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TITLE

The model of dynamic balance in therapists' experiences and views on working with suicidal clients: A qualitative study

SUGGESTED RUNNING TITLE

Dynamic balance in therapy with suicidal clients

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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ABSTRACT

Working with suicidal clients is frequently referred to as one of the most demanding and anxiety-provoking aspects of therapeutic work. The aim of this study was to obtain an in-depth understanding of therapists' experience in treating suicidal individuals and develop a theoretical model of it. Eleven psychotherapists (4 men and 7 women) participated in individual semi-structured interviews. The interviews were audiotaped, transcribed and analyzed by the principles of grounded theory. We developed a model of dynamic balance in therapists' experiences and views on working with suicidal clients. The model includes six core themes, which represent aspects of therapists' experience and views where a dynamic balance is needed between two different poles. The core themes are: (i) understanding of suicidality: the general vs. specific; (ii) the role of alliance: protective factor vs. no guarantees; (iii) attitudes: acceptant vs. life-oriented; (iv) emotional response: worry vs. trust; (v) responsibility: therapist's professionality vs. client's autonomy; and (vi) focus: suicidality vs. individual as a person. The model takes into account other variables that are relevant to the process and outcomes of the therapy: factors, related to the therapist and the client, as well as system regulations and therapeutic setting. The presented model may be helpful for mental health professionals in reflecting on their experiences of working with suicidal clients, describing the relevant topics and the way they relate to each other.

Key Practitioner Message:

- The present qualitative study led to the formation of a model of dynamic balance of therapists' experiences and views on working with suicidal clients.
- The model highlights six core themes that are always relevant in therapy with suicidal clients.

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- Therapists are advised to practice with dynamic balance in the areas described as the core themes.
- The model can help therapists to recognize aspects of their experience that may be useful for them to pay attention to in case of difficult experiences.
- With adapted interpretation the model may also be useful in different contexts.

Keywords: therapists' experience; suicidal clients; grounded theory; dynamic balance; understanding suicidality

1. Introduction

Providing effective treatment and care for help-seeking suicidal individuals is crucial (Hawton & van Heeringen, 2009). However, it cannot be automatically assumed that all mental health professionals feel competent to work with suicidal clients. Individuals with past suicide attempt rarely believe that a professional (or, in fact, anyone) could have helped them or that they would have accepted help (Michel, 2011b), demonstrating the difficulty of the helping professionals' position when encountering an individual in a suicidal crisis. Within the necessary knowledge, attitudes, skills, use of methods and techniques (Rudd, Joiner, & Rajab, 2001), it is relevant to explore professionals' attitudes and subjective experiences of working with suicidal clients, such as emotional responses (Barzilay et al., 2018), experienced difficulties (Rothes, Henriques, Leal, & Lemos, 2014), and therapeutic alliance with suicidal clients (Dunster-Page, Haddock, Wainwright, & Berry, 2017; Jobes & Ballard, 2011; Leenaars, 2006), as these are likely to influence their professional practice directly as well as indirectly, through personal well-being.

While the knowledge base on experiences of mental health professionals who had lost a client due to suicide is relatively extensive, less attention has been directed to the

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professionals' experiences with clients at risk for suicide and those who are in therapy after suicide attempt (Ramsay & Newman, 2005; Yaseen, Galynker, Cohen, & Briggs, 2017). Professionals' emotional responses (e.g. shock, disbelief, fear, self-doubt, and embarrassment) are, understandably, stronger if the client dies by suicide than in case of a suicide attempt (Scocco, Toffol, Pilotto, & Pertile, 2012). However, the inattention to therapists' experiences of working with suicidal clients is intriguing as non-fatal suicidal behaviour is frequent and is an emotionally significant event for the professional (Scocco et al., 2012). Furthermore, a better understanding of these experiences may facilitate further development of the potential for suicide prevention in healthcare.

As one of the most important elements of therapeutic work, a strong therapeutic alliance (the emotional bond between the therapist and the client and their agreement on goals and tasks of therapy) has a great significance in psychotherapy in general as well as with suicidal clients specifically (Leenaars, 2004, 2006, 2011; Michel, 2011b; Modic & Žvelc, 2015; Nienhuis et al., 2018; Orbach, 2001, 2011; Rudd et al., 2001; Schechter & Goldblatt, 2011). Therapists also rely on alliance in their risk assessment, as they assess suicide risk significantly higher if they do not feel that a connection is developing (Aherne, Coughlan, & Surgenor, 2017). Therefore, it is crucial to build a strong therapeutic alliance at the beginning of the treatment (Michel, 2011b).

Working with suicidal clients can evoke numerous difficulties and it is important how these difficulties are coped with (Schröder & Davis, 2004). Challenging emotions, such as fear, worry, aversion, frustration, incompetence, helplessness, discouragement, sadness, anger, and hate, may arise in therapists and lead to unhelpful reactions. As in psychotherapy in general, paying attention to countertransference is crucial, since it may lead to therapeutic inaction or inappropriate over-action (Wingate, Joiner, Walker, Rudd, & Jobes, 2004). The

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therapists' excessive fear of suicide may impede their ability to respond constructively. It can diminish their capacity to think flexibly and lead to alliance ruptures (Hendin, Haas, Maltsberger, Koestner, & Szanto, 2006). Furthermore, professionals' experiences are essential in the context of their own well-being and the quality of their work, since they predict the therapeutic process (Hartmann, Joos, Orlinsky, & Zeeck, 2015). High job demands (e.g. excessive caseloads, demanding clients) and insufficient resources can put the therapist at risk, as they can lead to burnout and emotional withdrawal. Thus, it makes sense to limit the practice to a very few highly suicidal individuals (Leenaars, 2004).

1.1. Aim

This study focuses on psychotherapists who are working with clients that experience suicidal ideation and/or have engaged in suicidal behaviour before or during treatment. The specific aim is to obtain an in-depth understanding of therapists' experiences in working with clients, with which suicidality was a relevant part of therapeutic work for a shorter or longer period of time, and develop a theoretical model of it.

2. Method

2.1. Participants

Eleven professionals (4 men and 7 women) participated in the study. They were aged between 31 and 60 years (M = 39.3; SD = 9.1) and had between 2.5 and 35 years (M = 9.9; SD = 9.9) of experience of therapeutic work within the following orientations: cognitive-behavioral, integrative, psychodynamic, systemic therapy and transactional analysis. Six participants were working in private practice and five in public institutions; however, many of the latter also practiced partially in different private settings. They had at least one experience of therapeutic treatment of a suicidal client, which we defined with two aspects:

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I. The professional and the client were engaged in therapeutic treatment. Crisis interventions and contacts with suicidal individuals outside of therapeutic context were excluded from the definition.

II. The client's suicidality was severe enough for the suicidality-related issues (concern for the client's life, treatment of suicidal thoughts and/or behaviour and effort to lower suicide risk) to become a relevant part of treatment. Suicidality might have occurred at any point of the therapeutic process and is considered as a relevant part of treatment irrespective of the primary reason for the client's entry into therapy and presence of other treatment focuses.

2.2. Procedure

Prospective participants were invited to take part in the study by e-mail invitation, which was primarily disseminated by different Slovenian professional associations of mental health professionals and psychotherapists to their members. Snowballing technique was also used, as the invitation was disseminated through social media and personal communication. The study was a part of a broader research design, within which mental health professionals participated in a quantitative survey and the interested psychotherapists took part in the present qualitative study. We conducted semi-structured individual interviews, guided by the outline presented in Table 1. The interviews were conducted between January and November 2018 at locations that suited individual participants and offered private settings. The interviews lasted approximately one hour. They were audiotaped and transcribed.

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2.3. Data analysis

Qualitative analysis was conducted by the principles of grounded theory, using the ATLAS.ti program (Scientific Software DevelopmentGmbH, 2018) version 8. Data analysis began with the segmentation of data and labeling individual elements with codes. *Initial coding* (labelling parts of data with codes with an attitude of openness to different points of view) was followed by *focused coding* (further use of the most important codes). The two coding levels were partially conducted simultaneously. The first interviews were coded predominantly on the level of initial coding. As we progressively build a more comprehensive understanding of the topic, the coding became more focused. The beginning stages of data analysis took place while we were still conducting the interviews. Following the principle of constant comparative analysis, we updated the latter interviews in accordance with the preliminary findings. We then developed themes through network constructing, which was done graphically by clustering and connecting associated or contradicting codes among each other. As some recoding is typically part of the analytic process (Braun & Clarke, 2013), we made further changes in the codes, e.g. merged codes with similar content and created smart codes (codes that contain several other codes). The analysis was guided by writing memos about the meaning of the codes as well as connections between them and the emerging networks. In line with the complexity of the topic, an essential part of the analysis was making comparisons between observations (Charmaz, 2006). The process led to the identification of several heterogeneous or opposing elements as relevant. It was completed when the themes were theoretically saturated, which means that no new insights to the themes and the model emerged and the newly developed theory was sufficiently detailed.

2.4. Reflexivity

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The first author is a psychologist and a researcher in suicidology. Her professional background shaped a theoretically based perspective on the topic, characterized by the humanistic therapy and the Aeschi approach principles of person-centeredness and therapeutic alliance. She designed the study in consultation with the co-authors, who have both academic interest as well as extensive clinical experience of working with suicidal clients, as supervisors. In accordance with the chosen methodology, the study was designed as a bottom-up exploration of therapists' experience. Even though the literature review was done prior to data collection, the analysis was conducted with an attitude of openness to what emerged from the data. The first author conducted the interviews and analysed them, which included the complete coding procedure as well as themes and model development. She did not have personal experiences of therapeutic work with suicidal clients, which helped her to keep an open-minded stance in this process. In order to ensure convergence, she discussed the data and the developing themes with the co-authors, who provided feedback on the adequacy of terminology, analytical process and interpretation. The findings are reported in accordance with the Guideline for Reporting and Evaluating Grounded Theory Research Studies – GUREGT (Berthelsen, Grimshaw-Aagaard, & Hansen, 2018) to ensure the inclusion of all relevant information into the manuscript.

2.5. Ethical issues and consent

The research was designed and conducted with careful consideration of the participants' well-being. It was approved by the Ethics Committee of the Faculty of Arts, University of Ljubljana. The participants were acquainted with the study procedures and the fact that the results will be reported in a fully anonymized way. They were aware that they may withdraw participation at any point without consequences and that they may discuss any potential

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disturbing thoughts with the researcher after the interview. They expressed their agreement by signing an informed consent.

3. Results

The findings are presented in the model of therapists' experiences and views on working with suicidal clients in *Figure 1*.

--- insert Figure 1 ---

Figure 1. Model of dynamic balance in therapists' experiences and views on working with suicidal clients

The model includes six core themes (understanding suicidality, the role of alliance, attitudes, emotional response, responsibility, and focus of therapeutic work) and additional background themes, identified on the basis of the results. The themes are described and illustrated with quotations in *italic* text. The quotations are edited and parts of text are left out (marked with /…/) to increase comprehensibility and relevance.

3.1. Understanding suicidality

The participants noted various risk factors, vulnerabilities and traumatic experiences that crucially contributed to the clients' distress and suicidality. They mentioned factors related to psychopathology and personality traits (e.g. anxiety, depression, addiction, personality disorders, impulsiveness), emotional distress (e.g. sadness, emptiness, hopelessness, guilt, shame, regret, anger, dissatisfaction with life), low social connectedness (e.g. social withdrawal, loneliness, problems in interpersonal relationships), and difficult life circumstances (e.g. important losses). Furthermore, they described suicidality as an aspect of human experience and a coping mechanism, as illustrated by the following quote:

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"I understand that this [suicidal ideation] helps the client to survive in this moment, in a way." (P10)

The participants therefore demonstrated having basic general knowledge about suicidality. However, they also find it essential to understand the individual client. As expressed in the following quote, this is crucial for successful therapeutic work:

"Why this [suicide] can be the only solution for someone, this must be understood first. If you only have your own interpretation and intention that you have to prevent and redirect the person, you can miss the aspects that vary from person to person so much. In a kind of philosophical way, one should try to approach this topic and think about it." (P06)

Even though general knowledge about suicidality is important, it may be unproductive to rigidly depend on one's professional interpretations, since important insights may only be obtained when the therapist focuses also on the client's subjective experience. The participants also described discussing the meaning and reasons for suicidality with the client; however, these may be difficult to understand:

"We went over this [possible reasons for suicidal behaviour], but nothing was clear there." (P09)

In this example a collaborative exploration of the client's suicidality was an important part of therapeutic work, as this was an enigma that the therapist and the client wanted to understand better. This process was guided by a dynamic balance between offering possible explanations and paying attention to the client's subjective experience in order to increase understanding.

3.2. The role of alliance

The participants believe that a strong enough therapeutic alliance can be a factor that protects against suicide. Firstly, they perceive uniqueness of alliance as a prerequisite for

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the client's openness about suicidality. They rely strongly on its protective mechanisms, such as acceptance, confidentiality, trust, and safety felt by the clients, as described in the following quote:

"That someone is with you, that someone appreciates you, that you are together, so that you can talk about all these things. This means, a sense of confidentiality, trust, safety, that someone is prepared to be with you, with all these difficult emotions. It is definitely a protective factor. I know that it often becomes a protective factor when they think about me outside of therapy." (P02)

Nevertheless, they emphasize that alliance cannot be regarded as a guarantee of the client's safety:

"On the other hand, I shouldn't expect that they won't hurt themselves because of it." (P09)

This statement encompasses the participant's realization that despite the importance of the alliance, ultimately, there are no guarantees that the client will not engage in suicidal behaviour due to the therapist's interventions.

3.3. Attitudes

The participants enable open discussions about suicidality by not avoiding the topic and inquiring about it when needed. They accept the client's suicidality without judgement or stigmatization, since they realize that clients might feel shame, fear or guilt because of it. They find it very important to respect the clients' autonomy regarding their lives. However, when discussing the individual's right to suicide with the clients, they continue by expressing life-oriented attitudes:

"My starting position is that an individual has the right to this decision. /.../ However, that usually, if they give themselves time, other perspectives open up to solve their problem. And I

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suggest considering the possibility that there are other ways. Nevertheless, they will always have that right." (P06)

The participant emphasizes that there are other options with the aim to meet the client's needs by instilling hope and alleviating the experienced cognitive constriction. The therapist might also aim to meet the client's interpersonal needs by indicating that the client matters to the therapist or other people:

"That I know that the client has the right; however, that I would be sorry if he died. /…/ This human approach to another person. /…/ The fact that he has this right had an effect in its own." (P08)

This example also highlights expressing respect for the clients' autonomy as well as life-oriented attitudes. As both are invaluable, the therapist's ability to balance skillfully between the two is the key to successfully convey the intended message to the suicidal client.

3.4. Emotional response

The participants often reported feeling worried for the client, ranging from thinking about how the client was doing to fearing that they might actually hurt themselves. However, they also noted that excessively afraid therapist can not be present with the client here and now, as illustrated by the following quote:

"If we are very afraid of this, we will do everything in order for it not to happen. We are not involved. I think that we are concerned with our own fear of it. /…/ It seems to me that one has to process this – that yes, we can prevent most suicides, we can't prevent all of them. /…/ If you lose your fear of this, then you can openly talk to people also about suicide and their suicidal thoughts." (P06)

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Although fear for the client is a natural response to the suicidal client, the therapists are mindful of the way it can be harmful for the therapeutic process as it interferes with the therapist's ability to be present with the client and to openly discuss suicidality. Participants also noted self-criticism that occurred as a result of feeling anxious while wanting to be strong. Instead of constantly seeking reassurance from the clients, e.g. with no-suicide agreements, they find it helpful to implicitly express the belief that the client will attend the next session, e.g. with a handshake, homework, and use of language:

"I put more emphasis on the next time. /…/ 'What would be your focus, what will we do then.' And everything, not in conditional tense 'what we would', but 'what we will', in the next session." (P09)

Therefore, trust that the client will live may crucially help the therapist to counterbalance the experienced anxiety and respond to the client in the way that conveys the therapist's belief that the client is able to overcome the current state of severe distress.

3.5. Responsibility

The participants feel responsible for the therapeutic process. They may question their competence, which can relate to the ethical requirement to practice within the limits of competence, or feel unprepared if they lack experience with suicidal clients. In response, they seek professional support, such as supervision, intervision and personal therapy. Some participants expressed the sense of responsibility for the client as the need to save and protect the client. However, they emphasize the importance of finding the right balance between own professional responsibility and the clients' autonomy:

"Responsibility. I am a very responsible person. I like to have control and to be responsible for a person. /.../ Caring for others, up until what point to look after them, and where to stop. Where to let them take care of themselves." (P08)

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Further on, the participants discuss the clients' responsibility for their own life in order to empower them:

"I also tried to put some of this responsibility on the client. /.../ I tried to strengthen him by this. I saw it as returning a kind of strength that the client felt that he had already lost. In order for him to become a bit more active." (P10)

Therefore, emphasizing the clients' autonomy does not only affect the perception of the therapist's responsibility; it may also help to view the client as an active partner in the therapeutic process.

3.6. Focus of therapeutic work

The participants share the opinion that suicidal ideation should always be taken seriously. For example, if the client is suicidal, suicidality becomes the primary focus for some time:

"Everything else is considered as secondary and we discuss, I don't know if only this, but for quite some time this is the focus of treatment. Because it seems to me that you can't cope with other things until you have ensured basic safety for the client. That, above all." (P02)

Therefore, the aim of focusing on suicidality is to ensure basic safety. Among the specific methods to achieve this, the participants mentioned interventions such as making safety plans or no-suicide agreements as well as increasing therapy session frequency and additionally referring the client to another professional. However, the participants also believe that it may be unhelpful to overreact if the client mentions suicidality:

"That maybe each suicidal thought is not a reason for an alarm. That this can actually overshadow everything else in therapy." (P01)

This statement indicates the notion that the amount of focusing on suicidality should be skillfully balanced with the focus on other relevant issues in the therapy in order to productively carry on the therapeutic process.

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3.7. Therapist, client and circumstantial background variables

The participants identified several other factors related to the therapeutic process, which are described as background variables, as they are general (not specific for working with suicidal clients) and/or circumstantial (predominantly not influenced by the therapist). Firstly, they noted some relevant therapist's factors:

"I knew that I had a supervisor, that I have my own personal therapy, through which I was processing it. That was very helpful for me." (P08)

This statement illustrates how the participants emphasized the vital role of professional support in facing the difficulties experienced when working with suicidal clients. Other mentioned therapist's factors were related to their knowledge, skills, experience and personal well-being.

Further on, they noted some client's factors, especially their motivation and compliance:

"I felt helpless, yeah. This was perhaps the strongest of all. I was helpless. If the client can't talk about it, I can't do anything, you know." (P10)

The participant experienced helplessness, as the client refused to talk about suicidality. Other participants described similar difficult experiences in cases when the therapeutic alliance was weak or non-existent. In some cases (e.g. with under-age clients) they also mentioned cooperation of the client's family as a factor that may influence the therapeutic process.

Among the circumstantial factors, the participants reported systemic difficulties such as lack of psychotherapy-related legislation and referral possibilities. Further on, one participant noted a dismissive attitude by another professional, who expressed the opinion that suicidal threats should not be taken seriously, which demonstrates an insufficient consensus regarding implementation of procedures among health professionals.

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Finally, the participants described circumstances related to the therapeutic setting. They noted that working with a colleague or in a team is valuable, or even necessary when working with suicidal clients. They also emphasized the importance of taking care of themselves:

"After such clients, I usually take some time for myself; I don't go directly from one to another, because it's too much for me." (P02)

Therefore, organization of working duties is relevant, as the work schedule and the amount of workload should ensure the therapist enough time to restore energy when working with challenging clients.

4. Discussion

The model of dynamic balance (see Figure 1) is a conceptual abstraction of the themes relevant in therapy with clients that experience suicidal ideation and/or have engaged in suicidal behaviour. The core themes are placed in the center of the model as they represent aspects of therapeutic work where a dynamic balance is needed between two different, seemingly opposing or even incompatible poles, specifically concerned with the way the therapist relates to the client's suicidality. Further on, the model includes background themes, related to therapeutic setting and system regulations, the therapist and the client. These variables are presented in the background, as they are less specific to the way the therapist relates to the client's suicidality and/or represent circumstances on which the therapist has limited influence.

General knowledge is needed to assess an individual's risk and decide on preventive measures and therapeutic methods. The participants identified a wide range of known risk and protective factors (Windfuhr & Kapur, 2011), demonstrating their understanding of the complexity of suicidality. They understand suicidal ideation as a response to distress or

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traumatic experiences and view it as a normal phenomenon, which is in line with the attitude that suicidal ideation in difficult moments is normal from the existential point of view and may even be helpful (Holmes, 2011). Professionals' explanations can help the client to feel less isolated and to gain knowledge on their state of mind (Michel, 2011a), which can contribute to decreasing feelings of anxiety and increasing a sense of control and hope (Orbach, 2001). However, each individual's story is unique. Our study shows that the therapist must sometimes set aside their theory-based assumptions in order to understand the client's subjective experience. This is important, as it has been previously noted that the client in a suicidal crisis needs to be heard, taken seriously and understood (Kuzmanić, 2011). As the reasons for suicidal behaviour may not be straightforward, therapeutic work strives towards a shared understanding of the client's experience (Østlie, Stänicke, & Haavind, 2018). Our study shows that the therapists' skillfulness in balancing between the general and the specific is helpful in advancing this process while strengthening the therapeutic alliance at the same time. Therapists' attempts to understand the client's experience are perceived as helpful in general (Modic & Žvelc, 2015) and may facilitate the development of alliance if the client has suicidal thoughts (Michel & Valach, 2011). Through exploration of the experience, the client's understanding of suicidality and themselves may change, which can contribute to overcoming suicidality (Kuzmanić, 2011).

In accordance with the existing knowledge (Michel, 2011b; Rudd et al., 2001), the participants perceive alliance as a protective factor and a prerequisite for therapeutic work with suicidal clients. This is supported by the findings that a trusting relationship facilitates disclosure of suicidal thoughts (Blanchard & Farber, 2020) and that discussing suicidality may help the client not to enact it (Holmes, 2011). It is also in line with the association between the quality of alliance and a lower rate of repeated suicide attempts (Gysin-

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Maillart, Schwab, Soravia, Megert, & Michel, 2016). However, as previously noted (Schechter & Goldblatt, 2011), the alliance cannot be regarded as a guarantee of the client's safety. It may be useful to keep in mind that losing a client due to suicide is considered an occupational hazard in therapeutic profession (Ramsay & Newman, 2005), even though suicide of a client is a significant event that considerably impacts professionals (Grad, 2011). A dynamic balance between relying on therapeutic alliance and accepting that there are no guarantees is needed in order to overcome the potential difficulties related to under- or over-reliance on alliance with the suicidal client.

The participants demonstrated the importance of having acceptant and life-oriented views regarding suicide and suicide prevention at the same time. Their preparedness to address suicidality reflects their understanding of clients' need to be asked directly, encouraging them to open up about suicidality (Blanchard & Farber, 2020). They do not avoid the topic or stigmatize the client, showing that their knowledge exceeds possible stigma-related reservations. In line with previous findings (Rimkeviciene, Hawgood, O'Gorman, & De Leo, 2015) they realize that the client might feel self-stigmatization because of suicidality. Their acceptant attitudes correspond with the empathic approach of assuming the client's perspective to see how they reached the point where suicide seems like the only option (Orbach, 2011). A categorical denial of the individual's right to suicide would imply taking away the client's autonomy, which could cause the client to feel as if the last thing they still control is taken from them. They could feel that the therapist does not understand them (Jobes & Ballard, 2011) and withdraw from the relationship. On the other hand, expressing respect for the client's autonomy demonstrates unconditional acceptance of the client (Modic & Žvelc, 2015; Schechter & Goldblatt, 2011) and empathic listening alleviates the client's sense of loneliness in their pain, building an atmosphere of trust (Orbach, 2001,

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2011). However, life-oriented attitude is needed to shift the client's ambivalence about dying in favor of living (Leenaars, 2004, 2011). Therefore, acceptance must be accompanied by orientation toward life. Our study shows that the therapists realize the importance of dynamically balancing between acceptant and life-oriented attitudes in order to undertake the right approach to suicidal clients.

As in psychotherapy in general, the therapist may feel a range of countertransference reactions and difficult emotions toward the client. According to our findings and in line with previous studies (Rothes et al., 2014), the predominantly experienced emotion may be fear for the suicidal client. Expressed in an appropriate way, anxiety may correspond with the client's needs to be taken seriously and engaged in an empathic interpersonal relationship. The client can interpret it as the therapist's genuine care and an indicator that their life matters. However, as previously noted (Rudd et al., 2001), the participants realize that excessive anxiety may be counter-therapeutic. It may contribute to overusing safety measures (Wingate et al., 2004), potentially leading to the client's withdrawal, and compromise the therapist's capacity for flexible thinking and mentalizing (Hendin et al., 2006). Therefore, trust that the client will live may empower the therapist and help them to regulate the experienced anxiety, which is crucial for the success of therapeutic work (Maltsberger, Hendin, Haas, & Lipschitz, 2003). Our study shows that therapists are aware of the need for a dynamic balance between anxiety and trust in working with suicidal clients.

Professionals are generally responsible for implementing evidence-based high-quality interventions and their confidence to do so is based on knowledge and experiences. However, when working with suicidal clients, their sense of responsibility may also relate to the actual responsibility for the client's life. When a person dies by suicide, guilt, shame and judgement emerge in the deceased's close ones (Poštuvan, 2014), and embarrassment,

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inadequacy or even incompetence in the therapists (Grad, 2011). In the presence of such feelings and the need to find explanations, a certain amount of responsibility for the death could be inappropriately attributed to the close ones and/or professionals who were in contact with the deceased. The burdening sense of responsibility may interfere with the effectiveness of therapist's work (Orbach, 2001). They may feel inclined to take control of the client's life (Goldblatt & Maltsberger, 2009); however, it is important to respect the client's autonomy (Michel, 2011b) and not to take their responsibility away by unwarranted reassurances (Leenaars, 2004, 2011; Rudd et al., 2001). This attitude is constructive for the client, as taking control and responsibility for themselves can help to empower them. Our study shows that the therapists find it crucial to dynamically balance between own professional responsibility and acknowledgement of the clients' autonomy. Professional support contributes to therapists' sense of security and facilitates a dynamic balance in this area.

The participants share the constructive belief that suicidality should be taken seriously. When a client communicates their suicidal intent, this is an aspect of interpersonal interaction that may crucially contribute to overcoming the crisis (Kuzmanić, 2011). Being ignored, on the other hand, may lead to disappointment and withdrawal from the system (Hjelmeland & Knizek, 2018). However, participants also noticed that overemphasizing suicidality would overshadow therapeutic work, hindering the possible pathways to improvement. This is in accordance with the notion that therapy should be multidimensional, targeting also the client's broader needs, e.g. underlying problems, vulnerabilities and symptoms (Brunstein Klomek, Krispin, & Apter, 2009; Hendin et al., 2006; Leenaars, 2004, 2011). Therapeutic changes (e.g. improved well-being, quality of life and coping skills) may indirectly contribute to decrease in suicidality. This broader focus is not

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chosen to avoid discussing suicidality, but because the client's needs are more extensive. It may also resonate in the client's openness, as they may assume that disclosing suicidal ideation would shift the focus to this topic and can withhold such thoughts if this is not something they want (Blanchard & Farber, 2020). The therapist's skillfulness in balancing the focus between suicidality and the individual as a person encompasses the ability to assess when and how it is appropriate to focus on one or the other and flexibility in meeting the client's needs in this regard.

Although most elements of the core themes have been noted and discussed in the literature previously, our study offers some new perspectives on them. Firstly, it emphasizes the need for a dynamic balance between the opposing poles in each of the core themes. These processes resemble the experiential oscillation that was described between getting closer to the client's experience and moving away from it in therapy with depressed clients (Roubal & Rihacek, 2016). However, to the best of our knowledge, the importance of dynamic balance has not been previously highlighted in the areas, which were identified in our study and are specific for therapeutic work with suicidal clients. Further on, the study integrates the themes into a model, where they are presented as interconnected and related to each other. For example, the therapist's skillful balancing between general knowledge and efforts to understand the client's subjective experience communicates acceptant attitudes toward the client and strengthens the alliance. It is related to the therapist's ability to balance own emotional responses and may demonstrate the belief that the client is able to bear the pain and ultimately find a different path (Michel, 2011b). Knowledge and continuous education contribute to the therapist's professionality and balanced view on responsibility. Interventions focused on suicidality and the client as a person are grounded on the therapist's understanding of suicidality, while the therapist's attitudes, emotional responses

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and competences are also important in this regard. Moreover, the therapist's ability for establishing dynamic balance in the core themes is also related to the various background factors, which influence the therapeutic process and may vary between regions and settings (e.g. private practice or public institution). For example, therapists' sense of competence and security are connected to the system regulations and characteristics of the therapeutic setting, as these are related to gaining knowledge and experiences as well as the availability of professional support (supervision, intervision, personal therapy), team work etc. Therefore, we share the view of Schmitz et al. (2012) that provision of suicidality-related training is a matter of systemic ethics. A similar position could be taken about other identified factors at the level of system regulations and therapeutic setting. Although a comprehensive overview of influential variables is beyond the scope of our study, it is important to note their relevance.

Finally, the outcomes of the therapeutic process are considered. The model proposes that in the context of relatively favorable background variables, the therapist's balanced experience and views regarding the core themes are related to positive processes in therapy. This enables successfully meeting the needs of the client with suicidal ideation and/or behaviour. The outcomes on the therapist's part are self-confirmation, contributing to optimal self-reliance, satisfaction, mental health, and prevention of burnout.

4.1. Limitations and future directions

This study has several limitations. The participants were heterogeneous in professional characteristics (e.g. age, years of therapeutic practice, theoretical orientations). Some participants were in training, while others were established professionals. Only a minority of participants had a personal experience of losing a client due to suicide, thus we cannot make conclusions regarding therapists with such experiences, as they may experience

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subsequent work with suicidal clients differently than those without it. Participants referred to diverse cases in terms of the clients' age (adolescents or adults) and severity of suicide risk (between moderate and extremely severe). Participants described their experience and views concerning specific clients or in general. When participants referred to specific cases, these differed in recentness; however, they choose cases that they remembered well. Finally, the generalization of findings is questionable due to the study design and small sample size. Further research should aim to verify the relevance of the model, its adequacy, and generalizability of the findings by the use of different research approaches. It may also be useful to explore the applicability of the model in similar contexts.

4.2. Conclusions

The presented model of dynamic balance in therapists' experiences and views on working with suicidal clients may help mental health professionals to understand different challenges and identify aspects of their experience that should be worked on, e.g. in different forms of professional support, such as supervision and intervision. The model depicts the relevant topics and the way they relate to each other in condense and abstract way, focusing on the therapists' experience and views while noting the presence of important circumstantial factors. The core themes of therapists' experience and views are specifically relevant for therapeutic work with suicidal clients and should always be considered in this context. However, to some extent they may also be informative in a wider sense, e.g. in psychotherapy in general (with a focus on the general part of the core themes), or in encountering suicidal individuals in non-therapeutic contexts (with adapted interpretations of the core themes, especially *the role of alliance* and *responsibility*).

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Accepted Article

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Table 1. *Interview outline with the topics and main guiding questions*

Questions
INTRODUCTORY QUESTIONS
When (in what kind of situations) would you say that suicidality becomes a relevant part of psychotherapeutic treatment?
Please, describe the basic characteristic of a client that you treated and had suicidal ideation and/or have engaged suicidal behaviour (e.g. severity of client's suicidality, presence and characteristics of suicide attempt).
THERAPEUTIC ALLIANCE
Please, draw a graph of the quality of therapeutic alliance with the client through time.
How would you describe the formation of the alliance with the client?
Can you describe your experience of a situation when you had a strong alliance with the client?
Can you describe your experience of an alliance rupture with the client?
What is your view on the importance of the therapeutic alliance with a suicidal client?
SUICIDALITY PEAK
Can you describe your experience of situation(s), when suicidality was most distinctively expressed? When in therapy was this (can you place it on the graph)?
EMOTIONS AND ATTITUDES TOWARD THE CLIENT
How would you describe your feelings and countertransference reactions toward the client?
How did client's suicidality affect therapeutic alliance and your attitude toward the client?
ATTITUDES AND KNOWLEDGE ABOUT SUICIDALITY
How did you interpret client's suicidality?
How did you address suicidality with the client (e.g. talking about suicidality in general, discussing reasons for suicidal behaviour, the right to suicide)?
DIFFICULTIES AND RESOURCES
What kind of difficulties did you encounter in therapeutic work with the client?
What was helpful?
CRISIS MANAGEMENT
What kind of crisis management interventions did you implement?
CLOSING QUESTIONS
Would you like to share any other thoughts about yourself, the client and the therapeutic relationship that came to your mind during the interview?
How do you take care of your own well-being, relaxation, and mental health?
What was it like to talk about this topic? How do you feel now?

Note: Although the questions are written with a focus on a specific client, the interviews enabled participants to switch between referring to specific clients and drawing from several different experiences.

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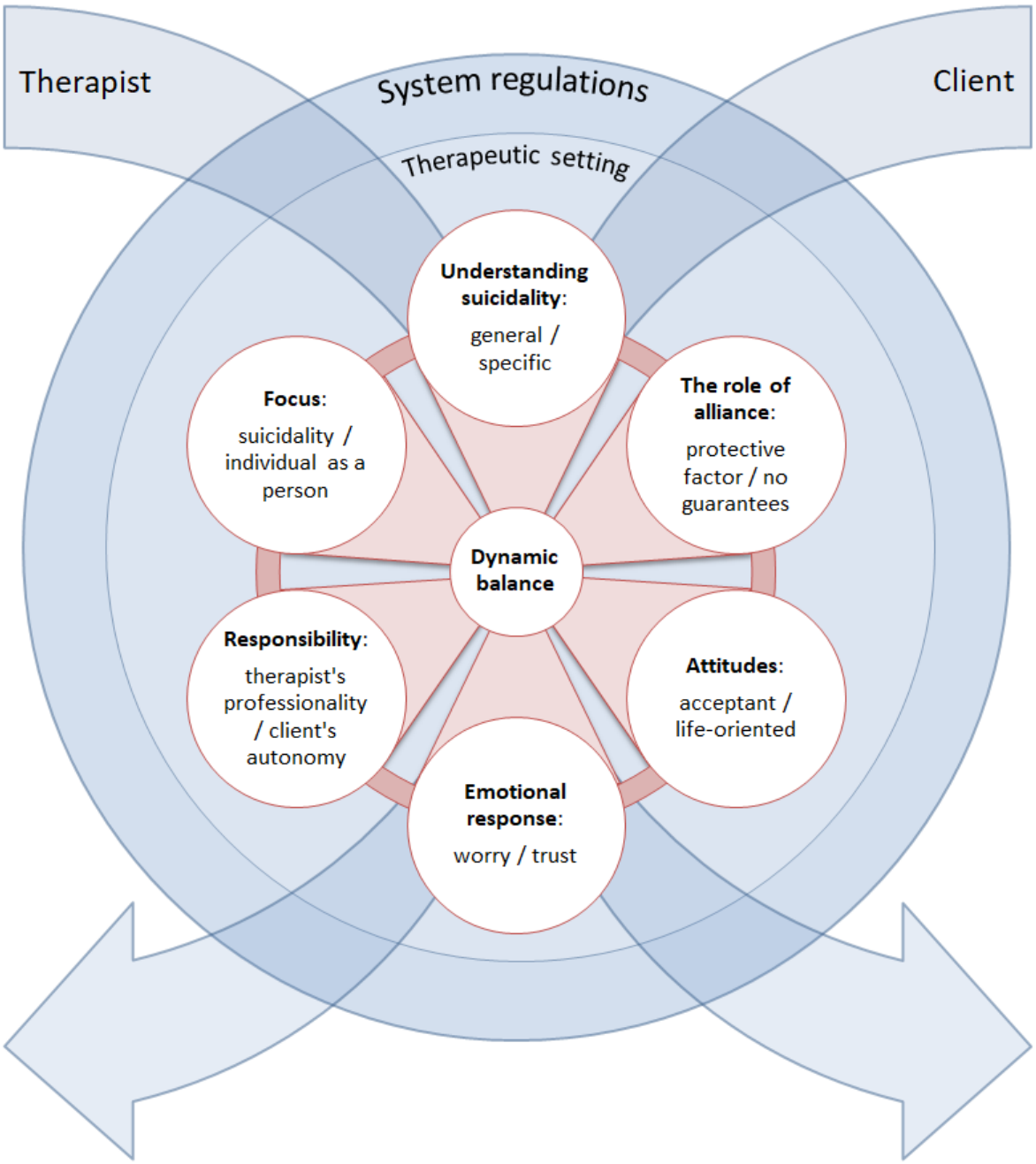

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