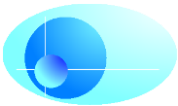
Workshop: Suicide and Therapy

Suicide is a serious topic, and a significant topic of mental health in our society today. Behind every suicide is an untold story of intolerable isolation. In front of every suicide is a sense of desolation, grief, and helplessness shrouded in shame.

'emerging narrative'



Commit (ing) or Act (of) Suicide

Behind the criminality of suicide – or self-murder as it was technically referred to – lies centuries of religious Christian teachings. To kill the self was an act against God and punishable in the afterlife with eternal damnation and eternal suffering. In this world, the body would be denied a Christian burial and instead be cast away, literally, into an unmarked pit, or a ditch. Suicide was a sin, a mortal sin that meant complete at utter damnation without hope of heaven. As the countries of Western Europe shifted from religious to secular societies suicide shifted from being a sin to being an act of insanity. Nevertheless, throughout the period of the 19th and most of the 20th century suicide remained a crime.

A person is tried in a court of law after being caught and are charged with committing a criminal act. So, we have the association, always, of an act committed being criminal. The use of language changes over time to be more discriminating to its meaning and usage. Committing suicide is now being challenged for its usage being associated to criminality. The move away from talking about committing suicide to phrasing that is less prejudicial. We use the phrase 'attempts' suicide so what would we use for a successful suicide? Is it simply that so that we have the phrases attempted and successful suicide? There probably needs to be more said and discussed on this.

I look at the use of language in terms of suicide being an action and in this context actioned suicide is the successful completion of the act, whereas attempted suicide in the incompletion of the act

Common Experiences

I am wanting to bring suicide into the ordinary events of our lives. I want to move us into awareness of the commonality we all have in thoughts and feelings and experiences that for some becomes intolerable and draw them to violence of the self.

> Suicide results largely from psychological pain and confusion and the main source of this pain is imagined, fantasised, and/or real thwarted psychological need … unrealised aggression and enragement against the world. Suicide is a form of acting out [which] we all do some of the time and is particularly prevalent in adolescence when we find

> ourselves confused and overwhelmed by new, impinging, and conflicting desires and impulses. Looking at suicide this way allows us to imagine why and what it must be like to be brought to this point and also to realise it is quite common to get into this state of mind. (Murphy, 2017)

We have in common thwarted desires and needs; we have in common the acting out behaviours to relieve the thwarted needs; we all have in common our sense of self being confused, overwhelmed, and conflicted.

For some, clearly, this becomes much too much. How did this happen; Why did this happen; What is happening?

> Suicide is a deeply profound and destabilising act which raises strong fears and consequently we have an understandable need for authoritative answers. (Murphy, 2017)

Those answers for 'the how' and 'the why' might easily lie within the medical world of diagnosis and pharmacology. However, I do not believe knowing how or why provides anything like sufficient exploration to help. The answer for what is it with this person that thwarted desires and needs hurt so much lie more with the consideration of a starting point of 'what is hurting?' and how 'does this hurt?' Suicide is the (sometimes final) display of the symptom of the thwarted need, the conflictual situation.

> perhaps the most helpful act in relation to the suicidal person: for us to try to tolerate what the suicidal person believes cannot be tolerated by them or about them (Murphy, 2017, pp. loc1182-1183)

As a therapist, you are being asked to tolerate frustration and rejection, and anger, and hopelessness, and despair, and conflicted needs. To tolerate being overwhelmed, and aggression. We are being asked to tolerate that which is intolerable. And remember our common experiences of needs and desires being thwarted; of being conflicted, confused and overwhelmed.

Therapeutic Approach

Clinically we are working from a Humanistic and Relational position an integrative theory of Gestalt (Perls, et al., 1951) and Contact in Relationship (Erskine, et al., 1999). In this framework then I am exploring interventions and therapist presence as relational interactions coming from a position of attunement.

The Gestalt position considers the suicidal actions, whether actual or fantasy, or ideations, to stem from the taking in messages and rulings in childhood that become not so much a 'should be' and more an 'as is' and the conflict arising from this introject needs to be turned inwards, rather than outwards. Theoretically

we are dealing with introjects that have become part of the ground for the client (Mann, 2013) for which the creative adjustment is a retroflected action. So, we have:

> The secret resentments, unmentionable and inexpressible, are retroflected and turn into feelings of guilt and worthlessness – from the torture of which death is the only feasible escape (Perls, 1989, pp. 8-9).

As a result of the unmentionable and inexpressible the emergent crisis is to act against the self. Suicide rather than homicide

The client with suicide thoughts, actions or fantasies is serious – deadly serious. What they are serious about, however, is the million-dollar question. It is not necessarily the act of suicide, and it is an act of killing. An article in the news caught my eye.

> An executive with a decade of experience with an international company was told he was to be made redundant. He killed himself by jumping from his office window. In the course of the months previously in discussions with the Human Resources department he became distressed and spoke of having nothing to live for and may as well jump off a bridge. The HR person never imagined that there was any intent there to do what he was saying. (Boyle, 2017).

Now, I am only speculating when I say that perhaps this man wanted to kill the shame of losing his prestige; of not being able anymore to provide financially for his family. Perhaps he wanted to kill someone for abandoning him. Consideration for the disguised meaning is important. And how many times, socially, might we here outbursts like "I'll kill you if you do that again!", "I've a mind to jump of a bridge!", "oh, just let me die!"

The person is most certainly making a point; is telling you something about the situation they are experiencing. So, to hear someone say "I've a mind to jump of a bridge!" indicates a level of distress that in this moment is encapsulated in the strength of the words. What is it about this situation that evokes this distress? That is what is to be explored.

I'm in two minds

The person making a statement like "I've a mind to jump of a bridge!" is actually splitting into a part of them that will act and a part that will be passive. The act will be to jump, and the passive will be to acquiesce.

> A genuine retroflection is always based upon such a split personality and is composed of an active (A) and a passive (P) part. Sometimes A and sometimes P will be in the

> forefront. "I get annoyed with myself" has more active character, "I deceive myself" more passive character. (Perls, 1969)

In saying "I have a mind.." indicates the separation of the unity of our being into parts; that the mind is separate from the body. What does the body say to the mind that wants to jump? What does the body want to instead? Which 'mind' is thinking of jumping? The thwarted mind? What of another 'mind' – the 'I've been frustrated before' mind, – what does that mind want? We all have these variable voices in our mind. Consider which voice you listen to, and when …

I approach the suicide situation with a view that there is some aspect that person wants rid of and that the circumstances at this time are such that all that seems possible is to kill the Self.

This is the only way

Whatever action is required, whether it be 'how do I get into town' or 'I need a way out of this life', usually we will have options to explore; hopefully others that we can bounce ideas off; someone to ask, to ask advise from. Also, as part of actioning how to get to town, or whether to live, a decision is needed – go on the bus to town, use a taxi; I need to change my job, I will go on a training course, I will learn new skills, etc.

At the time of contemplation of suicide there is a complete loss of relationship with others and the environment. An isolation with the single thought that the action of suicide is the only solution. This then creates the situation without choice. Not having choice supports the isolation from relationships. This then is the subtle and devious aggressive act against the Self – denial of choice.

Change or No Change

Decisions are needed because a change is needed with the current situation. Change is a powerful factor with suicide. More accurately, the resistance to change is the powerful factor. Effectively, what is going on within the state of suicide is that change is avoided and that might be avoidance of what has changed, or avoidance of a needed change.

With the disappearance of relationships and the denial of the situation and the environment the need for any other change also disappears. There is no need to attend to the conflict of changing the tumultuous situation that pushed the person to the precipice of the edge of suicide. More fundamentally, there is no need to change their way of being in the world – the very way of being that has precipitated suicide. Thus, it is not a choice of death, rather it is the avoidance of the choice to change.

For one part of the Self to perform an aggressive and violent act on the rest of the Self it is necessary for the Self to split by the alienation of the rest of the Self to be 'an other', i.e., there is the in-denial-me acting on the alienated-not-me. In this way, the person is able to imagine the situation for the better. Every suicide person has a fantasy to fulfil. The act of suicide is the hope of the hopelessness of the situation.

I want to emphasise what I just said, the person is able to imagine… IMAGINE is to see in the mind; the very mind that is alienating the Self. Imagining provides a rehearsal for the actual and with a person who has reached the edge to suicide the actual has, in fact, disappeared; relationships have disappeared, the living environment has disappeared; the real present has disappeared.

Interruption to Contact (of Self and Other)

Our worlds are co-created, and we each grow up adjusting to situations as best we can, given the circumstances we are in. As children, we create our self by adjusting to our environment and that includes how we behave and think in relation to those adults significant in our life. Here is the foundation of how we act in adult relationships. Our Contact Styles (Gestalt), our Script (TA) (Berne, 1969)

As adults, however, there is a degree of (unconscious) reluctance - resistance - to changing the underlying adjustments made as a child; we merely apply adult language to the rules and adjustments that were made. So here I am talking about, or at least moving to, introjections and retroflections; a fixed gestalt. (Perls, et al., 1951) (Philippson, 2009) (Yontef, 1991) (Erskine, et al., 1999) Also, this is, in the language of Transactional Analysis, Script Belief (Berne, 1969) (O'Reilly-Knapp & Erskine, 2010) (Erskine, et al., 1999)

For example

> The message received as a child is you are troublesome and difficult. This message is the introjection. As a child to ensure some connection to avoid abandonment you replace what for you was excitement (being difficult) and wishing to join in (being troublesome). You replace the excitement and desire with what is acceptable, calmness and studious observation. This substitution is achieved by suppressing the excitement and desire; this is retroflection. The impact of retroflecting the excitement results in an internal anxiousness and behaviour that ultimately displays as obsessive attention to body ailments. Meanwhile retroflecting the desire to be involved results in being distant in relationships.

- So outwardly here is a calm studious attentive individual appreciated and enjoyed by others.
- Perhaps in a close relationship is needy with health problems and emotionally reluctant to open up.

- And deep inside struggling with the containment of excitement and fearful of unbounded excitement; yearning for a close connection and fearful of being, at a minimum, troublesome, at most, intolerable.

The conflict in adulthood is between calm and studious - v - excited and involved. That is, the suppressed excitement and involvement that has disappeared from conscious knowing and sinking deeper into the psyche with each experience and encounter of life. The person was unable to complete the fulfilment of those early experiential needs and "Once an organismic need is condemned, the self turns its creative activity as aggression against the disowned impulse, subduing and controlling it." (Perls, et al., 1994, p. loc 383).

And this is not in awareness. By awareness I mean more than a knowledgeable condition; Awareness is a full embodied sense with cognition, affect and behaviour,

> Awareness is characterized by contact, by sensing, by excitement[1] and by Gestalt formation. (Perls, et al., 1994, p. loc 346)

Reliable Other

The above example is representative of many experiences of many individuals in many families, in many countries, across many times. So, what differentiates those that ultimately struggle with adult (or adolescence) living that has them seeking therapeutic intervention, and for some the descent into isolation from relational contact and suicide?

Unfulfilled desires are destined to repeat and these failures test the resilience and strength to continue. Yet these failures that we are all experiencing are not the damaging aspect that propels some to the suicidal edge.

> … it is not the traumatic event itself that … scars: it is the event unmitigated by healing through relationship …. What is truly damaging is the absence of a healthy relationship following such an experience. … we need a reliable other who will listen and respond to our pain. (Erskine, et al., 1999, p. 6).

Those that might descend into isolation from relational contact and to the edge of suicide will not have had a healthy reliable other to provide the healing through relationship.

[1] Excitement … covers the physiological excitation as well as the undifferentiated emotions. It includes the Freudian cathexis notion, Bergson's Élan vital, … and it gives us the basis for a simple theory of anxiety. (Perls, et al., 1994)

> Neglect and isolation produce a kind of cumulative trauma, a growing set of expectations that others will never be available and that life is difficult and painful. (Erskine, et al., 1999, p. 6).

The vital missing ingredient that limits the suicide state is our interconnectedness; the interpersonal dimension that includes the Self, the Other, AND the Between. Between us, most evident in the physical person to person being, is our relational space and connectivity.

For (Spagnuolo Lobb, 2015) this absence of relational space and connectivity reformulates the view of depression

> … as the lack of a sense of connection with the environment … [where] there is a disturbance of the betweenness, of the experience of being-with the other, which, as regards depression, turns into unreachability … (Spagnuolo Lobb, 2015) (loc 981)

our current societal experiences are dismantling the bonds and experiences of interpersonal living and leaving unfulfilled completion of relational experiences (p. loc 981). Unfulfilled in terms of our need for the witnessing, valuing, and impacting of experience; for closure.

> It is through relationships that a child learns to make interpersonal contact in increasingly sensitive and inclusive ways. It is through relationships that this same child learns to set and maintain boundaries. … To join internal with external contact: to ask for help or to enjoy the interpersonal transactions that make us fully human (Erskine, et al., 1999, p. 5).

We may be moving into an age where suicide is prevalent, if we haven't already.

Depression

I am repeating myself now … The absence of relational space and connectivity reformulates the view of depression

> … as the lack of a sense of connection with the environment … [where] there is a disturbance of the betweenness, of the experience of being-with the other, which, as regards depression, turns into unreachability … (Spagnuolo Lobb, 2015, p. loc 981).

Unreachability

The unreachability is such a hard situation to accept. Hard to accept because it actually shows us the distance that exists and how lacking in power we have to do something that can be

measure as helpful. We feel helpless, yet, actually, we are not, we merely need to take the perspective of the client. What it shows us is that ultimately change cannot be imposed; change only occurs by and from the person.

The Desire to be Desired

> a depressive experience is less related to the frustration of past desires than to the renunciation of the desire to be desired. (Spagnuolo Lobb, 2015, p. loc 907).

We all have a desire of interaction. As relational beings, there is the pull to interact, and this act includes a desire for the other to desire us. This relates to our sense of belonging and reciprocity. With depression, the person has no activation of the desire to be desired. This reduces, may even annihilate, any sense of belonging. As this holds and grips more tightly around the person the sense of belonging extends to encompass the sense of flow of experiences. Thus past, present and future are undifferentiated.

> depressive experiences lack … a perspective of what is going to happen and of the now-for-next[2] whenever it comes to experiencing betweenness, the transition from oneself to another, or the "middle mode"[3]. We are ontologically projected towards the future, and depressive experiences imply a collapse of this ontological dimension of the human being.

Inaction

The undifferentiated flow of time and the lack of desire for desire results in what I want to call inaction. Unlike 'middle mode'

> middle mode, neither active nor passive, but accepting the conditions, attending to the job, and growing toward the solution. (Perls, et al., 1994, pp. 22, loc785).

inaction is a lack attending and without desire for growth or responding to the environment. Energy is not generated nor accessed. It is as if the energies of the world flow around and do not stimulate.

Aggression

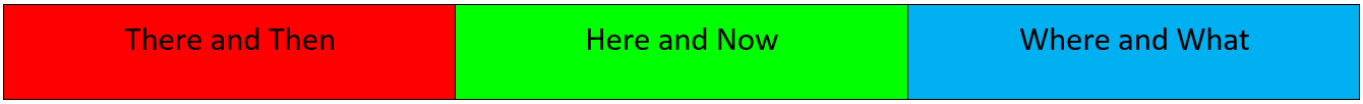
The withdrawal of interpersonal contact is initiated by the removal of aggression from the situation. Yet, aggression is a fundamental element in our being for assimilating change. All change requires destruction,

[2] (Spagnuolo Lobb, 2013)
[3] so admirably described by Goodman (Perls, Hefferline and Goodman, 1951)

which is loss, and creation, which is assimilation. Through various mechanisms aggression within the depressed situation is lost. Often, away from depressed situations aggression is also absent or minimal and this points towards some reasoning for how some individuals succumb to experiences that others shrug off. Namely the retroflection of their aggression.

The Suicide State

The person actioning suicide is in a frozen (present) moment. The frozen moment is the moment that was the present when they stepped to the edge of suicide. That moment that was There-and-Then becomes the enduring presenting time; it is their continuing Now moment. The Here-and-Now is not accessible, and most definitely there can be no contemplation for what might be; where life might go. There is only the There-and-Then being experienced as a continuing Now. For me, this is the suicide state. The state with which we are tasked to provide reachability for this person at the suicidal edge.



So, we need to appreciate that reasoning of what the future holds, what the past has given, and who is here now will so often fall on deaf ears. The person in this suicidal state is cut off from time-flow existence. They are moving more and more into an unreachable enduring moment.

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illustrating this…

In the ongoing flow of time the person has colour in their world and are able to function, generally connect and be able to recognise the world and have an impact.

Mounting frustrations and knock backs, or lack of value, appreciation and lack of recognition (for example) generate feelings along with the unconscious resentments and tensions move the person into a position of defeat, of inaction and this moment freezes in the mind.

Time flows by, and the world moves on however freezing the experience that has already occurred, the moment the person split from the conscious time flow, leaves in the mind this frozen moment as the current experience. So, Time is Frozen – the There-and-Then flows forward with time and so the Here-and-Now is supplanted with this Frozen Frame of experience

Now the person has fragmented, broken down inside and living in the frozen frame which makes the reaching in to make a connection can be so difficult. Not impossible as the many of those who have been talked down from bridges and the like can testify.

Warehouse of Resentment, Hate and Aggression

The person actioning suicide also has retroflected aggression to draw on. The retroflected behaviour has not removed the aggression; it has stored in – in the body, and in the mind. This seems ironic; that burying the aggression that could not be utilised in the historic experiences to protect and assert the Self now

becomes available for the destruction of the Self. Suicide, then, is an act of violence towards the Self rather than towards Other(s).

This context provides for an exploration of the parts of Self of the individual. What part of the Self is wanted dead? What aspect of their current life needs to cease to exist so that all will be better. This approach provides for an exploration with the person of the situation that is intolerable, and the defining of how this is intolerable. This will be shame based.

Whatever comes from such exploration, if anything, points towards a compulsion not to change the self and a compulsion for the situation – the Other – to change instead. So, we have the situation that 'I cannot change, and since the situation cannot change, I must cease to exist in this situation.

Therapist Involvement

The role required is of witness and be attuned, and seek to solve or initiate change. The therapist does initiate the relationship through attuned being. Being in the client's world is sufficient, though it may not feel so. This is sufficient because your authentic initiated communication reinforces the sub-liminal of the person to person presence. Actually, any shift to repair, fix, change etc., interferes with your presence in the client's world. What you are making happen is the client's presence being affected with yours; the client is not aware of this; as you the therapist is not aware of this liminal bonding.

This is about meeting the relational needs of your client, as indeed, is all our therapy work (Erskine, et al., 1999). Probably the single most important aspect of relational working that needs to have prominence is the therapist's willingness to initiate.

> … to have the other person in the relationship initiate the exchange. Any relationship in which I must always make the initial approach, always initiate, always take the first step, will eventually become dissatisfying if not painful. … it can also be important that the therapist begin the exchange and take responsibility for making something happen. … Taking the initiative in a relationship-enhancing way involves more, though, than attunement: it also requires genuine involvement. (Erskine, et al., 1999, pp. 144-145 loc3261-3269).

Yet, with the client that suffers to the extent of contemplating suicide reaching in with this degree of involvement is hard, possibly very hard. As are most clients caught in a depressive spiral.

Your situation is not of being separate, and safe from depression, and grounded. Your situation includes your client, as their situation includes you. As a matter of course you are in a depressive field, a suicidal

landscape that it is important for you to recognise and acknowledge. This is like going from a multicoloured scene to monochrome, to greys and drabness

The Therapist journeys from their world into the nightmare world of the client. In saying this I recall the Robin Williams film 'When Dreams May Come' in which he enters his wife's suicide world to save her. (When Dreams May Come, 1998)

The therapist needs to be able to recognise their own process, and pull to help. Also, it is very important to appreciate the mutuality of being with your client that supports the impact of their situation in yours. The following extracts explain the process that is initiated on meeting the client; an unconscious initiation of mirror neurons that occurs in all meetings of an Other.

Intervention

To reach the person in their frozen time frame and unreachable place at the edge of suicide requires us to relinquish our own sense of being important to this client; the client will not recognise you.

What is required is to be reachable and reliable. Through this the person may recognise and know you.

Initiate your involvement with being where your client is.

> Tell me where you are; how you are. Describe this nightmare so I can be with you.
>
> I will stay here with you, reaching and willing to hold on to you in this intolerable place.
>
> Hold on to me.

Reassurances in these moments are to be clear and confident and it is important the therapist holds the rejection of reassurances from the client.

> I have your hand, I am ok with you, I am not going anywhere
>
> Find me in that darkness, I am with you, hear me, touch me, stay with my voice.
>
> I will not fall, I am strong and can hold you.

Be willing to experience their world and reflect on what their world is like and look to compare with the actual here-and-now moment that involves you.

This exploration is to bridge the frozen experience with the present. This is to provide for recognition of the flow of time and for differentiating old experiences from the now experiences.

The work involves tolerating the client's nightmare and bringing glimpses of your shared world so that the client can be involved in untangling their retroflected behaviour, thought, feelings and bodily responses. This untangling will allow the client to examine introjections and be aware of their own desires and hopes.

The Process of Therapists' Experiential Oscillation

Have you seen the film Taken with Liam Neeson? (Taken, 2008)

Well, in the same spirit of speech…

You will oscillate in your interactions with the client, you will doubt yourself, you will feel a failure. You will feel threatened and you will give advice and help solve the symptoms and you will get stuck.

And you will join your client, and you will relate with your client, you will bridge the abyss and you will find your client.

The following is extracted from (Roubal, 2015) and is the result of research and shows how therapists oscillate in their approach with deeply troubled and traumatised clients; those that seem unreachable. The purpose here is to forewarn and thus forearm you with what to expect and what to do.

> **Phase 1: Sharing depressive experience.** Loc 5938
>
> the beginning … therapists' experience becomes similar to the experience of their depressed clients. Therapists experience self-doubt, feelings of failure, helplessness, hopelessness, and also overall dullness and tiredness. They are experiencing symptoms of depression themselves as if they were falling into depression together with their clients. They are losing distance from their client's experience, they are missing a broader perspective, and they feel that they are being pulled down into the depressive experience themselves … Loc 5955
>
> **Phase 2: Turning to oneself.** Loc 5956
>
> therapists start to perceive co-experiencing the client's depression as personally dangerous for them: "The client is pulling me down. It is killing me". Therapists feel threatened by the situation: "Not to sink into it too Loc 5984

much". The intensity of the therapists' depressive experience is increasing until it reaches a turning point, where therapists stop resonating with their clients' experience. … and instinctively start to protect themselves

Phase 3: Striving for symptom change. Loc 5985

therapists stop co-experiencing depression with the client and take a safer, Loc 6010 experientially-more-detached expert position. … then focus on the symptoms of their client's depression, thus they are able to externalize and depersonalize the overall depressive experience. This prevents them from falling further into co-experiencing depression and provides them with a feeling of distance. They take a more directive therapeutic approach, give practical advice to their clients, and try to help them solve their problems:

Phase 4: Distancing from depressive experience. Loc 6010

therapy … proceeds, therapists experience themselves distancing more and Loc 6040 more from the depressive experience of their clients. Therapists' efforts to change the symptoms of their client's depression appeared fruitless … Encouragement, activity, and an optimistic approach do not lead to any change; therapists are not satisfied with the results of their efforts. The clients are not changing according to the therapists' expectations. They stay depressive, immersed in their feelings of emptiness, resignation, and hopelessness. Therapists get the impression that they are "pushing somewhere where the path is closed" … the therapy situation gets stuck

Phase 5: Turning to a client. Loc 6040

becoming experientially so far from their clients now that they are losing Loc 6055 empathy for them. They protect themselves so much from co-experiencing depression with the client that they temporarily lose their helping position:

In this phase therapists experience most intensively the inner tension Loc 6060 between a natural tendency to protect themselves on one side and their professional responsibility on the other.

Phase 6: Focusing on the relationship. Loc 6061

therapists' experience starts to come closer to the depressive experience of Loc 6073 the client again. Instead of focusing on symptoms, therapists are turning to the relationship now: "I am joining her. Nothing gets better really, we will not come to any solution, will not come to anything [new], but a kind of contact can happen. I am with her, [...] [there is] some kind of a relationship"

Therapists are re-defining their role in the current situation and it helps them to start moving towards the client again: "I stop prompting him to move, and I join him instead" … Resignation to not changing the symptoms but focusing on the relationship instead makes their work personally meaningful again. Loc 6137

Attunement

When a therapist is attuned and conveys the understanding of a client's inner affective state, it provides the client with the experience that one's affective state can be seen and shared by another (Greenberg, 2006). Loc 6139

reaching the other through attunement and bridging the interpersonal "abyss" … created by the depression. Loc 6149

We can notice that a therapist's experience with a mourning client differs from that with a depressed client. With the mourning client the therapist experiences sharing depressive experience, but she does not perceive it as overwhelming or dangerous (as she does with depressed clients). Loc 6153

Different dynamics of mourning and depression Loc 6154

«In the mourning one loses the other to whom one is attached, in the depression one loses the conditions which make it possible to form such a tie» (Francesetti and Roubal, 2013, p. 442). Loc 6165

therapist's attunement to depressed clients can be seen not only as risky for burn out, but also reversely as natural and inevitable for the effective treatment of depression. «Mirror properties in our brains enable us to imagine empathically what is going on inside another person. Internal simulation– the process of absorbing and resonating with others' internal states– is thought to be the first stage of compassion, or "feeling with" other persons» (Siegel, 2012, p. 165). Loc 6173

attunement to a depressed client can be reduced when therapists become more aware of the actual in-session processes. Emotional contagion, which is mainly an unconscious, spontaneous, and involuntary reaction, could then be transformed into empathy, Loc 6194

When a therapist strives too much to pull the client up from the whirlpool of depression, both of them just slip more and more down into the black hole. she only holds the client and focuses on standing firmly herself, the client can stop desperate and useless attempts to clamber up faster and exhaust herself even more in doing so. Loc 6195

(Roubal, 2015)

Afterwards…

Shame, perhaps more than anything, has pervaded in the lives of those left behind by the person taking their own life. To speak of a family member killed by suicide is hushed or not spoken of.

There seems to be a move towards recording actioned suicides as narrative verdicts by coroners avoiding death by suicide in all but the most clear and exacting circumstances.

> Narrative verdicts, those that give an account of how an unexplained death occurred in a few descriptive sentences but do not make a clear pronouncement of any cause of death, are particularly tricky and are on the increase in the UK today. (Murphy, 2017) Loc 1031

Perhaps this is to provide solace to those bereaved; perhaps it is to remove a stigma for the bereaved; perhaps it is to stop inaccurate verdicts of suicide; and perhaps it is to disguise just how many suicides are actually occurring.

> what their increasing use indicates is how widespread and ongoing is our collective wish to disguise suicide. (Murphy, 2017) Location 1041

And suicide is becoming a more talked and discussed topic that will hopefully lead to less stigma and shame though I believe the real reduction of stigma and shame will come with increased education and understanding of the complexity of interactions that exist in living. An education and understanding of our shared nature; shared between all humans, species of animals, and the natural world. An education and understanding that shifts from a blame culture; away from demanding why, or how, and to seeking the what of the situation.

Those left behind…

Murphy (2017) has addressed this in such a way that in making notes and reading them back I decided to copy them 'as is' here…

Chapter Eight: Exploring the Consequences	Loc 1969
"It will generally be found that as soon as the terrors of life reach the point where they outweigh the terrors of death, a man will put an end to his life. But the terrors of death offer considerable resistance." So wrote the nineteenth-century German philosopher Arthur Schopenhauer in his essay, "On Suicide", in his Studies in Pessimism (1891).	Loc 1973

despite our ability to contemplate suicide, not many of us actually go on to kill ourselves.	Loc 1979
Despite out best efforts, and some not so good efforts, suicide is determinedly with us. We do not seem to be able to stay its hand.	Loc 1993
The person who dies by suicide is thinking only about escape, about themselves and about the satisfaction of some fantasy realised. They have broken their connection with the continuity of life, and consequently the continuity of relationship with others;	Loc 1996
the accusation left behind: “Why were you not enough for me?” Sadly this is not an accusation made against a real Other—it is one which whistles in the wind.	Loc 2008
Those bereaved by suicide will have certain things in common with those bereaved by any death but there are other aspects	Loc 2010
a range of emotions and states of feeling from shock, numbness, grief, pain, sadness, anger, and guilt.	Loc 2011
guilt and anger	Loc 2012
are often intense and long lasting.	Loc 2013
“I should have done more.” “If only I had known how they were feeling.” “Why didn't they tell me?” “I can't bear to think about how they felt and that they were on their own.”	Loc 2028
When the person takes her own life the bereaved may well be left with confusing feelings among which could well be relief.	Loc 2032
the bereaved may well be left with feelings that they have failed.	Loc 2042
those who are bereaved by suicide have in front of them a long, lonely, and hard journey to accepting that they will never know all the answers to “Why?”.	

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