Practising Hope With a Client Who Speaks Suicide

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ABSTRACT

Suicide issues have been a consistent concern in Malaysia and everyone within the society has a moral obligation to intervene to prevent suicide. Counsellors are one of the many professional groups charged with this responsibility. The practice of counselling clients in the context of suicidal ideation is a complex and challenging therapeutic process with professional, personal, social, legal, medical, and ethical issues, and with shades of uncertainties inherent to the suicidal threat shaping the counsellor-client relationship. This is a time when it is clear that responsibilities for and influences on practice go beyond the client in the room where counsellors negotiate roles and responsibilities, make difficult clinical judgements and ethical decisions, and take responsible actions. Decisions are not simple and straightforward, and care must be delicately considered for each individual in his or her specific context. In this paper, I present an experience-near account of how professional practice could be shaped by the value of a counsellor's personal lived experience. A qualitative with discursive approach was employed to examine a counsellor's personal lived experience and how she practised hope by taking small steps to support a client presented with suicidal ideation. I show how feminists value positions a counsellor's personal experiential knowledge in her practice to work alongside her preferred theoretical model which she was taught. I argue that the feminist principle of personal-political-professional offers a framework to recognise the shaping effect of counsellors' lived experience in their response to clients with suicidal ideation. My witnessing of counsellor's act of practice provokes me to re-examine my views of professional practice and the relationship between theory and practice. From the perspective of practice epistemology, I question how do one accounts for the kinds of knowledge one acquire from past experiences in life, within the landscape of professional practice?

Keywords: Qualitative research; Interview; Digital tools; Online; Internet

Article Info:
Received 30 March 2022
Accepted 30 April 2022
Published 31 May 2022

INTRODUCTION

In this paper, I present a complex example of Anuja's (a pseudonym) counselling work with a client who threatened to take her own life in the session from Weingarten's (2005) concept of hope. Anuja gifted me the opportunity to hear her speak of having witnessed her own mother's repeated suicide attempts when she was young; as well as surviving her own attempt to take her life. Experts argue that when planning suicide prevention initiatives, individuals with lived experience of suicide can contribute their wisdom to increase awareness and understanding of suicide, as well as improve care for people who speak suicide (Benson et al., 2015; Maple et al., 2016; Suicide Attempt Survivors Task Force, 2014). Anuja's examples of practice offered powerful evidence to demonstrate how a practitioner's personal lived experience can assist counselling practice.

In this paper, I first offer my own practising experience in the Malaysian context and the complex issues I encountered when counselling clients with suicidal ideation. Next, I will describe the research methodology that I drew on to learn about the participant's experiences when counselling clients with suicidal ideation, I next focus on the concept of hope from Weingarten's (2005) perspective. I then introduce Anuja's account of her lived

experience and moves to consider how Anuja's professional practice of care and commitment is shaped by these experiences. Lastly, I discuss my own witnessing, as a researcher, the position Anuja takes up in a counselling space where she lived experience can be valued in offering substantial support for those who are struggling with suicidal ideation.

Situating my research curiosity

I am a counselling practitioner with 13 years of experience in counselling clients with suicidal ideation from all age groups. As a counsellor in Malaysia, I am guided by the Counsellors Act 580 (Laws of Malaysia, 2006b) and Malaysian Counsellor Code of Ethics (Lembaga Kaunselor, 2011). The Act and the professional code govern Malaysian counsellors through a series of legal-ethical responsibilities when they offer counselling services to clients. My counselling practice is also influenced by the Legal Code Act 1997, which can be found in Section 309 of the Penal Code 574 (Laws of Malaysia, 2006a). This law states that: "Whoever attempts to commit suicide, and does any act towards the commission of such offence, shall be punished with imprisonment for a term which may extend to one year or with fine or with both" (Laws of Malaysia, 2006a, p. 125).

As a counsellor, I have negotiated with clients my professional decision to disclose their suicide risk to their families and invite them to counselling in order to increase support for clients. I experienced this as a time of delicate negotiation as I attempted to promote active participation by my clients and their families in the context of the legal and professional situation as well as the stigma that surrounds those struggling with suicidal ideation. This study arises out of my interest in counselling practice at the time of those negotiations.

Describing the research methodology

I applied a qualitative research design with a discursive emphasis to learn how counsellors position themselves within a combination of dominant and alternative discourses and how from these positionings they find different ways of responding to clients and their family members. Research materials were generated in semi-structured interviews with counsellors. This research design allowed me to adopt an "experience-near" (Bondi & Fewell, 2016, p. 30) inquiry in the interviews to engage "in depth with the reality and the lived experience of therapeutic practice" (Bondi & Fewell, 2016, p. 41) of the research participants to investigate accounts of specific and particular details of practices to see what possibly shaped counsellors' responses in the context of suicidal ideation and what positions they took up. It is therefore, this study can be considered as a demonstration of a "power of examples" (Bondi & Fewell, 2016, p. 41) research approach that engages with "the interpretive, reflexive, situated, and context-dependent character" (p. 30) of counselling experience.

To examine the research materials, I drew on Crocket's (2001) discursive analysis which focused on the exploration of discourses-in-action or discursive practices. Crocket introduced this analytic approach as a way of examining "instances of discourse practices" (p. 128) by focusing on "the discourse practices at work producing us as certain kinds of counsellors" (p. 127). In this sense, the analysis of research materials included a focus on the investigation of discourses-in-action to make visible a range of discourses that positioned counsellors, clients, and their families in a conflicting or collaborating relationship, and thus defined client resistance differently.

Some of the philosophical ideas and theories which guided the analysis process include Foucault's concept of discourse and Davies and Harré's (1990) positioning theory. Discourses are referred to as "sets of meanings, metaphors and representations, images, stories and statements" (Burr, 2003, p. 64) that can be found present in our speaking, social practices, and in institutions such as schools, hospitals, prisons, religious organisations (Weedon, 1997). Discourses offer subject positions for one to take up or resist. In my analysis process, an exploration of the practices of counsellors, clients and their families brought me closer to understanding how counsellors were being positioned as they engaged in these practices. Following the positioning that counsellors and other people took up gave me access to identify the playing out of particular discourses, points of tension between these discourses, and the position calls being offered, accepted, rejected, or changed in a power/knowledge relation (see Drewery & Winslade, 1997). Next, I traced the way counsellors and other people negotiated with the discourse(s) to position and reposition themselves, in order to investigate the complexity and variability of power relations that existed in the therapeutic encounter, as well as within the counsellors' working organisations. I called upon Foucault's (1972) ideas of discourse and power/knowledge to illustrate how power was diffused through prevailing and alternative discourses in shaping the practices and conversations the counsellors had had with their clients, and at times with those in their communities or families. As the effects of power became visible, I then unpacked the question of agency to understand how counsellors, while constituted by discourses, could simultaneously change their positioning through resistance.

Furthermore, I also paid close attention to the language employed by the research participants in their narratives, looking for the possibility of reading the research materials more richly and with more complexity. Burr (2003)

argues that language is not an innocent tool of communal interaction as when we speak of something, we produce knowledge. What is being said will situate and define others at the same time as it situates and defines oneself (Davies & Harré, 1999). Both the speaker and listener will be discursively positioned through their respective utterances (Davies, 2003). Davies and Harré (1990) introduce the process of taking up, changing, or rejecting positions in a conversion process as positioning theory, where positioning refers to "the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced storylines" (p. 48).

As discourses allowed certain individuals to say certain things, the language used by research participants to make sense of their worlds was shaped by the discourses that circulated within a cultural context (see Burr, 2003; Davies, 2003). Freedman and Combs (1996) argue that "[s]peaking isn't neutral or passive. Every time we speak, we bring forth a reality. Each time we share words we give legitimacy to the distinctions that those words bring forth" (p. 29). As conversations are dynamic in nature, individuals may shift their positioning as language evolves (Harré & van Langenhove, 1999). Hence, individuals may not keep the same positioning but assume different kinds of positioning during conversations. During the process of negotiating to position, an individual can be discursively constituted as agentic to accept or refuse to position him or herself in relation to available discourses (Davies, 1990). One who exercises agency is one whose identity is recognisable, who has the freedom to speak for him or herself, and is accountable for his or her own action (Davies, 1990).

In my analysis process, I use the concept of positioning and agency to examine what is it in the participants' speaking that constitutes them in particular practices; what discourses are producing this speaking; what discourses does this speaking re-produce; what actions are made possible/more possible or less possible or impossible on the terms offered by accepted positioning. The positioning of counsellors, clients and their families then leads me to explore the complexities of power relations that occurred in a therapeutic setting.

Weingarten's idea of doing hope

Weingarten (2005) suggests that hope is a "verb" rather than a "noun" (p. 159). In these terms, hope functions in a relational context (Weingarten, 2009). Hope becomes the "responsibility of the community. Hope is something we do together" (Weingarten, 2009, p. 354). In therapy, Weingarten (2007) regards hope as "a resource" that both counsellors and clients can "offer or receive, co-create or imagine" (p. 22). Weingarten (2010) describes the idea that hopes are co-created through the "metaphor of accompaniment" (p. 11). She further argues that hope can also be "achieved by taking action on behalf of one's [own] desires or commitments" (Weingarten, 2007, p. 13). Weingarten (2000) believes that people can do hope even when they are feeling hopeless. Her responses to people who feel hopeless can be, "Of course, you feel hopeless. It is not your job right now to feel hope. Rather, it is the responsibility of those who love you to do hope with you" (p. 402, original emphasis). In a challenging situation when a client is unable to do or hold such hope, the basis for the co-creation of hope is that a counsellor can do or hold hope on behalf of the client (Weingarten, 2010).

Anuja's lived experience of suicidal behaviour

Anuja is an Indian woman who practised counselling for two years after completing her counsellor training. She worked in a private university as a student counsellor. In the research interview, Anuja recalled witnessing her mother's repeated suicide attempts when she was a young child:

> *"I have seen my mom attempt suicide many times. She almost cut herself. Then this was what I remembered, she tried to jump out of the car and then we screamed, "Don't do that!" She also almost burned herself with fire, all these attempts really happened in front of us*."

In addition, Anuja recognised how disempowered she had been, even while being aware of her mother's situation:

> *"Whenever I or together with my brother witnessed our mother attempted suicide, we just stood there and begged her by crying loud, "Don't do it Mom, don't do it Mom!" But she still insisted on doing it".*

Cerel et al. (2008) suggest that individuals who are exposed to suicide may respond with symptoms such as posttraumatic stress disorder. Following this suggestion, it is possible that as a child, Anuja may have experienced confusion, shock, anger and guilt (see Cerel et al., 2008), accompanied by a sense of being powerless to help her mother. She appeared to have experienced the threat of losing her mother as ever-present. This experience may have led Anuja to become more alert to suicidal behaviours and to work harder in finding ways to keep her mother alive (see Beautrais, 2004).

At the age of 13, Anuja attempted to end her life by taking an overdose of painkiller tablets. This attempt was not successful as she found herself still alive the next day:

> *"It happened when I was 13, that year [my family and] I converted to Christianity. It was going to be my first Christmas, first New Year being a Christian…and my father questioned me in front of everybody [the family] about my relationship with a 20-year-old guy. I felt ashamed by the confrontation and I cried in front of my family...[because] my father didn't trust me, the man whom I trusted all this while…I took 20-24 tablets of Panadol [paracetamol] and went to my room…I said sorry to everyone on my bed. But then I was crying because I just felt like I shouldn't die, why should I do this. In the back of my mind I did not want to die, but I had already consumed the tablets."*

The range of responses described by Anuja are not unfamiliar. There are frequent reports that at the time of the attempt, individuals experience intense emotional pain, disconnection, depression, and hopelessness (Beyondblue, 2014; Sane Australia, University of New England, 2015). It is also noted that during an attempt, individuals may realise that they wanted to live (Nelson & Galas, 2008): people may experience suicidal thoughts, but they do not actually want to die, instead, they want to end the pain (Caruso, n.d.). In addition, Anuja recalled regret at having followed her mother's suicidal behaviour herself:

> *"I was telling myself, if I grow up, I do not want to do the same thing. Having this thought in my mind, when I first attempted suicide,…I regretted, I wasn't angry, I just regretted, I was like, "You said you wouldn't do what your Mom did, so what have you just done!"*

Anuja reported feeling grateful at having survived, alongside the feelings of confusion, anger, shame, and regret:

> *"I woke up the next morning [feeling] drowsy [and confused,] where am I? Am I a ghost appearing in the house?...Then [I heard] my mom asked, "Hey, how are you now?"…I realised, I touched myself, I am alive!…it mean I was destined not to die…Although [after the attempt] I went through a lot of 'downs' in my life, every nights [I was] crying feeling hopeless…[However] deep down [inside me] I just felt like I have the strength to move on."*

Moving between telling her experience, and making meaning of this speaking, Anuja refused to position herself as being 'hopeless'. Instead, she took up a position to evaluate how this experience had influenced her personal view of life as "precious":

> *"[T]hose things [the suicide attempts of my mother and my own] started to teach me to value life. When I knew I was alive the next day, I just realised that my life is precious. If I would have died, I should have just died, why was I still alive? There was something to achieve, there was something to do, and maybe this experience helped me to understand other people who might be in my shoes one day."*

Here is the beginning of a transformation process for Anuja. Her own experience of an attempt to take her life also brought her to a recovery process. This recovery, in the words of Garrett (1997), was not "a final point, but always an ongoing process" (p. 264). This shift has given her a sense of empowerment to transform, not repeat, the suicidal behaviour. She viewed her being "alive" after the suicide attempt as an invitation to become a valuable and contributing member of our community. Anuja spoke of her desire to offer support to people who presented with suicidal ideation. She also hoped that her insights into "value life" and "understand other people" could provide her with skills to support others in counselling.

Constructing bridges of support

When caring for a mother who frequently considered ending her life, Anuja did not give up hope but continued caring for her mother. Coupled with the insights gained through her own suicide attempt, her cumulative knowledge became valuable in tracing suicidal thoughts and contributed to effective intervention. I now discuss how Anuja applies the wisdom she gained through her lived experience to use alongside her professional training to offer a proactive approach to inviting a client to do hope together in suicide prevention efforts.

When counselling clients struggling with suicidal ideation, Anuja offered flexibility in the frequency of appointments and took initiative to maintain ongoing contact with clients:

> *"For clients who struggle with the suicidal ideation, I will meet them frequently as in daily and once I assess that they are at ease and ok, I will meet them weekly…I usually make*

> *monthly catch-up with my patients, if they don't turn up, so I made [the call] to catch-up. And also sometimes, it always alerts me out of sudden a client's name, or a student's name, appear in my mind, so I just quickly called them saying, "Hey, how are you doing?"*

Anuja gave an illustration of her proactive approach. She spoke of meeting a client during her counselling internship at a general hospital. Anuja explained that this was her first experience of the meeting as a counsellor trainee with a client who presented with suicidal ideation. The client, a young Indian Hindu woman in her early 20s, was referred to Anuja by the Psychiatry Department. According to Anuja:

> *"[The client] was diagnosed with borderline [personality disorder]. She has been sexually assaulted and abused. She was supposed to be admitted to the hospital but they [the psychiatrists] didn't do that, instead she was being referred to me…[The client] said she did not feel her family especially her parents cared for and loved her. She told me that there is "No point living, I think I should die".*

Anuja assessed that the client was seriously depressed and struggling with suicidal ideation. It would be common when a client who struggled with depression and suicidal ideation to work out a plan to take his or her life (Berk et al., 2009; Knafo et al., 2015). Anuja scheduled frequent therapy sessions for the client and the client turned up regularly for her appointments. As the therapy continued, Anuja reported that the therapy seemed to make a difference for the client. The client still struggled with suicidal ideation but it was less present. Anuja then reported that:

> *One day [the client] just stopped coming in. After almost a month…I didn't know what really happened… I called her out of concern."*

Anuja sensed that there was a need for a supportive response to prevent the client's isolation when she did not turn up for an appointment. Anuja took steps as an "active intervener" (Danto, 1991, cited in Colt, p. 320). Colt (1991), an American journalist and author, investigates the topic of suicide by interviewing hundreds of individuals with lived experience of suicide – those who attempted to take their own lives, those who experienced the suicide of a loved one, those who worked with individuals experiencing suicidal ideation – and shared their stories and experiences in his book, The Enigma of Suicide. In a research interview, Bruce Danto, a psychiatrist and former president of the American Association of Suicidology, promotes a proactive approach when counselling clients from this risk group:

> *I think we need to change the role of therapist from passive listener to active intervener… You can't simply sit back in your chair…and say, "All the work is done right here in my office with my magical ears and tongue." There has to be a time when you shift gears and become an activist…Support may involve…visiting a hospital, even making house calls. I would never send somebody to a therapist who has an unlisted phone number. If therapists feel that being available for phone contact is an imposition, then they're in the wrong field or they're treating the wrong patient…Once you decide to help somebody, you have to take responsibility down the line. (Danto, 1991, cited in Colt, p. 320)*

In contrast to Danto's suggestion, the hospital where Anuja worked advised counsellors not to share their personal mobile phone numbers with clients. This advice of not providing a personal mobile phone number to clients could be associated with Beck's (1992) idea of the risk society which the hospital wanted to avoid all possible risks to itself. Anuja's workplace guidelines aimed to reduce risks to counsellors and the organisation by prohibiting their employees from sharing their personal mobile phone numbers with their clients/patients. Another example was for the organisation to position a security officer outside the counselling room. When something goes wrong during counselling, the security officer is expected to intervene to protect both clients and counsellors. These organisational regulations or guidelines reflect how the discourse of risk infiltrates all aspects of an institution's practices. In this manner, the risk society indirectly promotes greater surveillance of professional practice, particularly in mental health services (see Beddoe, 2010). In managing risk, the conduct and practices of professionals are more closely regulated by the laws, code of ethics and institutional protocols.

Anuja's desire to be available for clients had been restricted by this guideline about the personal mobile phone number. She circumvented this regulation of not providing personal mobile phone numbers to clients by taking her own initiative to contact the client from a desk phone in the hospital when the client did not turn up for her appointment. Hearing about the practices or regulations of the hospital and Anuja's preference of care, I hold closely Levinas's (1981) notion of ethics: that in a situation with finite resources, Anuja saw as a priority to offer

infinite responsibility to the Other, that is to call the client when the client does not directly make contact with Anuja.

Holding hope for the client

In this section, I continue with Anuja's story about what happened after she managed to get in touch with the client. When the client accepted the phone call and talked to Anuja, there was a sign of hope for Anuja to re-establish a therapeutic relationship with the client. Anuja related what happened when she spoke to the client on the phone as follows:

> *"[The client said] there was a serious argument at home and she wanted to commit suicide… [I was] shocked, but then I asked her, "What happened?"… It took about 20-25 minutes to calm her down because I let her talk first, I let her cry."*

Anuja expressed shock when she first heard the client threaten to end her life. She heard the seriousness of the situation and remained calm. Her first move was to calm the client. She took steps to re-establish her therapeutic relationship with the client instead of calling on other resources, such as the Psychiatry Department or the police to rescue the client from harming herself. On the phone, Anuja made room for the client's voice by listening attentively to her story during their phone conversations.

By being with the client in her pain, Anuja took a stance to witness the client's experience of stuckness and hopelessness. In the face of such despair, Anuja went on to take up her responsibility to "do hope" (Weingarten, 2000, p. 402, original emphasis) with the client as I illustrate in the next section how Anuja can be seen to do and hold hope for the client.

Through the phone conversation, Anuja heard the presence of hopelessness in the client's speech. In response, she brought in an idea to re-establish the client's relationship with hope. Anuja recalled the hope that the client had told her in their previous conversation. She invited the client to think about the hope she wished for her life:

Then I brought her attention back to our previous conversation about how she wanted to live her life, "I want to go to another state/province, I want to work, I want to be independent, I want to have my own family."

By reconnecting the client with the hope she had had for her future life, an alternative story to the suicide story became available. Anuja continued to weave the thread of hope in their conversation by emphasising care, relationship and the value of life, telling the client:

> *"I care for [you] and [you are] important to me and how important your life is, how precious your life is."*

Anuja used implicit hope-related language to convey a message of her belief in the value of the client's life. However, Anuja reported that the client paid no attention to her efforts and insisted that she would go ahead with the plan of ending her own life. Anuja did not give up, she continued to hold hope for the client. She made hope explicit in their conversation:

> *"I continued saying to her that, "Please give us one more chance, for us to meet, for us to talk. I really hope that I could see you for one last time because I am concerned about you". I also emphasised that "You are important to me and I do not want to lose you". Then, the client finally said, "Fine, I will come for you for the very last time. I will end my life after I see you tomorrow"*

Anuja was seen setting a protective stance in her approach as part of her commitment to value life and she saw herself having the responsibility to make that possible. She used her professional power to take a stance for the client's life. She applied this power ethically within the therapeutic relationship. Anuja strategically and cautiously used her resources and courage as a form of care to support the client. She persistently spoke to the client from a position of care, such as, "I am concerned about you", and "You are important to me and I do not want to lose you". I interpret that from this position of responsible care. Anuja took up the responsibility to hold hope for the client until she was in the position to hold it for herself. Anuja's commitment to caring might have called the client into a different position. In this new positioning, the client was invited to participate in doing hope together by making a small step to meet Anuja the next day. The client's decision to meet marked her first move toward joining Anuja in a suicide intervention effort.

Anuja's personal lived experience informed her commitment to care. She paid close attention to the client's emotional and behavioural changes to help her to support the client. She was persistent when meeting challenges in her practice, rather she shaped her practice creatively to provide care to the client.

Doing reasonable hope together

In this section, I tell how Anuja responded to the situation when the client then came to counselling. The client showed up the next day to meet Anuja as she promised. Anuja reported that a security officer was on duty outside the counselling room as per the hospital's standard practice. In the therapy room, Anuja described that she sat facing the client and listened attentively to the client. Anuja recalled the incident as follows:

> *"[The client] was crying while sharing her story with me, then she said, "No, I'm going to die, I'm going to die"... She took out a knife from her pants, showed it to me, and positioned it at the wrist of the other hand. She said, "See I am going to cut!"*

This is one of those unforeseen situations in counselling practice when a counsellor has to make a decision on the spot. The earlier phone conversation with the client might have given Anuja time to evaluate any potential risks and prepare for the session. However, she was not prepared to meet a client who brought a knife into the therapy. Here Anuja is challenged:

> *"I think my eyes were like coming out, and I froze…I really didn't expect [the knife] because she came in without a handbag or carrying anything."*

Several factors could have positioned Anuja as she watched the client point a knife at her own wrist. One was witnessing her own mother's suicide attempts during her childhood. In addition, Anuja herself was a young beginning counsellor without any specialist training in suicide intervention skills. Therefore, it was not surprising that Anuja might have experienced a momentary frozenness as this was an unexpected event. As Anuja watched and listened to the client threatening to harm herself, a dilemma occurred out of her concern regarding the safety of the client and herself:

> *"I did not know what should be the appropriate response, I mean because that time I was not trained in this, and it was my first encounter and she was actually just 2-3 years younger than me."*

Anuja experienced an aporetic moment (Derrida, 1993) when facing an urgent situation that surprised and shocked her. The immediate concerns of risk, fear and accountability appeared in the space between Anuja and the client. In our research conversation about her counselling practice, Anuja explained what followed next:

> *"I stood up and moved closer to her to grab the hand that held the knife. I did not scream aloud but I said through my teeth, "No, you can't do this". In a moment, we were struggling. I pushed her hand that was holding the knife away from her wrist."*

Earlier in the research conversation, Anuja had told me how she had grown up with a mother who took actions to harm herself. Anuja had said:

> *"There were times when mom attempted suicide, I saw my dad reacted immediately to stop her from harming herself. I saw him doing the action."*

The above is an example of the many responses the family made to Anuja's mother's attempts of suicide: Anuja had witnessed her father reacting spontaneously to save her mother. Anuja's learning from these events offers one interpretation of her response to the client and the knife. By this account, it may be that Anuja listened to the history of her body's wisdom. Her own lived experience in her family prepared her to know that the danger would not overwhelm her. Her family's responses on many occasions were successful in stopping her mother from harming herself as her mother is still alive today. Anuja had witnessed these successful interventions.

When Anuja managed to push the client's hand that was holding the knife away from her own wrist, she described what followed next:

> *"I hugged her. I was confident that she wouldn't harm me, I took the risk and hugged [her]. [The client] was crying."*

Anuja took a risk to hug the client while the client was still holding the knife. A hug in this sense might serve several meaningful purposes, possibly preventing the client from further self-harm, at the same time, providing recognition and validation for the client's suffering. In this context, Anuja's professional judgement may have been influenced by the thought that they were of the same gender. Gender is one of the factors Corey et al. (2015) suggest counsellors consider in determining the appropriateness of touching clients. A hug between members of the same gender probably receives less scrutiny from the public and professional gaze in the gender-conscious society of Malaysia.

I look to Weingarten's idea of doing hope to explore how Anuja intervened by shaping the context – hugging the client – to again facilitate a space for doing hope together with the client. Weingarten calls on the practitioners to take "small, short ant steps" (Kotzé cited in Weingarten 2003, p. 11) towards practising compassionate witnessing. I am echoing Weingarten's suggestion to regard the hug as one of the ant steps of doing reasonable hope with the client. In order for hope to be possible, Weingarten (2010) suggests that it needs to be reasonable to direct "our attention to what is within reach more than what may be desired but unattainable" (p. 7). Doing reasonable hope involves "activity of making sense of what is happening to us, not a positive outcome" (p. 8) that aims at what can be achieved either by oneself or in collaboration with others. Weingarten (2010) further argues that doing reasonable hope is "oriented to the here and now, towards actions that will bring people together to work towards a preferred future" (p. 8). It is this practice of reasonable hope Weingarten (2010) believes may invite clients to hope that something better is possible.

As Anuja heard the client's crying had subsided while hugging her, she spoke into the client's ear, saying:

> *"Give me the knife now. I care for you so much, your life is so precious, give me the knife now*".

She dropped the knife on the floor. I took it and gave it to the security officer outside the counselling room. Once the situation was calm, Anuja then opened the door and handed the knife to the security officer. Even though the knife was not innocent, the security officer did not witness the action that could potentially be associated with harm. The action performed by the client was not visible to him. When he received the knife from Anuja, the meaning of the knife was unclear to him. In addition to this, I interpret Anuja's action of handing over the knife to the security officer as showing that she was aware of the risk and took professional responsibility to remove the knife from the client and the room.

Alongside her lived experiences, Anuja also had the knowledge that the security officer was available just outside the counselling room within hearing distance. In this sense, even though the therapy was private, calling the security officer into the therapy room to intervene was a possible response. However, she did not call the security officer at the moment her client took out the knife. Anuja explained:

> *"I do not want to make a havoc or drama …because whatever happened in the counselling room, sometimes it can be an issue with the people outside…I also do not want this issue to bother this girl more, "Oh my God! People know that I am suicidal…"*

I interpret this as part of Anuja's commitment to client care. If people outside the counselling room became aware of the client's attempt to harm herself, Anuja was concerned about the client being afraid of others' judgement. Anuja tried to protect the client from exposure and thus vulnerability. On the other hand, Anuja's response to the situation in the therapy room could also be understood as produced by a heightened threshold for risk to herself that developed in witnessing her mother's repeated suicide attempts. Anuja could have been recruited by the urgency for the safety of her client and responded with hasty action that placed her own life and her client's life at risk. Thus, I offer two possible readings here. One, Anuja's lived experiences supported her with wisdom, including bodily wisdom, to take responsible action to immediately intervene and remove the knife. Second, her lived experiences produced a blind spot about the extent of the risk to her own and the client's safety.

The giving

As I listened to Anuja share her lived family experience of self-harm and her journey of finding new meanings in these events, I turn to Weingarten's (2000) witness positions to understand Anuja's witnessing experience in relation to the suicide attempts of her mother (see Figure 1). Weingarten introduces a spectrum of witnessing experiences using a two-by-two grid by the intersections of awareness and empowerment. These witnessing experiences are divided into four quadrants that are shaped by one's awareness of significance/meaning and a sense of empowerment in relation to acting in response to what one witnessed. The quadrants range from being (1) aware and empowered, (2) unaware and empowered, (3) unaware and disempowered, or (4) aware and disempowered witness. Weingarten (2003) regards Witness Quadrant 1 as both desirable and constructive for people who witness violence. This position implies recognition that one is a witness to the traumatic event and has the knowledge and skills to help oneself and the others. By contrast, people who find themselves in Witness Quadrant 4 tend to experience distress more intensely. Weingarten (2000, 2003) argues that witnessing experiences can shift from one position to another. For instance, when caring and support are less or not available, the response of individuals who witness such trauma or violence may progress to anger, frustration, or despair that affects the life of an individual and others.

From Anuja's experience, I witnessed her witnessing herself having been transformed from an aware and disempowered witness (Witness Quadrant 4) to an aware and empowered witness (Witness Quadrant 1) (see Weingarten, 2000). She witnessed not only her struggle and despair as a child when her mother was desperate and as an adult when she herself was overcome by desperation but also her pride to be a giver to struggling others. The session with the client ended, and Anuja spoke about her experience:

> *"I felt proud that I saved a life that day…I was glad that I had the courage to call her. I had the guts to talk her from harming herself, I had the thoughts to call in the parents to join our session. It was a gift, God's gift."*

I hold Weingarten's (2000, 2003) witnessing theory close to my heart as I find ways to capture the shape of her words, such that Anuja's experience is heard with compassion. My witnessing position, as a researcher, is to be present to Anuja, her narrative of witnessing trauma, coping, and her commitment to care for the client. In my witness role, I further attempt to understand how I use Anuja's story of her lived experience as resources to develop suggestions that best interpret Anuja's practice when counselling clients who speak suicidal ideation.

In her narrative, Anuja positioned herself as a hopeful person working very hard to "do hope" (Weingarten, 2000, p. 402, original emphasis) with the client. The counselling process discussed in this paper reflected how the counsellor had been doing hope with the client as an approach to suicide intervention. Doing hope actions involved: 1) offering flexibility in the frequency of appointments and taking initiatives to maintain ongoing contact with clients. 2) persistently spoke to the client from a position of care, such as, "I am concerned about you", and "You are important to me and I do not want to lose you" to persuade the client to meet. 3) stopping the client from hurting herself with the knife to facilitate a space for doing hope together with the client. 4) handing over the knife to the security officer as an action to show that she was aware of the risk and took professional responsibility to remove the knife from the client and the room. 5) committing to the client's care by not calling the security officer into the room when the client was threatened with the knife to protect the client from exposure and being judged by others.

Anuja's personal relationship with hope came from her knowing that people could survive desperation. She witnessed her own mother, and she herself lived through the experience of despair. Being a young beginning counsellor intern without training in suicide intervention skills, Anuja consulted her lived experience of suicidal behaviours to help her cope with the uncertain situation of practice. In a situation of imminent suicidal risk, Anuja allowed herself to experience an aporetic moment (Derrida, 1993) of immobility and confusion about what should be an appropriate response. After she composed herself, she then responded in spontaneous actions and judgments that she probably had not thought about prior to performing them and was perhaps unaware of having learned. She took an involved stance to persistently remain available to witness the pain and despair experienced by the client. Anuja called on her 'self' and her personal experience as a resource to traffic between hope and hopelessness with the client. My research curiosity was piqued by Anuja's commitment and how her personal lived experiences had made way for this professional wisdom to be developed in her practice.

My witnessing of Anuja's act of practice provokes me to re-examine my views of professional practice and the relationship between theory and practice. From the perspective of practice epistemology, I question how does one accounts for the kinds of knowledge one acquires from past experiences in life, within the landscape of professional practice? The feminist principle of personal-political-professional (see Blackmore, 1999; Bondi, 2004; Crocket et al, 2009; Hooks, 2000) offers me the framework to recognise the shaping effect of Anuja's lived experience in her response to the client. The idea of the feminist principle of personal-political-professional is taken from the second wave of the feminist movement in the 1960s and 1970s that raised the slogan "the personal is political".

This feminist value positions Anuja's personal experiential knowledge in her practice to work alongside her preferred theoretical model which she was taught. I am grateful to Anuja for teaching me to look widely at the knowledge counsellors bring into therapy, including counsellor-derived knowledge from past experiences. The feminist idea of the interrelationship between personal-political-professional encourages me to take responsibility to bring the politics of lived experience into my counselling practice, learning and teaching.

CONCLUSION AND RECOMMENDATION

An important area of activity was challenging the authority of science and the legitimacy of the knowledge created (Lennon, 1999). The movement questioned and politicised knowledge created through the authoritative scientific experts are considered knowledge. The movement prioritised the voices of knowledge sharing and disseminating information without reference such as personal experience. Hanisch argued in 1969 in defence of consciousness-

raising groups, it is a "political action to tell it like it is, to say what I really believe about my life instead of what I've always been told to say" (Hanisch, 2000, p.113). This led to the idea that "personal problems are political problems" (Hanisch, 2000, p.114). As a counsellor educator, I want to include in the counsellor training programme the helping of students to bear witness to their own personal experiences. I aim to support them to find a space where they can work to be in a self-witnessing quadrant of awareness and empowerment (Weingarten, 2003). Through this witness quadrant, students may become aware of the influence of their personal experiences on counselling practices and call on the appropriate application of these experiences.

TRANSPARENCY STATEMENT

The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

ACKNOWLEDGEMENT

This study was part of the author's doctoral research project, and it was approved by the University of Waikato's Postgraduate Research Committee and Faculty of Education Research Ethics Committee. The author has been granted permission to conduct this research from the Prime Minister's Department via an official coordinating body known as the Economic Planning Unit. The funding body for this study was the University of Waikato Doctoral Scholarship. This research was supervised by Dr Elmarie Kotzé and Associate Professor Kathie Crocket, both from the Faculty of Counsellor Education, Te Oranga School of Human Development and Counselling, University of Waikato, New Zealand.

CONFLICT OF INTEREST

The authors declare no self-interest in the study conducted.

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