“...working through, especially I find especially that first page of CAMS and really figuring out what specific drivers and making it really individual rather than a general suicide bit. Or intervention for them; it’s really specific for each client. Am, and I think spending the time on the process doing that allows itself to feel collaborative.”

(Eimear, p.9)

Like her peers, Eimear attributes her active engagement in understanding the underpinning drivers of suicidality and valuing the time spent doing this with the client as facilitative to feeling attuned to the client’s suicidal experience. Equally, Isabella describes exploring the meaning of suicidality with the client and supporting them to engage in the exploration together:
“...lots of empathy and trying to come to an understanding of how the person got to where they are. Am, of what happened along the way, am, and how this was a place that they got to, am, and trying to help a person. I suppose take a step back and think through what the function of those thoughts might be; what their impact on their emotional wellbeing.”

(Isabella, p. 3)

Fiona recalls her experiences of clients responding powerfully to feeling heard and validated when they spoke about suicidality:

“I think the meaningful work is in engaging with it and if somebody is...if it’s a worry for somebody, or if it’s a big source of distress for somebody...it’s actually really valuable. People respond really well, am, to thinking about it and the fact that you are listening, the fact they you are kind of validating that it is a big deal.”

(Fiona, p. 15)

Aiden conveys how this process of trying to understand the process for the client actuates genuine connectedness and empathy:

“...one of the things that this allows is for us to walk away from being frightened of suicide and frightened of death and into...into the people’s world. This is where the person is at.”

(Aiden, p. 63)

In this extract from Aiden’s narrative we see an emotional acceptance of the person’s current suicidality and recognition that this is the starting point of their therapeutic relationship. In the same way, Bronagh explains the value she places on connecting with somebody who is dissociated from their own emotional experiences:

“...really trying to reach them and to get to the emotion behind that... one of the things I like about it is that the first number of questions aren’t really about suicidality. So there’s pain, press, perturbation, and most painful is it can kind
of be helpful for people where they don’t really want to talk about suicidality, but the whole lead up to it is about suicidality.”

(Bronagh, p. 51)

From this extract, it is evident that Bronagh is guided by the theoretical conceptualisation of suicidality and is connecting with the pain she knows to unpin the expression of suicidality, rather than an explicit expression or demonstration of distress from the client. Hannah echoes this experience in struggling to connect a person with their emotional experience but recognising it as the foundation of their suicidality:

“...because with suicidality, you’re really asking people to be really vulnerable, and to talk about their darkest thoughts. You know, it’s the ultimate escape to....to die of suicide, so you know, the person is obviously feeling very distressed.”

(Hannah, p. 10)

Whilst Hannah is drawing on the theoretical understanding of escape as a driver of suicide, her description of “ultimate escape” is akin to that of an attractive travel destination. It perhaps speaks to Hannah’s ability to empathise with the client’s suicidal wish.

As previously mentioned, Deidre’s experience of the CAMS differed from the other participants. Deirdre described the forms and paperwork implicated in the CAMS as a barrier to the relationship:

“I suppose I feel most therapy works within the context of a relationship, you know? That’s the model I would be working from....and risk kind of exists in that, but it’s not going to be any, like, paperwork or, you know, assessment or safety planning really that is going to...it’s more subtle - what’s going to change in the client.”

(Deirdre, p. 79)

Here, Deirdre illustrates the high value she places on the therapeutic relationship and her experience that interventions occur within that dyad. As it clear from this extract
Deirdre’s experience of utilising paper and pen measures of risk were not comparable to her experience of relationship-based interventions alone.

4.5.2 Establishing a Shared Way of Working

This theme refers to establishing the understanding of engaging in a collaborative manner of working together. For psychologists this is often a process of socialisation and modelling for the client. Aiden outlines his challenge to establish a collaborative with an older woman accessing the CAMS service:

“But, I suppose her working model was a bit different to mine, and I suppose that was what we ended up having to explore before we could be truly collaborative - was that shared space mentally between us wasn’t there, because I was operating on the assumption that collaboration is best and this is how we do it. But this person was saying, ‘that is not my experience; I want you to be the expert; and I need you to tell me what to do’. So initially it was quite difficult for her.”

(Aiden, p. 13)

This extract illustrates a number of key challenges experienced by Aiden. Firstly, he was positioned in a role of expert in the relationship which indicated a subordinate role for the client which merely reinforced Aiden’s sense of responsibility. Whilst Aiden is describing a dynamic challenge, he concludes that for the client it was a difficult experience. This may suggest some struggle with accepting this issue on some level, and putting distance with between the self and this difficulty. Eimear describes a similar experience as a consequence of her clients spending considerable time in medical systems wherein the medical professionals are the experts:

“For them to believe that it was collaborative took a bit longer. You know, it wasn’t their experience to have this kind of work done with them and it’s kind of…. especially around suicide, am, because they had, you know, conveyor belt or gone on a conveyor belt in terms of hospitalizations….the belief around ‘oh it’s…right I don’t get this, this isn’t usual. How does this work? Okay, oh right, you’re actually trying to understand me.’”

(Eimear, p. 26)
In comparison to Aiden’s experience, Eimear’s experiences appear to be validating for her as a clinician in terms of her clients feeling heard, understood, and appreciative of the shift in their experience of working with professionals. The image of the conveyer belt offers a striking insight into the continuous and institutional image Eimear holds of hospitalization for suicide intervention. The conveyor belt is salient in its disconnectedness from the individualist care that Eimear values. Hannah further expands on this and points to the empowerment clients report if they have not previously encountered this model of shared working:

“You’re approaching the problem with a client as...’you’re in the driver’s seat, you know what’s happened, I’m just trying to help you make sense of what’s happened for you’. And that can be really empowering for clients because [...] they might not have even been asked some of the questions we’re asking them.”

(Hannah, p. 18)

For Eimear, the experience of collaborating with clients has been a positive one with supportive feedback from her clients. Her description of how she engages clients in the process is indicative of Eimear holding the client’s resilience in mind by reminding them of their personal agency. She stresses their expertise in their life experiences and their control. Hannah feels the team approach is “very much, it feels very much equal. That the two of you are in it together” (Hannah, p. 5). However, for Deidre, the experience is quite different. She reflects that her experience of utilising the CAMS in establishing a collaborative working alliance is not “hugely, hugely, different” (Deirdre, p. 9) to her engagement in other therapeutic approaches. Whilst Deirdre earlier described suicidal clients as a discrete population, here she reflects that the relational dynamic is not very different. Deirdre’s experience differs from other narratives in that she does not consider the CAMS beneficial in terms of the relational component. On the other hand, a concentrated effort to establish a collaborative working alliance is important to John:

“...an attitude that collaboration is essential from the outset [laughs] I suppose, like, from the word go. Like from the first greeting; that collaboration is part of the process and I suppose that is communicated in all sorts of ways.”

(John, p. 24)
John refers to being mindful of his body language and using words which reinforce the understanding that he and the client are on the same team. As John expressed earlier, establishing collaboration is not only the preferred approach to working but is also adaptive in managing his perceived sense of responsibility. Bronagh and Fiona also speak about adopting a non-expert stance and focusing on uncovering interventions that prioritise the needs of the client:

“...my style, I don’t know would be very non-expert and ‘we want to put our heads together and figure out what might be helpful for you.’”

(Bronagh, p. 10)

“A big thing about the treatment plans is not, like, what you think they want, and what you think they should change; could be a little bit of that, you know, if their kind of goals are completely out of line with keeping them safe. It’s, you know, ‘What is the thing that’s going to make the difference in your life?’”

(Fiona, p. 41)

“Non-expert” is also interesting here because in many ways it acknowledges the expertise of the clinician but the preceding “non-“ suggests that it is not leading in the interaction. Fiona illustrates the unrehearsed nature of this way of working and the emerging needs for the client that would not have been uncovered in a didactic format. Similarly, Ciara speaks about the process of “figuring out together” (Ciara, p. 8) and remaining curious as to the drivers of suicidality for the client:

“And being really curious about what is underneath it...that you are asking the difficult questions but being able to do so in a way that’s, am, bringing the person on board.”

(Ciara, p. 10)

For Hannah, the experience of the egalitarian relationship is very authentic from the outset. She attributes this to the tight structure provided by the CAMS supporting paperwork.

“Am, it’s very much, it feels very much equal; that the two of you are in it together. You’re bringing, I guess, your area of knowledge around it, and they’re bringing obviously their life story. And you’re kind of working together


to put that in a nice structured form of what’s driving your suicidality. Am, so it kind of it feels like those people are on a.....just an equal footing from the very beginning.”

(Hannah, p. 5)

Reflection Box
I found this theme of establishing and socialising people to a collaborative way of working very unexpected when it emerged in the narratives. It brought to the surface my assumptions in this research design that collaborative working was a preferred approach for everybody. It encouraged me to reflect on the containment of the expert position for some people, especially older adults, where demonstrating deference to people in positions of authority is more familiar. This theme is a stark reminder that the experience of collaborative working is actually quite unique for a large number of people accessing services.

4.6 Systemic Challenges
The fourth superordinate theme which emerged from the participant’s narratives describes overcoming the challenges experienced in the systems encircling the therapeutic work. These include ‘Tension and Battles with the medical model’, ‘Finding my Voice’ and ‘Challenges of the CAMS’.

4.6.1 Tension and Battles with the medical model
With the exception of Fiona, all of the participants alluded to the tension of the power dynamics within services wherein Psychiatry or the medical model of care holds a position of authority. As Fiona summarises concisely: “how the team views suicide and whose job it is to manage risk, am, is a big issue” (Fiona, p. 74). A common thread throughout participant accounts was the various experiences of compromise with medical leadership of the team:

“So collaboration is what we aim to do, but I think that, as a profession, that probably has lower status, am...and certainly holds less position of authority. We are put into a position of compromise more than collaboration.”

(Aiden, p. 47)

Aiden questioned the assumption of leadership/clinical lead of the multidisciplinary team and indicated that such positions were not held on merit but by profession.
Furthermore, he explained that psychiatry can take decisions independent of the team which is a clear source of frustration:

“There is a sense that one profession is...for some reason that is unclear to the rest of us... assigned the role of clinical lead, and they make a lot of decisions, including decisions about the level of risk on somebody’s suicidality.”

(Aiden, p. 47)

Deirdre partly attributed the decision-making tensions which arise to risk adversity and the uncontained anxiety held by psychiatry owing to their position of perceived accountability:

“...and I would say that the psychiatrists in the teams would still regard themselves as holding the clinical risk.”

(Deirdre, p. 55)

She also observed an apparent lack of equivalence on the team, whereby treatment trajectories with a client can sometimes “overrule or override you” (Deirdre, p. 55). Like Aiden, she conveys the frustrating impact of this dynamic:

“Certainly depending on the consultant psychiatrist, and some would be very risk averse, and would sort of jump in and hospitalize regardless of sort...of what the treatment plan was for that person and that can be really...[sighs], can be really... be really unhelpful sometimes, you know.”

(Deirdre, p. 44)

Hannah, Bronagh and Ciara echo these frustrations with the dominance of the medical model of care and risk adversity in treatment decisions for clients. Bronagh describes how this impacts referrals to her for CAMS care as hospitalisation is the preferred intervention of the psychiatry clinical lead:

“...it doesn’t happen that often where they come in as an outpatient and they’re very suicidal...She’d [the psychiatrist] nearly have them hospitalized.”

(Bronagh, p. 40)
Hannah further underscores frustration with hypervigilance of the person’s safety without exploring their potential for resilience and supporting them to be active in their management of suicidality:

“…a culture of maybe an over-reliance on admitting people who have a suicidal thought and maybe not too much of a team decision on how we should approach the person. So it might be a very quick admission rather than giving any thought to a CAMS way of working and allowing the person to, am, stay out in the community and, am, take responsibility for their own piece in managing themselves.”

(Hannah, p. 16)

The fear-driven decision making by the medical team lead as observed by Eimear points to a cautious and reactive approach to risk from the team. This is antithetical to the reflective approach which Eimear earlier proposed as key to working effectively with clients experiencing suicidality. Here, she outlines how anxiety prevents referral to psychology for CAMS intervention:

“There is an automatic fear and…in the day-to-day work, they [suicidal clients] don’t come up that much, and I wonder is that fear-based and they are kind of brought into hospital a lot more? Or they are not being brought to team or psychiatry hold them a bit more? And I really see that fear within, you know, registrars and people that don’t feel like they can hold that.”

(Eimear, p.15)

Indeed, Isabella echoes similar fear-driven team reactions:

“Risk is a real fear, and often…it overcomes therapeutic best practice, you know?”

(Isabella, p.27)

Being attuned to team fears, anxieties, and reactive practices is noted by John as an essential component to his approach. He described the possible consequential effect this holds for his own practice in terms of becoming overwhelmed and assuming an expert position:
“So I do think that the greater level of anxiety, which could be definitely impacted by the lack of service level supports, am, could push into a less collaborative mode of working in that sense; in that you could become more didactic.”

(John, p. 17)

Ciara highlights the localised, subjective, and changeable nature of feeling heard in her team, and the reliance on establishing a good working relationship with the clinical lead:

“A little, am. I think CAMS has shifted it [traditional hierarchical approaches] somewhat, am, but it depends on kind of relationships. By ‘relationship’ I mean relationship with the psychiatrist…That might have changed. There is a new psychiatrist, and so, I suppose, it’s just going to be around kind of building that relationship, you know.”

(Ciara, p. 34)

While Ciara emphasised that the team were open to the CAMS framework and that it was being used regularly, there is nonetheless a sense that she is working quite hard to prove her competence through her relationships with psychiatry to maintain this openness to the framework. Indeed, she notes that “at times, I feel like it falls back to the hierarchical thing”

(Ciara, p. 34)

There is also an unusual conflation of opposing responses to risk experienced by Isabella, in which she outlines the passive response to risk that can occur also:

“Desensitized. And people can be not believed. Am...and there can be no action. I certainly have memories of going to teams and trying to communicate the distress that somebody is in.”

(Isabella, p. 11)

Her use of the word ‘desensitised’ here communicates a fatigued and apathetic response to her efforts to convey suicidal pain. She noted that risk is the standalone area of concern for that team with regard to suicidality. So, in the absence of suicidal intent, the distress is not held as valid nor indeed Isabella’s efforts to convey the
distress. Those complaints of battling to be heard are also endorsed by Grainne who reports how change to the long-established way of working is “discouraged very subtly... in very subtle ways but it’s there” (Grainne, p.19). She reflected how she currently does not utilise the CAMS framework in one of her part-time posts:

“It’s funny because I’m so pro-CAMS, and I’m so into it, and I find it so useful but... I’m in an adult mental health service at the moment... But because it isn’t part of the working culture there I’ve got lots of battles to fight and it hasn’t been one that I’ve fought yet... because I think those kind of hierarchical structures are so entrenched that that’s a difficult thing to change.”

(Grainne, p. 19)

Grainne reveals the position of compromise she holds in a hierarchical, medical-model team and the impact on her own practice, such as in the use of CAMS. She also draws attention to the considerable effort and tensions of “lots of battles to fight” that she experiences, not only in relation to the conceptualisation and intervention of suicidality.

4.6.2 Finding My Voice

In the context of team tensions regarding the dominating medical model and the projected identity of Psychologists being CAMS practitioners, participants have found ways of nurturing an understanding of suicidality in their teams. In addition, mentoring the utility of the CAMS for colleagues is also an approach for some participants. Aiden described disseminating the theoretical understanding of suicide by utilising team meeting conversations to model client formulations:

“So really it is about taking part in that conversation and really helping to deliver that collaboratively developed, I suppose, formulation of what is driving the suicidality and trying to bring that to the team.”

(Aiden, p. 38)

For Aiden this proactive approach subtly conveys key pieces of information that he would like the team to take on broad in terms for understanding suicidality as distinct from pathological discourse. He mentions deconstructing the medical model
categorisations of suicidality and presenting a narrative, holistic understandings of suicidality for the person:

“We can almost, possibly out of self-protection, de-personify the person, um, into categories such as ‘depression; and, um, ‘risk of death; and ‘suicidal ideation’ but...as...let’s keep this person’s life and their story and their view and their wish and their skill and their experience and everything that they have going on; let’s keep that as part of our conversation because that is really what is going to work.”

(Aiden, p.64)

In this way, Aiden hopes to inspire MDT colleagues to become aware to the psychology in their use of their CAMS training. Bronagh illustrates a similar modelling and mentoring approach to supporting her team to engage with the CAMS more consistently:

“I’m just kind of highlighting ’well this was very painful for them and this was really stressful for them so it sounds to me like these intrusive thoughts are a real driver, let’s put those down, what do you think?’ So I’m kind of shaping it a bit with them and I would have, like always, you know, ‘if you ever want to talk to me about the CAMS or if you’re needing a bit of help with it, I’d be delighted to talk to you about it.’”

(Bronagh, p 32)

For Bronagh, creating a culture of empathising with the underlying distress was her approach to creating a shared conceptualisation of suicidality. Bronagh also illustrates a mentoring role she has taken with other interested MDT members who are tentatively utilising the CAMS framework in their practice. Her use of particularly effusive language here is interesting, “I’d be delighted” and perhaps conveys the depth of her desire to have others embrace the CAMS approach in their work. Ciara is also attempting to build on the initial interest in the framework that is emerging in her team by establishing a peer support group, again adopting a mentoring role:

“I think there is an openness, but maybe a kind of, am, a bit of, am, am....I suppose reluctance about using a new approach, so we’re trying to bring in a kind of CAMS support, peer support group where we can support each other
Expanding on that, Eimear ensured that the Psychologists in Clinical Training on placement with her team utilise the CAMS framework in their client work and discuss this at team meetings. Eimear finds that the MDT respond positively to watching the Psychologists in Clinical Training acclimatise quickly to the framework and demonstrate positive experiences through discussion at team meetings:

“The work of trainees that would be here with me as well have worked out really well, because they, especially when they start, they have the capacity to take someone on really quickly. Am, so in terms of the suicide piece it’s been useful because they can go, ‘ah, look, I can take that person for CAMS model’ and then feeding back to team in terms of the outcome, how positive that’s been […] So it’s kind of been filtered through a little bit; they’ve seen what the experience has been like and they’ve seen the outcome. Am, so I think that’s been helpful.”

(Eimear, p. 29)

John similarly describes the benefits of having the CAMS to structure feedback to the team regarding the progress of suicidality. Like the other participants, John takes this as an opportunity to model the theoretically sound understanding of suicidality:

“I find the CAMS so useful, and particularly useful in terms of, am, clearly being able to report to the team around, am, you know, assessment and intervention around suicidality as well.”

(John, p. 29)

4.6.3 Challenges of the CAMS

The participants’ experiences of the challenges of the CAMS were varied but the strength of viewpoints was noted and merited commentary. Throughout her narrative Deirdre remained resolute that the CAMS framework was not a good fit with her therapeutic approach. There were a number of aspects that Deirdre found lacking, in particular the relationship and collaborative way or working.

“I think that the relationship is lacking in it, that’s what I would feel….to me, the paperwork always felt like a bit of a barrier as well, you know.”
“I suppose I would feel that in terms of the relationship piece I think it’s richer in DBT. I would feel that you would have a stronger relationship with your DBT client than you would with say your CAMS clients when you’re really focusing in on the suicidal drivers. And if their suicidal resolves that’s great - they can go back on the waiting list, you know...To me that’s not really collaborative because it’s...you know it’s almost all you care about is the suicidality and then once that’s resolved it’s...it’s... the intervention is over.”

As previously outlined, Deirdre held that the reliance on SSF forms created a barrier to connecting authentically with her clients. She believed it merely created a mechanism for holding the psychologist’s own anxiety but did not serve to enhance the experience for the client. Her opinion is in stark contrast to the collaborative and containing experiences articulated by the other participants and there is a sense that for Deirdre the CAMS relationship feels superficial and solely preoccupied with suicidality. She perhaps feels she is dismissing the holistic needs of the client by discharging them to the waitlist; a tension she clearly expressed regarding the centrality of the therapist-client relationship to her practice. Nor is Deirdre alone in her concerns about the paperwork; most participants revealed that completing the forms presented challenges for a small number of clients.

“...on the occasions where a person will refuse maybe to complete CAMS maybe because again because of literacy issues or, am, education issues, or others issues that might just drive to not want to use a form.”

“Aiden, p. 61”

“...looking at how confident or comfortable they are in writing. Am, sometimes that can be a bit of an issue.”

“Eimear, p. 41”

“One person didn’t like writing because I think they had quite traumatic school experiences. Another girl actually, another woman, forgot her reading glasses. So there’s actually, yeah, there can be impact in those ways.”
Aiden outlined his approach to overcoming the challenges of using the forms with clients who found them difficult for any reason:

“Well, we’ll have the, am, conversation, am, but you know I’m going to follow the, you know, same plans, you know; risk factors; reasons for living; reasons for dying; self-rated risk of suicide; and so on...coming up to, you know, a safety plan. A therapeutic plan all based on the risk assessment and working towards the drivers so, yeah, yeah, I feel more safer using this process.”

(Aiden, p. 61)

Aiden illustrates how he finds safety in the process of the CAMS assessment so continues with the approach through a conversational dynamic. Bronagh describes a similar approach to overcoming the issue with forms:

“It wouldn’t ever be that I’d put it off the table and say ‘okay we won’t do this; it’s just the way in which we do it.’”

(Bronagh, p. 77)

Bronagh describes a laborious force that emerges through repeated use of the forms across successional sessions. Likewise, Fiona also adopted a flexible approach to this aspect of the framework where she felt it was appropriate:

“Coming back in and going ‘okay let’s think about your suicide again’ when there is an ideation can be a little bit frustrating for clients, so I think you need to […] but I think you need to am, just kind of play it by ear and be flexible with it....Am, but, like, stick to the treatment plan that you’ve come up with. But not necessarily every week filling out the form fully.”

(Fiona, p. 19)

In addition to capturing the familiarity and confidence she has with the framework, this suggests a response that aims to meet the client’s needs in terms of managing fatigue in the sessions.
Chapter Five: Discussion

5.1 Chapter Introduction
This chapter provides a critical discussion of the findings of this study in the context of the existing literature and also, the distinctive contributions of this study are identified. Taking into account the key findings outlined in Chapter Four, literature from Chapter Two will be discussed. The strengths and limitations of this study will be outlined, in addition to a critical reflection of the research process. Potential clinical applications and future directions for research are provided. This chapter concludes with a summary of the study.

5.2 Review of Research question
From the limited research in relation to clinician’s experiences of working with clients who are suicidal, some potential issues were identified. These included the clinician’s felt sense of responsibility, issues of control, fears of blame and negative countertransference (Cureton & Clemens, 2015; Gaffney et al., 2009; Galavan & Repper, 2017; Jobes, 2016; Jobes et al., 2000; Jobes et al., 2018b). Given, that CAMS is proposed as a potential remedy to these challenges, this study sought to explore the clinicians’ lived experience of collaborating using this framework and provide a clearer understanding of the individual clinician’s experience. Subsequently, a broad overarching research question was formed: ‘What are the CAMS clinicians’ experiences of collaboration?’

5.3 Findings in the context of previous literature
This study has provided detailed insights into the experience of collaboration for mental health clinicians using the CAMS approach with clients who are experiencing suicidal ideation. This study demonstrates that the use of a qualitative methodological approach provides context and personal meaning to the experiences of the clinicians. Whilst recognising the idiography of each of the participant’s narrative, connections between narratives emerged during engagement with the data and that pattern of connections will now be discussed further. As demonstrated in the previous chapter, four key themes were identified in relation to the clinician’s experiences of collaborating using the CAMS: Finding safety, Regulation of the Self, Connecting and Systemic Challenges.
In this section, the key findings of this study are considered in the context of existing literature. In the interest of clarity, subordinate themes are used here to guide the discussion of existing literature and applications to this study.

5.3.1 Finding Safety

All participants in the study spoke about finding the CAMS as a source of safety in their work. Various aspects of the CAMS provided this, including trusting in the evidence-base underpinning the development of the framework, valuing the thoroughness of the assessment or finding containment from the structure and organisation of the process. In the CAMS training and indeed the CAMS manual (Jobes, 2016), the theoretical models of suicide are synthesised in a comprehensible format. The CAMS draws on theories from Baumeister (1990), Beck (1996) and Shneidman (1959, 1987). In addition, participants in this study spoke about training and education in relation to the psychological models of suicide as transformative learning experiences. This theoretical understanding provided clinicians with a frame of reference to conceptualise suicide and also a mechanism in which to process their own experiences. This is in line with Brown et al. (2011) who have suggested that theoretical models of suicidality have a therapeutic role in creating a shared understanding. It’s reasonable to suggest that in this instance, the theory is providing a containing, therapeutic frame for the clinician’s personal process. For the participant who found that the CAMS approach wasn’t a good fit for her therapeutically, she spoke about the value of the theoretical conceptualisation of suicidality that the CAMS offered. Whilst this is something the clinicians in this study clearly valued, it also speaks to a dearth in professional training reading the psychology of suicide.

In relation to the structure and organisation of the framework that participant’s valued, it is noted in DBT literature, where Miller et al. (2011) found lower levels of cortisol and self-reported stress in DBT clinicians in comparison to controls. The authors concluded that this may be in part due to the structural elements of therapy, such as clear intervention goals and team consultations. Whilst most participants felt contained by the structure and process, concerns were also raised in this study that the CAMS may be functioning to meet the emotional and intellectual needs of the clinician and not specifically the clients. Indeed Galavan and Repper (2017) acknowledges that assessment activities can be experienced as coercive, uncaring and for the benefit of the clinician or equally, the authors offer that assessments can be experienced as
helpful, collaborative and for the benefit of the client. The authors posit that an individualised, collaborative approach make the experience more meaningful for both client and clinician.

In the current study a number of participants spoke at length about feeling supported within their teams, the departmental psychology team and/or the multidisciplinary team. Having a peer reflective space that is responsive and accepting of the vulnerabilities and challenges of the work was valued as a key source of support. This forum appeared to have a reciprocal peer skill development element to the reflective space, which was appreciated in the participant narratives. In an Irish study of psychotherapist’s experience of suicide prevention, the authors recommended the creation of a work environment where the personal resources of the clinician are enhanced (Moore & Donohue, 2016). Moving beyond the suicide specific research, this is reflected in research on peer group supervision by Akhurst and Kelly (2006), who found that a safe space facilitated a culture of active learning in terms of applying theory to practice and promoted a solution-focused approach.

Participant narratives in this study focused on describing the benefit of having colleagues and team members that are interested in and/or use a psychological understanding of suicide. This also took the form of feeling authorised to use the CAMS approach in a dominant medical model environment. In this study, participants valued the shared experience of the CAMS being used by other team members. For participants, this described a meaning greater than solely validation and support. It extended to a learning culture and skill development. Whilst this team consultation is not prescribed in the CAMS framework, it seems to have naturally evolved in teams. Again, moving beyond the suicide literature to DBT research, Swales (2010) describes a training functioning to the structured team consultation process of DBT intervention. Swales noted that development of skills in this team environment maintains clinician’s resilience in working with the challenges and complexities of clients presenting with BPD.

Participants’ narratives spoke about finding safety in the team environment where the responsibility felt shared and they felt less isolated in their work. Leenaars (1994, p. 354) speaks quite candidly about collegial support, noting “there is almost no instance in a therapists’ professional life when consultation with a peer is as important as when
he or she is dealing with a highly suicidal patient”. Leenaars suggests that topics to discuss in this instance include the therapists own feelings, countertransference reactions as well as the advisability of hospitalisation for the client. Of note here, Leenaars weights the clinician’s emotional wellbeing more heavily on this list. This is in keeping with research that suggests that clinicians practicing in teams are less distressed than those in private practice or isolated posts (Pearlman & Saakvitne, 1995). In addition, Book, Sadavoy, and Silver (1978) also emphasized the key role the mental health team play in terms of clinician validation, intervention direction and sometimes correction of the clinician’s approach to the client. This supports the participant narratives in this study which describe the benefit of ‘checking with’ MDT colleagues and the value of learning from one another.

5.3.2 Regulation of the Self

A narrative shared amongst participants was being attuned to their own internal processes in terms of what they were bringing to the work (Attuning to the Self) and what was being triggered by the work (Difficult Emotions). Participants spoke about being curious and self-aware about their personal and professional experiences. It is clear that reflection plays a critical role in their work. This is illustrated in the literature where reflective practice is gaining more attention and there is encouraging support for benefits of this practice (Mann, Gordon, & MacLeod, 2009). Of interest, Schön (2017) described that reflective practice often functions as a framework from processing difficult or complex issues that clinicians face, but their training did provide them with the skills to deal with it. One participant spoke about using a structured reflective space held in a psychology team that facilitated shared reflection on therapeutic challenges, such as resistance. Countertransference and maintaining awareness of the potential impact in the work is established in the literature (Cureton & Clemens, 2015; Jobes et al., 2018b; Leenaars, 1994; Maltsberger & Buie, 1974). Whilst not a prescribed element of the CAMS framework, reflective practice was a strong theme for all participants in terms of coping with the personal demands of the therapeutic work. Participant narratives discussed being mindful to avoid burnout, by remaining attentive to work demands and the personal resources required when working with persons who are suicidal. This is mirrored in the research, Leenaars (1994) suggests that a clinician’s caseload must be limited in terms of suicidal clients, noting the impossibility of providing effective care without risking burnout or
emotional detachment from the demands of the work. In addition, separation of work and home life was valued by participants in this study. This is supported in the literature by Gurrister and Kane (1978) who found that clinician’s needed to compartmentalise in order to cope with the demands of working with clients who are suicidal.

Participants narratives revealed philosophical curiosity about suicide and personal beliefs with regard to moral and ethical viewpoints. The impact of personal beliefs regarding suicide are established in the research (Bernstein, 2001; Lussier, 2004; Roose, 2001). Consistent with Rycroft (2004), participants in this study were in tune with their beliefs and attitudes and are aware to the potential impact on the therapeutic work.

Of interest, two participants in this study spoke about maintaining awareness to adrenaline bio-feedback in risk situations and being cognisant of their tendency to become a rescuer to the client in that situation. This is supported somewhat in the literature by the quantitative study conducted by Jacoby (2003) that reported that the strongest countertransference response for clinicians was an urgency to intervene. However, Jacoby reports this sensation was accompanied by feelings of anxiety. In addition, Gurrister and Kane (1978) found that clinicians felt protective over their clients. Whilst, these are somewhat similar, the description of the rescuer and the hero reported in this study appears to be a novel finding that would be interesting to tease out in further research.

Participants in this study spoke about the intensity of adverse emotions that can be triggers by the suicidal client. These emotions included anxiety, responsibility, fear, pressures, isolation, worry, vulnerability, feeling self-critical, unskilled and not feeling “enough”. These findings are supported by the academic literature in relation to working therapeutically with suicidal clients. Anxiety and worry are referenced widely in the literature (Gurrister & Kane, 1978; Porter, 2013; Reeves & Mintz, 2001), as is professional responsibility and pressures (Anderson, 2000; Moody, 2010; Porter, 2013; Ting, Sanders, Jacobson, & Power, 2006), fear and vulnerability (Jobes et al., 2018b; Reeves & Mintz, 2001; Roose, 2001) and self-questioning (Moody, 2010). What’s notable about the findings of this study is that negative emotions are directly internally for the clinician. Whilst other studies have reported aversion, malice and
anger (Maltsberger & Buie, 1974; Milch, 1990; Reeves & Mintz, 2001), not one participant spoke about negative emotions towards their client. From the participant narratives, this is likely the results of a number of factors. Firstly, participant narratives illustrated a strong conceptual framework of suicidality as a function of unbearable distress which facilitated empathy. Secondly, the participants spoke about finding safety in the CAMS process which facilitated the ability to accept the client where they are at and be curious to their experiences. The findings from this study illustrate that intense difficult emotions remain in the therapeutic work but appeared to be more muted than reported in other literature, and negative countertransference was not reported in this study.

5.3.3 Connecting

Of interest, participants described authentic connection with clients as a process of relative ease, which they attributed to a number of aspects of the CAMS framework. Participants spoke about conceptualising suicidality as a maladaptive coping mechanism for unbearable pain and distress. This understanding of the function of the suicidal wish appeared to facilitate genuine empathy for the client and connectedness in the relationship. This is in line with the fundamental approach promoted by the Aeschi working group (Michel, 2011) and the CAMS (Jobes, 2016); which views the suicidal thoughts, sensations and behaviours as actions that contain personal meaning for the client. Participants’ narratives in this study revealed similar mechanisms for overcoming client ambivalence by meeting it with empathy. In the literature, this is explained as a process whereby the theoretical understanding shifts the position from a moralising one to a place of empathy with the client (Jobes, 2000). Indeed, this is also supported in DBT literature where understanding suicidality as a primary effort to cope is at the core of the approach taken by clinicians in forging an alliance with DBT clients (Linehan, 1993; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). In this study, participants spoke about using a phenomenology approach in understanding the idiosyncratic process of suicidality for the person. This seems to be key in terms of providing validation to the client but also receiving powerful, validating feedback from the client. It must be noted that for one participant, the above experiences did not apply. She felt the dominance of the paperwork was a barrier to the relationship and that the CAMS didn’t really facilitate the relationship in any way.
This appears to be a novel finding in the existing, limited, research and deserves a more focused, nuanced exploration in further research.

Of interest, participants in this study spoke about taking time to socialise clients to the collaborative, shared way of working. This is illustrated in the literature in the original academic writings of Bordin (1979) in terms of agreeing treatment goals, agreeing tasks and developing the personal bond. Indeed, Horvath et al. (2011) proposes that a strong alliance is frequently the outcome of negotiation. Participants’ accounts demonstrated this negotiation through discussions around roles, sitting side by side and figuring out how to complete the SSF. It reflects what Luborsky (1976) described as the collaborative relationship (type two, phase two therapeutic alliance) developing whereby the clinician and client team together. Participants illustrated how adopting a non-expert position facilitated genuine curiosity for their clients’ experience of suicidality. In addition, participants’ references to the clients’ agency is pertinent with respect to combating issues of control that is cited in the literature (Galavan & Repper, 2017; Hendin et al., 2004; Jobes et al., 2018b). Some participants spoke about being surprised by the goals created in the co-authored treatment plans, as it remains tightly centred on meeting the needs of the client, as described by the client.

5.3.4 Systemic Challenges

This was an interesting and surprising finding in this study. Participants’ narratives in relation to team tensions were all in some form of compromise within a medical model system. Within this theme, participants’ narratives conveyed collective frustration and activation of their threat/fear system in some interactions within the dominant medicalised model of care in Ireland. Collaborating with the medical model system in relation to suicidal clients appears to trigger adverse emotions. So whilst participants spoke about feeling supported by their colleagues, it is discordant working models and the medical hierarchical organisation that underpinned the narratives of this theme. For example, the focus on risk in relation to suicidality featured in the participant narratives as a key source of divisiveness, as it was felt decisions (on a team and organisational level) were sometimes driven by fear rather than therapeutic rationale. So where participants in this study conceptualised suicidality with a phenomenological approach, medical clinicians conceptualise suicidality in an illness model. In the illness model, treating the psychiatric condition (e.g. medication or perhaps hospitalisation) is the key focus, rather than the difficulties underlying the suicidality
Indeed Orbach (2001) cautioned that the phenomenological approach to suicidality is a challenge for clinicians and teams trained to view suicidality with a defensive lens. For participant’s their experiences of didactic dynamics, at team and organisational levels, triggered emotive responses of frustration, feeling unheard, invalidated and dismissed. Of interest, this dynamic is similar in description to the literature of coercive, defensive and risk adverse practices when the clinician, or in this case the team, feels pervasive fears regarding blame and responsibility. Whilst it is acknowledged in the literature as a radical shift from the pathology conceptualisation of suicide within the medical model (Galavan & Repper, 2017; Jobes et al., 2018b), the challenges of utilising the CAMS within a medical model appears to be an original finding in the existing literature.

Participants shared challenges with the CAMS framework also, most notably overcoming client resistance to co-authoring or utilising the SSF. In this study there was a clear sense of participants feeling secure in their understanding of suicide and the CAMS process in order to creatively adopt the approach to meet their clients’ needs. This is mirrored in recent preliminary research conducted with clinicians using CAMS with a homeless population where literacy difficulties posed problems for engagement with the SSF (Adams, Kroll, Murray, & Condron, 2018).

It must be noted that one participant felt very strongly that the CAMS was deficient with regard to the relationship element, when compared to her experiences with DBT intervention. For this participant, the use of the CAMS as a focused assessment and intervention, followed by discharge to the psychology waitlist was understood as a source of frustration. She felt there was a superficial connection with the client’s distress as the distress was only addressed to the point of reduced risk. Indeed, this is discordant with the Aeschi approach which outlines the importance of acknowledging that suicide has a past and is not determined solely by the present (Michel, 2011). As mentioned earlier, this warrants more focused exploration in further research.

5.4 Limitations of the study
All research studies inherently have limitations and this study is no exception. One limitation was the variance in experience of the participant sample, ranging from two to 12 years (M=6). Of note, it was overlooked in the study design to collect information regarding length of experience with the CAMS framework. This may have
contextualised novice and experienced CAMS clinicians’ experiences in some way. However, the specialised suicide service, from which the participants were recruited, commenced in 2015 along with the CAMS training for clinicians. This leaves a maximum variance of 3 years of experience with the CAMS.

Whilst participants were informed and assured that the field supervisor, a known expert and supervisor in the CAMS would not be involved in the research analysis, a possible limitation might be an underlying element of social desirability. So while participants appeared quite open and honest about their experiences in interviews, they may have been measured in their responses about negative aspects of their team experiences. This was evidenced in advance of one interview, where Deirdre asked if I would be interested in her experiences being represented in this study, and requested reassurances regarding the confidentiality arrangements in place for the study.

It must be acknowledged that the findings of this study are not necessarily representative of the views of other psychologists utilising the CAMS and the small sample size means that findings cannot be generalised. However, a sample size of ten participants was considered acceptable given the richness of the data that emerged from the narratives. Smith and colleagues (2009) have suggested that a sample size of four to ten interviews is sufficient for doctoral IPA research. This study is at the upper limits of this guideline, and whilst it facilitated more diversity in the data, it is likely that a larger sample size than ten would have compromised the idiographic nature of the participants’ accounts.

Despite many multidisciplinary teams receiving training in the CAMS framework, in practice the role has fallen predominantly to the Psychology discipline. As such, this study focused on psychologists’ experiences of the CAMS only. Whilst this contributed towards the homogeneity of the sample, it limits the experience of this framework to a singular discipline.

5.5 Strengths of the study
This study aimed to address the evident paucity in the research exploring clinician experiences of working with clients who are suicidal. The findings offer valuable insights and expands on previous research (Gaffney et al., 2009; Moore & Donohue, 2016; Reeves & Mintz, 2001). In addition, it contributes generally to the field of clinical suicidology.
To date, this literature has tended to focus on countertransference difficulties experienced in the therapeutic relationship and identifying the ways in which a clinician assesses and manages suicidality. This study finds that the use of the CAMS framework plays an important role in providing a safe base for the clinician (in terms of understanding suicidality, as well as the structures and process of the framework). It also provides a mechanism in which to process difficult emotions (by the self and with others) and a way of communicating a formulation of suicide to the treating team. Most importantly, the CAMS facilitates a collaborative, therapeutic way of working. However, the CAMS does appear to have its limits also, insofar as it does not appear to be embedded in the wider organisational and team culture and so for the clinician, it can feel isolating and invalidating. At the same time, clinicians place high value on collegial support. The findings from this research may help inform aspects of the CAMS training process as well as wider CAMS implementation literature.

Using Interpretative Phenomenological Analysis generated in-depth and rich narratives around the experience of using the CAMS with clients who are suicidal. It facilitated analysis of meanings embedded in the data and signposted original opportunities for further research. IPA, as described by Smith et al. (2009), is transparent about the limitations of this approach, such as the subjectivity of the researcher bias and associated assumptions in the analysis of the data.

There is a clear dearth of qualitative research in the literature and growing concerns that research in suicide has become subsequently stagnant (Hjelmeland & Knizek, 2010). This current study responds to this appeal for qualitative research to provide insight and understanding that may be helpful for suicide intervention.

5.6 Critical Reflection
As the researcher in this study, it is necessary to be aware of the importance of acknowledging my positioning, personal values and expectations in this study. Whilst my interests and preconceptions were noted previously (Chapter 3: Methodology), it is important to explore how these may have impacted on the research process and interpretation of the data.

Before the conceptualisation of this study, I held the experience of participating in a clinical psychology peer supervision forum and bearing witness to the reflections of a senior psychologist grapple with their personal and professional responses to the
suicide of a long term client. I bore witness to some of the difficult “what if” questions that were triggered for that psychologist. The ensuing group reflection was eye-opening for me, as a Psychologist in Clinical Training, but appeared to be a familiar experience for many in that forum. I found it overwhelming to consider experiencing the death of a client, with whom you’ve formed a strong relationship with over many years. The work/life compartmentalisation of grief and associated emotional responses seemed extraordinary to me. I was also very aware in that forum of the hypervigilance and professional apprehension regarding the organisational review that would be initiated for that clinician and their team. My initial preconceptions centred on the trajectory of my own career and the likelihood that I would be that psychologist in that peer supervision forum, grappling with a client suicide. It felt very real and very frightening but also, unacceptable. Where was the supportive response for this clinician? Where was the recognition of vulnerability? How anyone could be expected to cope with ongoing work with clients who are suicidal, whilst also grieving with limited avenues for responsive support? I had assumed that suicide would be considered a significant event, that there would be ample support provided to clinicians and teams involved. For me, the impact on a person could not be ignored.

Having worked in the field of mental health during clinical training, I was aware of the essential risk related questions that I was to ask if a client expressed suicidality. However, I had never encountered psychological models of suicide or psychotherapeutic approaches, other than being aware of DBT team interventions. As I familiarised myself with the literature in the field of suicide, I realised preconceptions about suicidality were related to my own lack of knowledge of the psychology of suicide. It brought up “what if” queries for me in thinking of clients I’d worked with who expressed suicidal ideation and how I didn’t fully understand what they were going through.

In tandem, my own enthusiastic interest in collaborative clinical practice, contributed to a passionate interest in this research. Whilst I had become familiar with the disseminated literature in relation to the CAMS and suicide, I had not been exposed to the CAMS in my clinical experiences and I had not engaged in the CAMS training. This contributed to my genuine curiosity of participant experiences during interviews.
My experiences of being a Psychologist in Clinical Training likely facilitated my development of rapport and trust with my participants. Conversation flowed easily from the outset and most volunteered a sense of identification with me, for example “Oh I remember doing my interviews for my thesis”. This likely favourably encouraged rich and detailed participant accounts and a willingness for participants to become involved in the study. It was important to me that the interviews were conversational as I knew from my read of qualitative literature that this aided quality, in-depth data in terms of following the participant’s account and asking probing questions. When I was transcribing the participant interviews, I became aware to the confidence I gained with this as the interviews progressed across the data collection period. This was most definitely supported by supervision during this time and reflections on the transcripts.

I found data analysis particularly challenging and enormously time consuming. I felt clumsy and overwhelmed as I grappled with analysing and finding ways to accurately reflect the complexities of the participants’ experiences. Initially I felt very unsure about my interpretations and found myself seeking reassurances from IPA literature and my supervisor. I felt huge responsibly to represent the participants’ experiences thoroughly in the presentation of the findings, choosing quotes to give voice to the participants and then finding ways to reduce my word count so I would have enough words to do justice to the interpretation and implications of the findings. As I worked through this challenging phase, I noticed I was reaching for similar coping mechanisms to my participants—exploring in personal therapy what was being triggered for me in this process, connecting with peers that were sharing the experience and making time for self-care activities.

5.7 Implications for Clinical Practice
The researcher is hopeful that the findings from this study will provide knowledge of the clinician’s experience of collaborating with clients who are suicidal using the CAMS framework. The findings of this study have a number of implications for clinical practice.

Firstly, the importance of finding safety was a strong theme in this analysis, finding safety through peer and team support. This involved having a structured, psychologically safe space for reflection in the team, akin to peer supervision. This
was in place for some participants and indicated as a future desire for others. This is not part of the CAMS intervention, but the availability of this reflective peer support was particularly useful for clinicians in regulating their emotions and also feeling supported in their individual work. This highlights a need for a genuine culture of reflectiveness, openness and acceptance of vulnerability in mental health teams. In contexts where suicidality is a frequent presentation for the intervention team, creating and protecting reflective space is an important priority. This would allow clinicians to explore the emotional impact this work holds for them, to reflect on fears, anxieties, personal and professional concerns they may hold when working with suicidal clients. Whether this kind of support can develop into a structured element of the CAMS framework is uncertain, but it is clear that this is a helpful mechanism when working with such a challenging client group. Alternatively, the findings of this study have shown that this is happening naturally in some teams and it is perhaps a support that can be introduced and prioritised by individual teams.

Secondly, establishing a shared understanding of suicide was found to be a strong theme for all participants, resulting in individual efforts to model, mentor and informally disseminate information about theoretical understandings of suicide and the CAMS framework for intervention. Given the radically different understandings of suicide from medical model and psychological approach, there is a clear need for multidisciplinary mental health teams to develop a shared understanding of suicide and their roles and values in relation to suicide.

Training and education in relation to suicide was a striking finding of this study, as the CAMS for many participants served as their first introduction to psychological models of suicide. Introducing suicide-specific education in professional training programmes for clinicians could be one way of promoting this understanding.

Indeed, such reflections need to be prioritised at an organisational level. The findings of this study clearly show that when working with clients who are suicidal, clinicians are hypervigilant to the pressures of the wider system. Fear regarding blame, professional reviews and being thought of as incompetent by peers are very real pressures for clinicians and teams. This appears to be poorly dealt with by the wider mental health service currently. It is clear from the findings of this study that clinicians
require a supportive, safe base in order to engage in effective, collaborative therapeutic work. Clinicians, and the clients they are supporting, require this at a minimum.

5.8 Future Research
As the CAMS is considered appropriate for any discipline, it would be interesting to explore the experiences of other professionals’ (nursing, occupational therapy, social work, psychiatry) of using the CAMS and working therapeutically with clients who are suicidal. The experiences of consultant psychiatrists would be a particularly interesting research area, where the research question could perhaps focus on the experiences of those with a greater degree of responsibility on the team and that could include the consultant or a principal psychologist who supervises a number of senior clinicians in a service.

A number of challenges in using the CAMS were found in this study, for example overcoming client rejection of the paper and pencil SSF work. This may be interesting to explore in further detail from both the clients’ and clinicians’ perspectives.

A feature that emerged in this study’s findings was the report of adrenaline driven biofeedback that was ignited when working with risk and is associated with feelings of honour and credit. This could be worth exploring with clinicians in terms of identity and motivation in their work with people who are suicidal.

5.9 Conclusion
The primary aim of this study was to give voice to clinician’s experiences of collaboration when using the CAMS framework with suicidal clients. A review of the literature highlighted many therapeutic challenges for clinicians working with clients who are suicidal, a dearth in the literature regarding clinician perspectives and a lack of qualitative research in the field of suicidology generally.

What this study found was that the experience of collaborating in incredibly complex, involving reflections of one’s own personal process, regulating difficult emotions triggered by the work, finding safety in the CAMS framework structures and collegial support, and navigating wider systemic challenges. A critical review of the research process, in addition to strengths and areas for improvement have been outlined. Key implications for clinical practice and future directions for research have been identified.
References


Shneidman, E. S. (1959). The logic of suicide In E. S. Shneidman & N. L. Farberow (Eds.), *Clues to Suicide*. New York McGraw-Hill.


Appendix 1: Information Sheet

Participant Information Leaflet

Study title: “An exploration of clinician experiences of working collaboratively with clients expressing suicidal intent”

Principal investigator’s name: Brid Fogarty
Principal investigator’s title: Psychologist in Clinical Training
Telephone number of principal investigator: [Redacted]
Co-investigator’s name: Dr. Eoin Galavan
Co-investigator’s title: Senior Clinical Psychologist
Consultant co-investigator’s name: Dr. Malcolm Garland
Consultant co-investigator’s title: Consultant Psychiatrist

You are being invited to take part in a clinical research study to be carried out at [Redacted].

Before you decide whether you wish to take part, you should read the information provided below carefully. Take time to ask questions – don’t feel rushed and don’t feel under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you.

You don’t have to take part in this study.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out. You don’t have to give us a reason. If this situation should arise, any of your data will be removed.

Version 3 Date 17/05/2018
Why is this study being done?

The study seeks to explore the lived experiences of mental health clinicians who work with clients expressing suicidal intent. In particular, the collaborative process of the Collaborative Assessment and Management of Suicidality (CAMS) approach will be explored. Research has shown that there are many challenges for clinicians working collaboratively with suicidal clients, such as personal opinions regarding suicide, the sense of responsibility for another person’s life, the fear of making a mistake or legal proceeding instigated against them, countertransference and personal and professional distress. This study specifically aims to better understand clinician’s experiences of the collaboration process with suicidal clients using the CAMS approach.

Who is organising this study?

The study is being carried out by Bríd Fogarty (Psychologist in Clinical Training), Dr. Eoin Galavan (Senior Clinical Psychologist), Dr. Malcolm Garland (Consultant Psychiatrist) and Dr. Sharon Houghton (Clinical Co-Ordinator at University of Limerick).

Why am I being asked to take part?

You are being asked to take part because you have completed the Collaborative Assessment and Management of Suicidality (CAMS) training and have applied this approach to working with clients expressing suicidality.

How will the study be carried out?

This study will be asking clinicians who work or have worked with the Suicide Assessment and Treatment Service (SATS) to participate in interviews. It is estimated that 10-12 clinicians will complete these interviews.

What will happen to me if I agree to take part?

Following expression of interest, a time and location for a research interview will be arranged between you and Bríd Fogarty. The interview will take between 40 to 60 minutes and will be audio recorded. The interview will be exploring aspects of your work with people who have been suicidal and your experience of the collaboration process. You will have the option to review and amend the transcript of your interview in the weeks following your interview.

All information will be kept confidential and at no stage will the participant or their clients be identified in the findings that are reported.
What are the benefits?

You have experience in the field of applied suicide intervention and your insights and views are therefore beneficial in the field of suicide research. By taking part in this study, you are adding to the literature base on suicide and helping mental health professionals to gain further understanding of the process of working with suicidal clients. The interview may also give you the opportunity to think about the collaboration approach in a way that you have not had the opportunity to do so previously and could be an interesting opportunity to personally assess where you stand.

What are the risks?

Suicide is a sensitive subject and talking about your clients who have had a history of suicidal behaviours and intent may be difficult. Distressing images and experiences may arise in discussing this topic and it is advised that you have appropriate supports in place in the knowledge that you will be discussing this topic.

Is the study confidential?

All information that is collected during the course of the research will be kept strictly confidential. All participants’ identities and the identities of their clients will be made anonymous. The study will be submitted as part of the researcher’s Clinical Psychology Doctoral Thesis. It is the intent of the researcher to apply for the research to be published in an international peer-reviewed journal when complete – the participants will not be identified in any way. An executive summary of the research can be provided for participants on request. In addition, the researcher will offer a presentation of these results to the services of the participants involved.

Where can I get further information?

If you have any further questions about the study or if you need any further information now or at any time in the future, please contact:

Name: Brid Fogarty
Email Address: bridget.fogarty@uws.edu.au
Phone No: 0411 123 456
Appendix 2: Recruitment Email

Recruitment Letter (Version 3) – 17/05/2018

Dear Potential Participant,

My name is Brid Fogarty and I am a Clinical Psychologist in Training in the University of Limerick, working under the supervision of Dr. Sharon Houghton in the Department of Psychology. Along with Dr. Eoin Galavan (Senior Clinical Psychologist) and Dr. Malcolm Garland (Consultant Psychiatrist), we are undertaking research which aims to explore the internal processes of clinicians working with suicidal clients. This research is specifically interested in the lived experience of working collaboratively with clients who are expressing suicidal intent or presenting with suicidal behaviours. In particular, the collaborative process of the Collaborative Assessment and Management of Suicidality (CAMS) approach will be explored.

You are invited to take part in a research interview in relation to your practice and experience from working with this approach with suicidal clients. Interviews will be recorded by the researcher (Brid Fogarty) and transcribed verbatim to be analysed for a research thesis. Interviews will last between 40 minutes and 60 minutes and may involve sensitive discussion in relation to therapeutic process with clients you have worked with. They can be organised to take place in Trinity College Dublin, University of Limerick or at your current workplace. All identifying information will be anonymised, participants are free to withdraw their information at any stage and participants have the right not to answer questions. The purpose of the study is to develop further insight into the experiences of clinicians working with suicidal clients and add insight to the area that may not have previously been researched.

We are inviting you to take part in this study. If you are happy to take part, we would appreciate if you could please contact Ms. Brid Fogarty as soon as possible to enable us to organise a time and location suitable to you for the interview. Please read the information leaflet attached. If you have any further queries about this study, please do not hesitate to contact Brid by phone at or by email at . We hope that you will be happy to take part in this study and to contribute your valuable insight. Thank you for your time.

Yours sincerely,

Brid Fogarty
Psychologist in Clinical Training

Dr. Sharon Houghton
Clinical Co-Ordinator, University of Limerick

Dr. Eoin Galavan
Senior Clinical Psychologist

Dr. Malcolm Garland,
Consultant Psychiatrist
Appendix 3: Consent Form

Participant Consent Form

Study title: An exploration of clinician experiences of working collaboratively with clients expressing suicidal intent

<table>
<thead>
<tr>
<th>I have read and understood the Information Leaflet about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.</th>
<th>Yes ☐</th>
<th>No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand that I don’t have to take part in this study and that I can opt out at any time. I understand that I don’t have to give a reason for opting out.</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>I am aware of the potential risks of this research study.</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>I am also aware that my participation in this study will be audio-recorded and I agree to this. However, should I feel uncomfortable at any time I can request that the recording equipment be switched off. I am entitled to copies of all recordings made and am fully informed as to what will happen to these recordings once the study is completed.</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>I have been given a copy of the Information Leaflet and this completed consent form for my records.</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>I know that I am entitled to full confidentiality in terms of my participation and personal details.</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>Storage and future use of information:</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
<td>I give my permission for information collected about me to be stored or electronically processed for the purpose of scientific research.</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
</tbody>
</table>

Participant Name (Block Capitals) | Participant Signature | Date

Version 2 Date 04/04/2018 Page 1
To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

| | | |
|-------------------------------|--------------------------------|-----------------|-----------------|
| Name (Block Capitals) | Qualifications | Signature | Date |

2 copies to be made: 1 for participant and 1 for PI
Appendix 4: Interview Schedule

Semi-structured Interview Schedule (Version 3 – 22/05/2018)

This is a semi-structured interview whereby I have a list of questions about the topic that I will be asking you. I may also pick up on some of the things you discuss and ask questions about them. Everything you say is useful so please feel free to keep talking if you feel it is relevant.

- How long have you been working in the area of supporting people who are suicidal?
- Approximately how many people have you supported who have been suicidal?
- What has been your experience of client suicidality?
  - Has anybody you’ve worked with completed suicide?
- Tell me a bit about how you work therapeutically with someone who is suicidal?
- In CAMS the therapeutic alliance and working collaboratively with the client is the cornerstone to this approach. For example, the side-by-side seating arrangements and the co-authored assessments and intervention plans.
- What are your thoughts on collaboration with suicidal clients?
- How does this approach feel for you?
- How does the possibility of the person’s death by suicide impact on you?
  - In your personal life?
  - In your professional life?
  - Can you describe to me how this, if at all, impacts on the collaboration process?
- How do you work collaboratively with somebody who is suicidal?
- Tell me a bit about how you fully engaging in the collaboration process?
- Tell me a bit about your fears regarding fault, blame or appraisal when working with suicidal clients.
  - Can you describe to me how this, if at all, impacts on the collaboration process?
- What do you believe makes collaboration possible?
- The CAMS model is used routinely in the North Dublin Suicide Assessment and Treatment Service (SATS). Do you feel acceptance of the model within your team impacts on your engagement with the CAMS model?
- What does the co-authoring process feel like?
- Is there anything that has come up for you in these discussions, that you have not mentioned yet, that you think might be particular relevant to the topic?

Difficult experiences may have been discussed in this interview whereby distress may have emerged for you. Is there anything that we have spoken about that may be distressing for you now? Do you feel you may need additional support in relation to what we have discussed? Would it be helpful for me to give you a call in the coming week? The HSE provide Counselling Services that is a professional, confidential counselling and psychotherapy service available free of charge in all regions of the country. I can provide you with contact details if you are interested.

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These questions are a guideline but it will be up to the researcher to pursue relevant data within the interview and to pose the necessary questions to do so.

Appendix 5: Sample of IPA analysis process (Participant A)
Interview one themes

1. Attachment & own process
   * self reflection
   * difficult emotions with client
   * overcoming trauma
   * interrupted grief
   * seeking support & being vulnerable

2. Connecting with client
   * process of working together
   * connecting authentically
   * exploring suicidality with confidence
   * appreciating client resilience

3. Embracing CAMS
   * confidence in work/skill
   * overcoming barriers
   * safe, pre & post CAMS
   * holding ethical challenges of others not using CAMS.
4. Seeking Safe Spaces
- Safety in my team
  - Tension & anxiety with wider governance system
  - Understanding suicidality through CAMS framework
  - CAMS structure & process
  - MDT support
- Tension in Mental Health System misunderstandings

5. Supporting my team to understand
- Nurturing understanding in colleagues
  - Tensions in MDT
  - Tension as expert in MDT
  - Role modelling & mentoring CAMS practice
  - Keeping client voice at MDT table
- Tension in MDT not supportive
Appendix 6: Ethical Approval

Ethics (Medical Research) Committee - Beaumont Hospital
Notification of ERC/IRB Approval

Principal Investigator: Ms. Brid Fogarty, Psychologist in Clinical Training (HSE/UL)
REC reference: 18/36
Protocol Title: An exploration of clinician experience of working collaboratively with clients with suicidal intent
Consultant Co-investigator: Dr. Malcolm Garland, Consultant Psychiatrist, HSE DNAMHS
Ethics Committee Meeting Date: 16th March 2018
Final Approval Date: 26th April 2018
From: Ethics (Medical Research) Committee - Beaumont Hospital, Beaumont, Dublin 9

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Dr. Peter Branagan
ERC/IRB Convener’s Signature
Approval # 2, dated 15th June 2018*
Appendix 7: Extracts from Reflective Memos

03/08/2018

First interview. I thought it went well. I’m so glad my nervousness subsided when we were chatting before the interview. Key impressing thoughts from that interview:

- Being self-aware
- Seeking support when feeling vulnerable
- Asking directly about suicide; frank and direct approach
- Confidence in skill
- CAMS was big learning moment – difference in working with suicidality pre and post CAMS training
- Team very supportive and reflective
- Psychology looked to for expertise with suicidality
- Keeping the client voice at the MDT table

I’m happy we covered all aspects of the interview schedule in a conversational way. It was a bit stilted at the start but it felt like we got a good flow going. I’m feeling really energised now. I feel like there is a lot of depth in the interview. I’m looking forward to starting the transcribing and analysis to see what emerges from this interview in terms of themes.

22/10/2019

Interview eight. What an interesting interview! She seemed so open, honest, frank and at the same time, really vulnerable. I really felt like there is good data in the interview. That bit at the end about the hero complex is new, she seemed to kind of offer it in secrecy, like a confession – I wonder is it associated with feelings of shame? The way she said “did anyone else mention it to you?” it was kind of like she was checking if she was the only one. I wonder if that kind of rush of adrenaline is sustaining in the work? It can’t be adaptive, but it could be sustaining I guess. Such an interesting interview – looking forward to transcribing that later and processing through it in more detail.
03/12/2019

Finished supervision with [Name]. I was feeling quite anxious regarding the analysis - worrying about getting it right and making correct interpretations. I brought transcript D to supervision with exploratory comments. I’m feeling a lot more reassured that I’m on the right path now. I feel more sure of myself in identifying the emergent themes. It was good to talk it through with [Name]. It was useful to discuss the emotions of trauma that are emerging in Transcript D – feeling guilty when she goes on holidays, hypervigilance to local fatalities on train lines and guilt about abandoning clients when she left that service or went on holidays / maternity leave. It’s really shocking when you put the emotions together like that. I’m becoming more aware to the subtle underlying distress in this narrative that didn’t have that emotional impression in the interview. The dialectical opposition of trauma and nurturance is complex and striking in this transcript – I’m thankful for supervision to tease the complexities of this transcript out together.

03/03/2019

The results chapter is way too long. I have far too many quotes in there – but which ones do I take out? They all seem important! I need to somehow have enough words left for a discussion. I’m finding it tricky to represent Deirdre’s voice and concerns appropriately. I feel like she gets drowned out a little by all the other harmonising experiences. Perhaps this is a reflection of her real life experiences also? Actually, she was quite tentative in sharing those experiences with me, perhaps that is contributing to my general feeling of protectiveness of her voice? I have supervision later – I will have to discuss it then. I’m holding this felt sense of huge responsibility to capture their voices accurately but also, I need to finish this draft soon, time is ticking on.