Counselling in the context of suicidal ideation in Malaysia

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ABSTRACT

Counselling is particularly challenging in the context of potential harm through suicide. This is a time when it is clear that responsibilities for and influences on practice go beyond the client in the room. Socio-cultural and political influences range across the legislative, medical, religious, cultural, institutional and educational considerations that counsellors must give attention to. In complex and challenging situations counsellors must negotiate roles and responsibilities, make difficult clinical judgements and ethical decisions, and take responsible actions. The ethical principle of 'do no harm' becomes complex and may not be universally understood and agreed upon. Decisions are not simple and straightforward, and care must be delicately considered for each individual in his or her specific context. Manualised approaches to suicide prevention may not always be sufficient in the face of practice complexities.

In this study, I examine the shaping effects of socio-cultural and political aspects on counselling practice in Malaysia in the context of suicidal ideation. I particularly emphasise how counsellors are positioned when these aspects intersect with the counselling process; how counsellors respond to, resist and change their positioning in order to minimise the risk of harm, and enhance life-affirming possibilities. Data were generated in semi-structured interviews with counsellors in Malaysia. Analysis of data included a focus on the investigation of discourses-in-action to bring forward a range of discourses that positioned counsellors, clients and their families in a conflicting or collaborating relationship, and thus defined client resistance differently. A discursive analysis of data illustrated that within the tensions between ethical choice of respecting clients' right to autonomy and protecting client safety, counsellors found ways to engage in practice wisdom and work to co-construct with clients a relational, flexible, care-ful, creative, ethical responsive dialogic practice. The analysis shows how counsellors skilfully and delicately wove counselling, cultural/religious and personal knowledge together to produce practices tailored to the particularity of a specific client, while taking account of serious considerations for client safety. I argue that these practices should be understood through the imaginative possibilities of philosophy, showing how a Levinasian understanding of *the Face of the Other*, and a Derridean

understanding of hospitality, highlight the highly developed relational-dialogic-responsive skill critical to counselling practice alongside clients where there is risk of serious self-harm.

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DEDICATION

I dedicate this thesis in loving memory to my kind and much-loved uncle **黎远来** and brother-in-law **卢锦财** who did not live to see the completion of this project. Life is not the same without you, but you are never far from my thoughts. I feel your spirits with me all the time inspiring me to hold tight to my position no matter how rough the life journey gets.

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CHAPTER ONE
INTRODUCTION

Chekhov's Ivanov

> *I am 40, and already I am spending my days in a dressing gown. With a heavy head and a sluggish soul. Exhausted, broken, cracked. Without belief, without love, without hope ... In love I find no tenderness. In work I find no relief. In song I hear no music. In speeches I hear nothing new. Everywhere I go I feel revulsion for life. (Kramer, 1997, p. 5)*

The above are Ivanov's lines, from the play *Ivanov*, expressing the agony he was experiencing. *Ivanov* is the work of Russian playwright Anton Pavlovich Chekhov, which was first performed in 1887 in Moscow, Russia (Brenner, 1989). Chekhov approached this theatre play from the lens of a writer, a medical doctor and an individual who might be experiencing mental health problems (Lewis, 2006). The play's storyline centres on Nikolai Ivanov, a Russian landowner who struggles with life and takes his own life by the play's end. The range of reactions of the people surrounding Ivanov become the focus of the play (Brenner, 1989). Chekhov does not focus on a singular interpretation frame for Ivanov's problems. He structures the play to offer different opinions about Ivanov's experience through other characters surrounding Ivanov's life, such as his wife, his best friend, his best friend's wife, a young woman who is in love with Ivanov, a physician, and the manager of his estate. Each of them offers different interpretations of Ivanov's experience. These interpretations are shaped by various forms of knowledge, such as medical (physician), and entrepreneurship (estate steward) that produce what is sayable and thinkable. Chekhov does not offer explanations of what lead Ivanov to take his own life. He leaves the audience with multiple meanings of Ivanov's experience and at the same time challenges the audience to "appreciate the possibilities of interpretive diversity" (Lewis, 2006, p. 56). A clear message from the play is that there is no absolute truth to Ivanov's suicide, and that taken-for-granted ideas about suicide could and should be questioned.

Chekhov's *Ivanov* reverberates the unspoken questions I brought to my research project that a singular biomedical model-based counselling approach was not enough for the complex practice of counselling those experiencing despair or

hopelessness, and having thoughts of suicide. A multiplicity of mental health problems and more possibilities for defining the meaning of suicidal behaviour becomes visible through a close reading of *Ivanov*. I am called to learn new ways of thinking and practising by being suspicious of my established values, beliefs and questioned the assumptions about the meanings of suicide. I used this study to investigate counsellors' experiences when counselling clients struggling with suicidal ideation.

I introduce the main threads of and background to my study in this chapter. I first offer my own practising experience in the Malaysian context and the complex issues I encountered when counselling clients with suicidal ideation. I then present the cultural landscape that shape the perception of suicide and counselling practice in Malaysia. Next, I offer a brief overview of suicide prevalence worldwide and in Malaysia, including the initiatives taken by the Malaysian government to prevent suicide. I also discuss counsellor education to highlight counsellors' preparedness in responding to clients with suicidal ideation. I then present social constructionism and the idea of knowledge as socially constructed and the constitutive force that language plays in the construction of knowledge specifically in counselling dialogues. I conclude this chapter by presenting the research questions and the organisation of this thesis.

Situating my research curiosity

I am a counselling practitioner with 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). This law has a significant effect for how the wider society views suicide, and for counselling practice. However, reporting

suicide risk remains voluntary as the law does not have a mandatory reporting regulation under the Penal Code 574. This gives counsellors the discretion to report the suicide risk of a client when the client is judged to be at imminent suicide risk.

As a counsellor, I have negotiated with clients my professional decision to disclose their suicide risk to their family 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.

In responding to clients who express suicidal ideation, counsellors are expected to protect client safety while at the same time managing multiple tasks. These tasks include assessing suicide risk, engaging clients in understanding possible reasons for suicidal ideation, responding to requirements of the law, the professional code, and considering cultural aspects in a clinically sound and ethical manner (Reeves, 2010). When there is an immediate risk of a client taking his or her own life, counsellors are required by the law (discretionally), the professional code and perhaps institutional protocols to disclose the suicide risk to the relevant authorities or the client's family members in order to protect client safety. In some situations when a client's family members are not available, involuntary or emergency hospitalisation of a client may be necessary.

Contacting a client's family members and engaging them in the counselling process can be a challenging task for counsellors practising in Malaysia because of the suicide legislation, family values, parenting practices and stigma surrounding suicide. Although the decision to alert the client's families about suicidal ideation is an ethical move, I encountered some forms of resistance from clients and/or their families. For example, some clients resisted my suggestions to inform their families or to refer them for psychiatric assessment. When I informed clients' family members about the suicide risk, some families might perceive this information as humiliating, and turning the table by blaming me for what they saw as putting the idea of suicide in their child's/family member's mind. In addition, the cultural values related to parenting practices might produce different meanings to the

concept of confidentiality to clients and their families. These situations often challenged me in my work to obtain consent from clients to notify their families and to deliver the news to families. This work involved delicate difficult negotiation with clients and their families.

The study of Jacobson, Osteen, Jones, and Berman (2012), which was conducted in the United States, indicated that some counsellors avoid facing clients' families because communicating about their family member's suicide risk produces extraordinary stress for professionals. Counsellors receive mixed reactions from the families when they are informed of suicidal ideation of a family member (Slovak & Singer, 2012). Some families react by disagreeing and arguing that their child/family member is not at risk for suicide; some minimise the risk by perceiving the risk is not as serious as the counsellor believes; and there are also families who experience shock as they are not aware of their child's/family member's problem or they might have suspected but not acknowledged the risk (Slovak & Singer, 2012). It was my hope to find out in my project how counsellors approach clients' families with the information, what challenges they faced, what skills they called on and what actions they took.

There is a strong cultural stigma surrounding suicide and suicidal ideation in Malaysia (Foo, Mohd. Alwi, Ismail, Ibrahim, & Jamil Osman, 2012; Vijayakumar et al., 2008). People of all religions in Malaysia view suicide with great repugnance. Death by suicide is considered a 'bad death' that family members may experience shame, judgement or social exclusion (Feigelman, Gorman, & Jordan, 2009; Sudak, Maxim, & Carpenter, 2008). Historically, people who take their own lives are perfunctorily and hurriedly cremated or buried, denied the proper customary funerary rituals accorded to those who die 'good deaths' (Leach, 2006). Although many of these traditions are not practised in contemporary society, suicide is often seen as shameful to both individual and collective family. For family who lost a loved one to suicide, this shame may lead to family's decision to keep suicide a secret. In most situations, medical pronouncements on suicide diagnose an individual with suicidal ideation as displaying a symptom of a mental health problem (Marsh, 2010). For an individual struggling with suicidal ideation, this diagnosis frequently adds to the shame and embarrassment to the individual and his or her family (Azhar, 2003; Foo et al., 2012; Loo, Wong, & Furnham, 2012; Sudak

et al., 2008). Given that suicide is commonly associated with embarrassment, disappointment, shame, fear of judgement and labelling, people experiencing suicidal ideation are often wary of expressing their struggles openly. This knowledge and experience motivated me to examine how counsellors build relationships with clients that are safe, comfortable and open enough for them to talk about suicidal ideation.

Embarking on this research, I was curious to investigate counsellors' skills and abilities to negotiate socio-cultural and political aspects while holding up their responsibility to protect the safety of clients, respecting client autonomy, and arriving at an ethical decision. I now introduce some Malaysian cultural beliefs to offer a better understanding of communication patterns, family values and parenting practices, which play a crucial role in shaping counselling practices, as well as clients' and families' responses to counsellors' therapeutic interventions.

Malaysian cultural landscape

Malaysia, a federal constitutional monarchy in Southeast Asia, shares borders with Thailand, Singapore, Indonesia and Brunei (Forbes, 2003). Malaysia is a country with great diversity of religious and cultural beliefs and practices (Gannon & Pillai, 2015). It has a multiethnic and multicultural population of 28.4 million people in which 68.6% are Malay people, who are Muslims by birth; 23.4% are Chinese people, who identify as mainly Buddhists, Taoists and Christians; 7% are Indian people, who are mainly Hindus; and 1% of other ethnicities (Department of Statistics, Malaysia, 2016).

Whilst Bahasa Melayu (Malay language) is the official language, various Chinese dialects, Indian and indigenous languages are also spoken, with English broadly used in the context of commerce and education (Smith, 2003). Islam is the religion that all Malay people subscribe to, but the country's constitution allows people from other faiths freedom of worship. Many religious festivals of different religions are nationally gazetted public holidays, for example, the Birthday of Prophet Muhammad, Hari Raya Aidil Fitri, Hari Raya Haji, Deepavali, Wesak, Thaipusam, Christmas, and Chinese New Year. People from different ethnic groups and believers of different faiths celebrate these festivals in public (Gannon & Pillai,

2015). During such festivals, Malaysian people who had migrated to towns and cities will travel to their family home in the suburbs or villages to celebrate with their families and friends. The practice of returning to a home village for the festive seasons is referred to as "*balik kampung*" (Gannon & Pillai, 2015, p. 247). *Kampung*, is a Malay word which means "a birthplace, a location where one's parents live, a hometown, [or] a vicinity where one's extended family lives" (Din, 2017, p. 36). *Kampung* may also represent "a place of emotional significance that one feels connected with a degree of belonging" (Din, 2017, p. 36-37). *Balik kampung* is commonly observed across all ethnic groups (Din, 2017; Gannon & Pillai, 2015). The practice of *balik kampung* speaks of the value of filial piety, attachment and obligation to the group to which one belongs (Din, 2017; Gannon & Pillai, 2015). The relationships with parents, other family members and friends who live in the *kampung* are also strengthened through this practice.

Interpersonal relationships among members in the groups (family, tribe, nation) are emphasised in the Malaysian culture. Social control is also managed through these relationships to ensure conformity of group members to social norms and values. In such a cultural context, most Malaysian people tend to have a strong sense of hierarchy, and respect for authority is seen as a virtue (Hofstede, Hofstede, & Minkov, 2010). Individuals with authority are regarded as significant role models of expert knowledge and wisdom. For example, at home, parents are role models and children are taught to respect their parents and be obedient to the family's rules. At work, subordinates seek direction from their supervisor whose position is higher in hierarchy. At school, students are expected to respect their teachers and it is common that students are often reluctant to ask for help when they are in doubt. In counselling, counsellors are commonly viewed as experts, thus clients often feel uncomfortable to take a participating position and expect counsellors to take an expert position.

Relational way of communication patterns

Within everyday relationships, Malaysian people are expected to uphold the values of politeness, helpfulness, dependence, and trust so as to preserve harmonious relationships with others and to avoid confrontation (Abu Talib, 2010; Dahlia, 2008; Raja Mohan & Sorooshian, 2012). In a business or social meeting,

relationship building is often priortised before getting down to serious discussion or performing a task. It is thus common for many Malaysian people to exchange pleasantries with others or to set the scene for the meeting (Abdullah, 1996). Such practices create the context for face saving, which is a core social value and maintains social harmony as well as personal relationships (Gannon & Pillai, 2015).

Face saving refers to ways of speaking or conducting oneself with the purpose of protecting one's dignity or reputation and/or those of others by avoiding embarrassment or humiliation to self and/or others (Dong, Xun, & Robert, 2013; Edelmann, 1994). Ting-Toomey (1999) identifies this communication process as *facework*. Drawing from The Shorter Oxford English dictionary on historical principles, the concept of *face* is Chinese in origin, and is associated with two Chinese conceptualisations: liǎn (脸) and miànzi, (面子) (Fang, 2003; Ho, 1976). According to Lin (1936), this *face*:

> is not a face that can be washed or shaved, but a face that can be "granted" and "lost" and "fought for" and "presented as a gift" […] Face cannot be translated or defined. It is like honour and is not honour. It cannot be purchased with money, and gives a man or a woman a material pride. It is hollow and is what men fight for and what many women die for. It is invisible and yet by definition exists by being shown to the public. (p. 190-191)

Miànzi (面子) refers to an individual's prestige or reputation in the eyes of others, it is "a reputation achieved through getting on in life, through success and ostentation. This is prestige that is accumulated by means of personal effort or clever maneuvering" (Hu, 1944, p. 45). Miànzi (面子) is thus seen as being a status 'granted' by others. Liǎn (脸) refers to one's "moral character" that he or she reflects when interacting with others (Hu, 1944, p. 45). This dimension of face is the respect an individual receives from others for his or her "good moral reputation" (Hu, 1944, p. 45). When one loses his or her liǎn (脸), a person may experience rejection from other members within the community and find it difficult to "function properly within the community" (Hu, 1944, p. 45). Liǎn (脸) therefore must be earned, it cannot be 'given' by others.

In Chinese culture, one can lose face (Chinese: 丢脸, [Diū liǎn]) or give face (Chinese: 赏脸, [Shǎng liǎn]) to self and others. For example, when a teacher makes a statement in class and students do not grasp the meaning of the statement, most of them may prefer to remain silent and pretend to understand. The silence serves a double purpose. On the one hand, silence may indicate their need to 'save' their own face and avoid 'losing' their face (Chinese: 丢脸, [Diū liǎn]). They may be hesitant to ask the teacher to clarify the statement as by doing this may show their own weakness in public and reflect that they are not as smart as others. On the other hand, the use of silence may signify their desire to 'save' a teacher's face. The students attempt to give face (Chinese: 赏脸, [Shǎng liǎn]) to their teacher as a way to respect and preserve the teacher's position and reputation. Expressing disagreement, or interrupting their teacher especially in a public setting is considered culturally inappropriate as it may be seen as questioning and disrespecting the teacher's expert authority.

Face saving plays an important role in the communication patterns of most Malaysian people. The desire to 'save' one's own face and at the same time respect others' shape people's interactional behaviours. To meet this desire of saving face, people tend to make indirect statements in their conversations, such as implying, hinting, or suggesting; and use non-verbal communication, such as silence, facial expressions, tone of voice, or body language (Abu Talib, 2010; Gannon & Pillai, 2015). The responses from an indirect statement can be interpreted as ambiguous and thus meanings can be left open or unsaid. This may be important to preserve relational equilibrium (Ting-Toomey, 1999). These communication patterns and values shape the way clients indirectly express their concerns and respond to counsellors' expectation to speak. The ability to recognise the culturally specific meaning attached to clients' utterances and indirect way of communication facilitate counsellors' understanding of the moment-by-moment conversations. This may contribute to the development of the counselling relationships with clients in the context of suicidal ideation (see Abu Talib, 2010).

Family values and parenting practices

High commitment to a group can place great value on family as a social structure (Abu Talib, 2010; Gannon & Pillai, 2015; Othman & Abdullah, 2015). Family is the first loyalty and primary obligation for its members. This is where an individual may be expected to sacrifice their own needs and interests for the good of their parents or the family's good name and status (Abu Talib, 2010; Mak & Chan, 1995; Meer & Vandecreek, 2002; Raja Mohan & Sorooshian, 2012). The family relationships are mostly defined by hierarchy requiring much respect for the elderly especially male members (Abu Talib, 2010; Othman & Abdullah, 2015). Parents play an important role in promoting the attitude of respect for authority of their children from an early age. Parents are regarded as authority figures and children are expected to obey their parents' directives or wishes with limited room for self-expression (Keshavarz & Baharudin, 2009). A behaviour of 'talking back' to parents is considered disrespectful in many Malaysian families. The practice of respect for authority is related closely with the concept of filial piety, which is an important cultural value that governs the familial relationships of the majority ethnic groups in Malaysia (see Rao, McHale, & Pearson, 2003; Tiwari & Pandey, 2013; Zawawi, 2008). I further explore the topic of filial piety in Chapter Three.

Group interdependence is fostered while personal autonomy is less encouraged among family members (Abu Talib, 2010). When facing life challenges, it is culturally acceptable for individuals, even well into adulthood, to consult their parents or older members of the family before making decisions as part of their filial conduct (Abu Talib, 2010; Baptiste, 2005; Mak & Chan, 1995). In such a context, family often becomes the main source of support for individuals. In addition, Chinese and Indian families often treat individual problems as private family affairs, which are not to be disclosed to outsiders (Baptiste, 2005; Mak & Chan, 1995). Most parents expect their children to seek advice from within the sanctity of the family (Abu Talib, 2010; Almanzar et al., 2014; Mak & Chan, 1995; Meer & Vandecreek, 2002). In this respect, seeking external help may indicate poor guidance and discipline that one has received from parents/family (Keshavarz & Baharudin, 2009). This help-seeking behaviour of a child/individual may in turn lead parents/family to experience a loss of face and shame.

Parents often place high emphasis on the pride and shame principle as a parenting practice. Children are required to behave in accordance with family expectations and prevent shame to the family (Baptiste, 2005; Keshavarz & Baharudin, 2009; Mak & Chan, 1995; Meer & Vandecreek, 2002). It is believed that the actions of an individual contribute to his/her family's *face* (Abu Talib, 2010). A successful child or adult child enhances family pride, while inappropriate behaviour not only reflects poor parenting, but brings shame as well as dishonour to the family name. The responsibility for a child's well-being is emphasised to such an extent that the parents call on their rights to monitor and have knowledge concerning the whereabouts and activities of their child (Van Schalkwyk, 2010). These cultural and parental expectations regarding what is acceptable and what is not shape individuals' experiences and behaviours, understanding of the question of confidentiality and responses to suicidal ideation.

The cultural values and norms practised by most Malaysian people produce what can be viewed as 'good' behaviours for parents and their children. 'Good parents' in the Malaysian context are those who nurture and offer support to their children, as well as closely monitor and stay involved in their children activities. On the part of children, 'good' behaviours include demonstration of filial piety and loyalty to parents. An individual who does not live up to their parents' expectations may experience tense relationship with family members or be at risk of being disowned as a punishment (Baptiste, 2005; Conrad & Pacquiao, 2005).

The burden of suicide in Malaysia

We live in an era where the prevalence of suicide continues to be a global health and social problem that devastates individuals, families and communities. Globally, The World Health Organisation (WHO) reported that approximately 800,000 people took their own lives in 2015, situating suicide among the leading 20 causes of death (WHO, 2016). This represents a suicide rate of 10.7 per 100,000 population, with men are almost twice as likely as women to take their own lives. WHO estimates that approximately 1.53 million people will end their own lives in the year 2020 (WHO, 2012). Cross-nationally, Eastern European countries recorded the highest suicide rates, Central-South American and Eastern Mediterranean

countries the lowest rates, with suicide rates in the United States, Western Europe, Asia and Africa somewhere in the middle (Nock et al., 2008).

The tasks to reduce suicide rate and prevent suicide remain challenging for many countries worldwide (WHO, 2014). WHO calls for more research to develop better understanding of suicide, the determinants of suicidal behaviour and mental health interventions to support people at risk of suicide (WHO, 2014). The majority of prevention and intervention strategies are initiated by government and local communities to reduce suicide. In recent years, initiative has been to shift suicide prevention and intervention strategies from an approach of psychiatric diagnosis and individual pathologising effects, to prevention and intervention support within families and communities (Community Action on Suicide Prevention Education and Research, CASPER, 2011; LaFromboise, & Lewis, 2008; Wexler et al., 2016). Prevention and intervention programmes frequently include a combination of: mass media campaigns; public education campaigns to promote awareness within schools and at the community level; and improved access to, and community linkages with, mental health services, such as counselling and suicide helplines. In addition, in some places there are restrictions on lethal means such as firearms, and restricted access to 'suicide hotspots' such as bridges and high-rise building (CASPER, 2011; WHO, 2012).

WHO (2016) claims that for each individual who died by suicide there are more people attempting to end their lives and struggling with suicidal ideation. The conceptualisation of the term suicidal ideation in my study draws from the Australia's Headspace National Youth Mental Health Foundation (2009): "thoughts that life isn't worth living, ranging in intensity from fleeting thoughts through to concrete, well thought out plans for killing oneself, or a complete preoccupation with self-destruction" (p. 1). Research shows that individuals experiencing suicidal ideation are more likely to attempt to end their own lives (Bernert & Roberts, 2012; Forster & Wu, 2002; Nugent & William, 2001). A survey carried out cross-nationally by Nock and colleagues (2008) in conjunction with the World Health Organization and World Mental Health Survey Initiative estimates that 60% of individuals struggling with suicidal ideation attempt to end their own lives within the first year of onset.

In Malaysia the Institute for Public Health (IPH) of the Ministry of Health carries out a National Health and Morbidity Survey (NHMS) regularly to gather information about the pattern of common health problems experienced by its population. The NHMS 2006 reported that 6.3% of 36,519 research participants included in the survey disclosed that they were struggling with suicidal ideation. Of this group, 11% were individuals between 16-24 years old (Institute for Public Health, 2008). The NHMS 2012 reported that 7.9% of individuals age between 13-17 years old experienced suicidal ideation. This number increased to 10% in 2017 (Institute for Public Health, 2017).

Suicide is a public health problem in Malaysia. In 2000, an estimated of 5.3 per every 100,000 people took their own lives (WHO, 2018). This rate saw a slight increase to 5.5 per 100,000 in 2016 (WHO, 2018). It is possible that this estimation could be much higher as suicide attempts are likely to be under reported due to the stigma associated with suicide attempts and suicide legislation. This statistic does not include suicides that go unreported and under-reported because of the religious, cultural and legal factors (Khan, 2005). Suicide rates amongst the different ethnic groups vary considerably. The suicide rate in the Indian community is the highest with 3.67 per every 100,000 people took their own lives, followed closely by the Chinese population at 2.44. Malay people recorded the lowest rate of 0.32 (National Suicide Registry Malaysia, 2009). These statistics are based on medically-certified deaths by suicide. However, 2009 was the last report as the suicide registry has ceased its operation after this year (Ministry of Health Malaysia, 2017). A further reason for the potential unreliability of suicide statistics concerns classifying and reporting, particularly discrepancies in jurisdiction enforcement, standardisation reporting of coronial deaths and police investigation, which may likely lead to significant variables in rates of suicides (Harrison, Pointer, & Abou Elnour, 2009; Walker, Chen, & Madden, 2008). In addition, suicide rates may be underreported in many Muslim countries, including Malaysia due to the religious sanctions of suicide in Islam (Lester, 2006; Pritchard & Amanullah, 2007).

In response to the burden of suicide, the Malaysian government called for a five-year National Suicide Prevention Strategic Action Plan to reduce suicide-related deaths and injuries (Masiran, Haniff, Ali, & Abdul Hamid, 2017). This initiative commenced in 2012 aimed to establish mental health services in the community

mental health centres to make services available to a wider population. The development included increasing the ratio of mental health professionals, in particular psychiatrists, to the population from 1:150,000 to an ideal of 1:50,000; and promoting various support offered by the non-governmental organisations such as online and telephone crisis support services.

The meanings of suicide have shifted gradually over the centuries along with the changing socio-political and cultural relationships in societies (Brown, 2001; Tondo, 2014). Suicide was morally permitted, accepted, and glorified in the antiquity (before 5th century). The society during this time viewed suicide as an ordinary everyday occurence (Brown, 2001). Positions towards suicide gradually began to shift from the 5th to 17th century. During this period, suicide became to be perceived as a sin in many religions and the legacy of individuals who took their own lives were tainted (Brown, 2001; Tondo, 2014). People in the community spoke ill about those who died by suicide and their families might experience social exclusion. Individuals struggling with suicidal ideation continued to experience stigmatisation when suicide was increasingly becoming a medical-psychological issue in the late 18th century (Brown, 2001; Marsh, 2010).

In the Western world, suicide is commonly understood through various risk profiles such as age, gender, socioeconomic status, physical illness, cultural values, addiction and mental health problems. There are many reasons that contribute to an individual's decision to end his or her life by suicide but no singular explanation leads an individual to consider suicide. Rather, suicide is a complex interplay of various issues such as personal, social, political, psychological, cultural, environmental and biological (Buitron et al., 2016; Goldston et al., 2009; Greydanus & Shek, 2009; Haggard-Grann, Hallqvist, Langstrom, & Moller, 2006; O'Connor, 2011; Pompili et al., 2008; Pompili et al., 2011; Reeves, 2010). Individuals who struggle with various life challenges may be overwhelmed with pressures that exceed their abilities to cope. In the coping process, they experience tremendous emotional pain such as shame, guilt, fear, anger, humiliation, and despair (Shneidman, 1998; Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003). In response to this pain, suicide may be chosen as a way to escape this unbearable pain when hope of relief is lost (Nahaliel et al., 2014; Shneidman, 1996, 1998; Soumani et al., 2011). In this sense, suicide can be understood as a response

to coping with intolerable emotional pain that overwhelms an individual's hope and reason for living.

Ribeiro and Joiner (2009), clinical psychologists from the United States, propose that individuals who are thinking of taking their own lives often believe that they are a burden to others and experience an absence of sense of belonging. They explain this idea through the lens of Joiner's (2005) theory of suicidal behaviour. In this theory, Joiner (2005, 2009) proposes that an individual's vulnerability to suicidal behaviours increases when he or she experiences both a desire to take his or her life as well as the ability to do so. The two aspects of one's belief that one is a burden to others and experience an absence of sense of belonging, contribute to the development of one's desire to take his or her life. The feeling of being a burden to loved ones also has resonance in a collectivist culture such as Malaysia, where individuals often experience constant pressure to uphold family or group honour (see Baptiste, 2005; Keshavarz & Baharudin, 2009; Mak & Chan, 1995; Meer & Vandecreek, 2002). Investigating the context of suicidal behaviour within a collectivist society was undertaken by Zaroff, Wong, Ku, and Van Schalkwyk (2014). They employed Joiner's (2005, 2009) theory of suicidal behaviour to explore risk factors for undergraduate university students of Chinese ethnicity between the ages of 17 and 23 years in Macao. Their study indicates that these two aspects play a role in explaining suicidal behaviours of the research participants.

In Malaysia, Kok, Van Schalkwyk, and Chan (2015) explore the potential problems that contribute to suicidal behaviours among students aged 15-25 years old. A total of 625 students responded to two open-ended questions: "I think young people commit suicide because ..." and "Ways of suicide prevention ..." (p. 57). On the first question, their research highlighted emotional problems among the top reasons people take their lives. These emotional problems included experiencing frustration, experiencing that "there might be a certain point in life when they feel too confused, at a loss and there is no one else to help", and "they were overwhelmed by feelings of sadness or disappointment until they couldn't think straight and acted brashly" (p. 58).

According to the cultural beliefs of many Asian people, including Malaysian people, the emotional problems experienced by individuals are considered

something that take place only in their 'mind' (Ng, 1997; Ng, 2013). Individuals are expected to be able to overcome these struggles on their own through self-determination and self-control. When they are incapable of doing so, and turn to a 'mental doctor' (a psychiatrist or counsellor) to 'fix' their 'mental problem', their help-seeking is understood to reflect internal weakness, lack in faith, or come from 'bad' family. (Foo et al., 2012; Loo et al., 2012; Raja Mohan & Sorooshian, 2012). Having to rely on mental health professionals to help with their 'mind' or psychological problems may lead people, experiencing these emotional struggles, to feel a sense of inadequacy and defectiveness (Loo et al., 2012). In such situations, individuals who are seen visiting a mental health professional such as a psychiatrist or counsellor can probably produce feelings of shame or embarrassment, fear of being perceived as a failure for being unable to resolve problems on their own as mentally disturbed.

Preparing counsellors for meeting with clients experiencing suicidal ideation: Counsellor education in Malaysia

I introduce counselling practice in Malaysia in Chapter Three, but I bring forward the discussion about counsellor education in this section to highlight counsellors' preparedness in responding to clients with suicidal ideation. Counsellor education in Malaysia mainly adopted the training models, curricula and counselling modalities from Western contexts, particularly North America (Mohd Daud & Bond, 2013). Counselling theories taught to Malaysian students include psychoanalysis, person-centred therapy, existential therapy, gestalt therapy, reality/choice therapy, behaviour therapy, cognitive therapy, and rational-emotive behaviour therapy (REBT). In Malaysia, the study by Mohamad and Rahman (2011) showed that while 60% of 241 counsellors did not declare a theoretical orientation, rational-emotive behaviour therapy (REBT) and a Rogerian person-centred approach were the most widely preferred modalities among the remaining 40% of counsellors.

These approaches to counselling focus on individual problems, symptoms, negative emotions and disorders (Russo & Kemmerer, 2006), and mostly offer objective and empirical counselling interventions to counsellors in their work with clients. Drawing from this perspective, a counsellor is often encouraged to be an

independent observer and take on a detached expert position in relation to clients. Working in a modernist epistemic counselling culture, counsellors frequently position themselves and are positioned by others as experts with the knowledge and skills to *diagnose* and *fix* a person. Counsellors thus assume the responsibility for conceptualising problems experienced by clients and setting therapeutic goals, while clients are expected to accept these interventions (Gehart, 2016).

Counsellor education and training programmes in Malaysia have been actively developed, monitored and offered in public and private universities or higher learning institutions since 1996 (Mohd Daud & Bond, 2013). The Malaysian Board of Counsellors has the responsibility accrediting counsellor education programmes in Malaysia. The Standards and Requirements of Counsellor Training (Piawai dan Kelayakan Latihan Kaunselor) developed by the Board sets minimum training requirements for students to complete in order to qualify for application to register as a counsellor in Malaysia (Lembaga Kaunselor, 2012). These requirements include the completion of at least 252 hours of supervised practicum and 504 hours of supervised internship (Lembaga Kaunselor, 2012). The Standards are centred on ten different core areas in the discipline: human growth and development; the helping relationship; multiculturalism; group counselling; career development; testing and assessment; ethics, legal and professional issues; research and appraisal; practicum and internship (Lembaga Kaunselor, 2012). Suicide assessment and intervention training is not a core subject in the Standards. Engagement in this training depends on the discretion of respective learning institutions or counsellor educators to incorporate such topics in classroom curriculum.

One of the core models introduced by counsellor educators for training student counsellors in responding to clients with suicidal ideation is the crisis intervention approach (Ahmad, Kamal, & Mohamad Sulaiman, 2018; da Silva, Siegmund, & Bredemeier, 2015; James & Gilliland, 2005; Roberts, 2000; Westefeld et al., 2000). A crisis intervention model approaches suicide intervention based on the premise that a person struggling with suicidal ideation is experiencing a crisis, and so crisis management is emphasised. In times of such crisis, suicidal behaviours are considered a temporary and ambivalent state (Stillion & McDowell, 1996). Hence, a crisis intervention approach often focuses on offering short-term care to support individuals, with a primary aim of preventing them from taking their own lives

(Flannery & Everly, 2000; Granello, 2010; Roberts, 2000). Crisis intervention models offer clear and manualised frameworks, for example Granello's (2010) seven-step model with 25 practical strategies, to guide counsellors when counselling clients with suicidal ideation. These crisis intervention models begin with establishing a rapport with clients, assessing suicide risk, identifying clients' problems, connecting clients with internal and external resources, developing problem-solving plans, and finally incorporating support and follow up plans (Flannery & Everly, 2000; Granello, 2010; Roberts, 2000; Rojas & Rogers, 2013). Some crisis management approaches include the application of a no-suicide contract, a safety plan, referral for psychiatric assessment, medication and/or hospitalisation.

The role of counsellors practising within a crisis intervention approach tends to prioritise problem solving in order to achieve a therapeutic aim of preventing suicide. In the process of focusing on a methodical application of such an intervention, counsellors may not pay a great deal of attention to building relationship with clients (Leenaars, 1994; Rogers & Soyka, 2004). In situations where counsellors are required to take authority as suicide prevention experts, clients are in turn expected to trust the counsellors and be guided by their management of the crisis, even when client autonomy may be restricted.

While counsellor education courses do not address the needs of all populations, counsellors are ethically required to take personal responsibility to increase their competencies through continuing education (Lembaga Kaunselor, 2011, clause C.2.f). Counsellors who have not been exposed to suicide assessment and intervention training therefore have a greater obligation to ensure that they develop competency in this area. Counsellors are encouraged to learn about risk factors and warning signs to aid them in identifying potential markers for more serious problems (Nugent & Williams, 2001). It is also important for counsellors to understand the taken for granted truths or knowledge about suicide, and take a critical stance to question them (Reeves, 2010). This is because these knowledges may potentially lead counsellors to avoid discussing matters related to suicide and to be less sensitive to clients' needs. For example, counsellors in various studies have been found unwilling to mention suicide or to ask their clients about suicide directly during a counselling session (Palmer, 2008; Reeves & Seber, 2010; Reeves

et al., 2004). Some of the reasons reported by counsellors include feeling fearful and incompetent (Reeves et al., 2004); being afraid of putting ideas into clients' minds (Reeves & Seber, 2010); or having the potential of pushing clients towards suicidal behaviour (Palmer, 2008). Questioning these beliefs about suicide offers practitioners a new way of understanding suicide includes those who are struggling with suicidal ideation, and recognising risk to provide timely support (Capuzzi, 2002; Joiner, 2010).

The research questions

In this thesis, I examine how counsellors support clients struggling with suicidal ideation. I became particularly interested in what knowledge counsellors call on when working with the socio-cultural and political aspects of the legislation, and medical, religious, cultural, institutional and educational contexts that present a complex situation for counsellors, clients and their families. My research curiosity shaped the following research questions that guided this study:

In the context of counselling those experiencing suicidal ideation:

a) How do counsellors work collaboratively with their clients?
b) What approaches do counsellors use to develop a good working relationship with the families?
c) How do counsellors assist the families to become effective partners in the counselling process?
d) How does the legislation shape counselling practice and family responses?
e) How does the worldview of those involved shape counselling practice and family responses?

The first three research questions explored the responses and meanings that counsellors made when counselling in the context of suicidal ideation. These questions examined the discursive knowledge and practices counsellors drew on to navigate their way around the socio-cultural and political aspects when supporting clients. The last two questions were set up to investigate how the law and cultural values shaped counselling practices and family responses, and the position calls counsellors or clients took up, resisted or changed when meeting these components.

Poststructuralism and social constructionism provided the theoretical and methodological research framework of my study. In this chapter, I introduce social constructionism as a conceptual framework that threaded through the entire thesis. I present in Chapter Two the philosophical ways of thinking that I employed to examine and understand the stories of the research participants. My primary aim was, through the research questions, to make visible the discourses that are at work in practice contexts, the range of subject positions available to counsellors and the positions calls that counsellors may take up, resist or change in relation to counselling clients with suicidal ideation. Implicit to this approach I identify the power relations at work just below the surface of the working discourses when counselling clients with suicidal ideation.

Social constructionism: Language and its role in knowledge construction

I have chosen to walk my research hand-in-hand with social constructionism, particularly the idea of knowledge as socially constructed and the constitutive role of language in knowledge production. Taking a social constructionist stance challenges me to adopt a critical approach to investigate knowledge and practices that are often regarded as 'truth' and created by taken-for-granted assumptions.

Social constructionist ideas propose that knowledge is constructed by members of particular cultures through social interaction (Burr, 2003; Gergen, 1994). On these terms, it is impossible for knowledge to exist outside of human thought and action. This means that what we know as knowledge is "a by-product of communal construction" (Gergen, 2001, p. 806), it is not something *out there* to be found or discovered, or "something that a person has or doesn't have, but as something that people do together" (Burr, 2003, p. 9). Anderson (2003) further describes knowledge as "in-there-together, two-way, give-and-take, back-and-forth exchange" (p. 149). This knowledge provides for individuals to shape their lives or constitutes themselves, and gradually over time, such knowledges become "codified as the rules", achieves a status that is accepted by members of general public, and continues circulating within society (Freedman & Combs, 1996, p. 23).

In the production of knowledge/reality, language plays a constitutive role (Burr, 2003). The constitutive character of language is captured in Burr's (2003) description:

> [L]anguage provides the basis for all our thought. It provides us with a system of categories for dividing up our experience and giving it meaning, so that our very selves become the product of language. Language produces and constructs our experience of ourselves and each other. (p. 62)

In this way, language becomes performative as it can produce knowledge/reality which shapes the actions, thinking and speaking of individuals (Davies, 2001) and their worlds: "when people talk to each other, the world gets constructed" (Burr, 2003, p. 8). Gergen and Gergen (1991) describe this performative and generative nature of language as follows:

> [T]he conventions of language and other social processes (negotiation, persuasion, power etc.) influence the accounts rendered of the 'objective' world. The emphasis is thus not on the individual mind but on the meanings of people as the collectively generate descriptions and explanations in language. (p. 78)

For instance, an individual's understanding of suicide may be coming from what he or she learns from others and what his or her own experience with suicide has been. Knowledge about suicide occurs within a process of relational and meaning-making. Drawing from this perspective, knowledge about suicide is culturally and historically situated, and it does not neutrally reflect the world (see Burr, 2003; Gergen, 1985). In this sense, there is no ultimate truth about suicide or suicidal ideation and taken-for-granted ideas can be questioned. Social constructionist thinking invites a reflexive stance towards taken-for-granted knowledge, and a position of suspicion that questions this knowledge (Burr, 2003). When people are suspicious of their assumptions or beliefs about the world, they become aware of gaps in their knowledge and they may open themselves to the consideration of alternatives understandings: "In its generative moment, constructionism offers an orientation toward creating new futures, an impetus to societal transformation" (Gergen, 1999b, p. 2). I take up a social constructionist analytical stance to explore the taken-for-granted nature of discourses that constitute the counsellors when counselling clients struggling with suicidal ideation.

My research was a journey of exploring counsellors' experiences by consistently questioning taken-for-granted or usual practices. In research interviews, I adopted a position of *not-knowing* (Anderson & Goolishian, 1992) and to orient my interview questions with ongoing curiosity to challenge these taken-for-granted beliefs (Gergen, 2009). As I approach the participants' experiences in data analysis, I give up my position as a knower alongside my belief about the participants' experiences as *facts* or *truths.* I focus on understanding their experiences as one of many that could be told, therefore there are many possibilities to interpret an experience and no interpretation has truth status. My preferred orientation "is to open the commonplace to critical inspection and to explore the possibility of fresh and more viable alternatives" (Gergen, 1999a, p. 19). By making explicit these alternative practices, I hope to offer counsellors a greater agency to position themselves when counselling clients who speak suicidal ideation.

Overviews of the upcoming chapters

I describe in Chapter Two the philosophical landscape which informs this study. These include Derrida's (1998) deconstructive work, Davies' (2000b) idea of "troubling" the seas (p. 14), Foucault's (1972) understanding of discourse and power/knowledge relations, and Davies and Harré's (1990) positioning theory. I also introduce Levinas's (1969) and Derrida's (2005a, 2005b) ideas of ethical responsibility, in order to define the position of counsellors in therapeutic relationships.

In Chapter Three, I present the counselling profession in Malaysia and its development. I consider the importance of the cultural knowledge for counselling practices at the time when clients are assessed to be at imminent risk of suicide. I particularly emphasise the practice of seeking counselling and investigate the consideration that it can be viewed as a major questioning of social norms for many Malaysian people. The interaction between some cultural practices and counselling models from Western practices produces tension in the therapeutic relationship, and I discuss how this tension adds to the complexity of offering support to clients struggling with suicidal ideation. I also discuss how suicide is understood as an illness, a crime, a sin and a burden from medical, legal, culture and institutional perspectives in order to offer a better understanding of the Malaysian contexts.

The research methodology is outlined in Chapter Four. I discuss how I employed a qualitative research design via face to face interviews with research participants to generate data. This discussion is followed by a presentation of the research processes that were involved in recruiting research participants. Finally, I introduce the approach I used to produce transcripts and investigate the research materials.

In Chapters Five to Ten I present the lived experience of counsellors when counselling in the context of suicidal ideation. In the analysis of the research materials, I paid attention to the discursive practices of counsellors. The analysis makes visible the work of discourses in the practice context and how the counsellors negotiated between their professional responsibilities and their obligation to the law and respect of cultural values. In the work of unpacking the practices, I bring to light power relations, locate the positions that counsellors chose to take up, and the knowledge they called on to offer responses to the dilemmas they have faced in this negotiation process. I organise the results chapters by three main themes to reflect my presentation of ideas in relation to counselling in the context of suicidal ideation: working with the law, cultural values and counselling model; relationship building and suicide risk assessment; and the interaction of personal experiences in professional practice.

The thesis concludes in Chapter Eleven with a discussion on the ways the research participants assumed ethical responsibilities to engage in practice wisdom to co-construct with their clients while working alongside state law and regulations, professional code of conduct, manualised protocols, counselling theories, cultural and personal knowledge in situations where matters of harm, client welfare, rights and responsibilities are at stake. I identify an approach to working with clients who are thinking about taking their lives. The approach I put forward is what I have come to call relational dialogic-responsive practice. In this last chapter I present the ethical philosophy of Levinas and Derrida to enrich this practice in responding to suicidal ideation.

CHAPTER TWO
PHILOSOPHICAL LANDSCAPE OF THIS STUDY

Introduction

> [Philosophy] is imagination which crosses domains, orders, levels, knocking down partitions, co-extensive with the world, guiding our bodies and inspiring our souls, grasping the unity of mind and nature; a larval consciousness which moves endlessly from science to dream and back again. (Deleuze, 1994, p. 220)

I have chosen to ground my research within a philosophical orientation to build a framework for understanding counselling in the context of suicidal ideation, and to guide the analysis process presented in the results chapters Five to Ten. Deleuze's comments above on philosophy offer some thoughts on why a philosophical orientation was significant to this thesis. Through engaging with philosophy, this thesis entered the territory of active imagination. Framed in this way, writing a thesis shaped by a philosophical landscape had given me the opportunity to engage with the research materials in ways that my imagination was able to "cross domains, orders, levels, knocking down partitions, co-extensive with the world, guiding [my body] and inspiring [my soul], grasping the unity of mind and nature" (Deleuze, 1994, p. 220). Through the philosophy, I had access to different possibilities of reading and interpreting the data to bring forth the complexities and multiplicities of research participants' stories. Engaging with the imaginative role of philosophy potentially led me to produce something different, new ideas (Deleuze, 1995), and to "bring into being that which does not yet exist" (Deleuze, 1994, p. 147). Colebrook (2017) claims that "philosophy…is not a discipline (in the sense of a specific terrain of know-how or expertise) but a *not knowing*" (p. 652, original emphasis). Following this claim, Taguchi and St. Pierre (2017) investigated Colebrook's idea of how philosophical thinking in education "create[s] orientations for thinking" (p. 646) which, "actively bring forth a potential becoming of what we *not yet are* and a future that we do *not yet know*" (p. 645, original emphasis).

While Deleuze (1995), and Taguchi and St. Pierre (2017) offer me the idea of engaging with philosophy as a creative practice, St. Pierre (2004, 2014) shows me ways of using philosophical ideas in an educational research practice context. Her

work draws from the critical theories and poststructuralist ideas of language and the subject through the ontological turn (St. Pierre, 2014). As a practitioner who had read the science of counselling in the context of suicidal ideation, I dreamed of the creation of difference for my thesis. In the course of this study, I met practitioners, research participants who helped me explore this dream. In dialogue with what these research participants gave me are the conceptual ideas that philosophers gave me.

With philosophical ideas and concepts in mind as I read the research materials, St. Pierre's (2004, 2014) ideas opened up a space for me to ask questions, such as, "what does this data produce if I think with Foucault's notion of discourse?" This approach invited curiosity and helped me to be open to new directions in different way of thinking and using language to capture unexplored professional landscapes of counselling practice. I became more sensitive to the nuances and complexities of the research participants' experiences. My experience resonated with St. Pierre's (2014) suggestion that turning to philosophical concepts and ideas in research inquiry offers a platform for researchers to think differently. Following St. Pierre (1997), this thesis "produce[d] different knowledge and produce[d] knowledge differently" (p. 175). My hope is that this professional knowledge will contribute to enhance counsellors' thinking and practice in working with people struggling with suicidal ideation.

I go on now to describe the particular philosophical ideas that have inspired and guided me in this study. I begin with Derrida's (1998) practice and ideas of deconstruction and Davies' (2000b) troubling of "the seas" (p. 14) as a metaphor to trouble the boundaries between binaries produced by discourses. Next, I move to introduce Foucault's (1972) notion of discourse and the complex power/knowledge relations. I especially focus on the interplay of power/knowledge relations through discourses in the shaping of individuals' experiences and practices. From the perspective of power/knowledge and discourse, I also discuss Davies and Harré's (1990) positioning theory. Alongside positioning theory, I touch on the concept of agency and its relationship with resistance and power. I particularly highlight how agency opens possibility for the counsellors to practise otherwise and make a difference. Next, I investigate Levinas's (1969) and Derrida's (2005a, 2005b) ideas

of ethical action in order to describe the stance counsellors take towards the other in therapeutic relationships.

Deconstruction

Deconstruction is introduced by French philosopher Jacques Derrida. I used deconstructive work to guide me in the analysis of the counsellors' narratives of their experiences when counselling clients struggling with suicidal ideation. Alongside Derrida, I also include the work of other Derridean scholars to offer more understanding about deconstruction: Spivak (1998), Sampson (1989), Davies (2000a, 2000b), and Jackson and Mazzei (2012).

To define deconstruction, it would perhaps be a safer practice to quote the original words used by Derrida himself, but he resists the commitment to a 'fix' meaning (Derrida, 1972). In his early work, Derrida (1998) introduces deconstruction as a practice critical of traditional Western philosophical discourse. He then continues to offer detailed ideas of deconstruction in his work *Of Grammatology* in which he uses deconstruction as a form of textual reading to question the relationship between language and the production of meaning (Derrida, 1998). Derrida (1997) argues that no meaning has truth status, but each meaning represents many possibilities of interpretation constructed by individuals in their search for meaning. This implies that a concept and its opposite, or binary oppositions, are already co-present within each meaning or text. In other words, the 'work' of deconstruction includes highlighting what already exists in the meaning or text itself (Derrida, 1997). According to Derrida, there are many binary oppositions, and they can be sameness and difference, for example man/woman and normal/abnormal, presence/absence, speech/writing and life/death.

Part of the 'work' of deconstruction involves the interpretation process of these binary oppositions. This process invites a practice of double reading seeking to bring the binary opposition into awareness, and then to subvert the binary oppositions that dominate one's ways of thinking or behaviour (Derrida, 1982). Derrida writes:

> Deconstruction cannot limit itself or proceed immediately to a neutralization [of the hierarchical binary opposition]: it must, by means of

> a double gesture, a double science, a double writing, practice an overturning of the classical opposition and a general displacement of the system... Deconstruction does not consist in passing from one concept to another, but in overturning and displacing a conceptual order, as well as the nonconceptual order with which the conceptual order is articulated. (Derrida, 1982, p. 329)

This approach aims to demonstrate that these dual aspects (sameness and difference) to an opposition can consist of contradictory or undecidable values. Disrupting these dual aspects makes it possible "to see the multiple discourses in which we are inevitably and contradictorily caught up" (Davies, 1994, p. 2). Derrida (1972), thus emphasises that deconstruction "has nothing to do with destruction" (p. 231) of a system of meaning. Derrida (1990) also contends that deconstruction is not a methodological process:

> Deconstruction is neither a theory nor a philosophy. It is neither a school nor a method. It is not even a discourse, not an act, nor a practice. It is what happens, what is happening today in what they call society, politics, diplomacy, economics, historical reality, and so on and so forth. Deconstruction is the case. (p. 85)

Derrida (1990) argues that deconstruction as a method may frame or structure an individual's thinking to a particular conceptual system of meaning, which is not the purpose of deconstruction. To assist the deconstructive purposes, Derrida (1998) suggests an approach of *sous rature*, or translated as "under erasure" by Spivak (1998) in the preface to her translation of *Of Grammatology*: "write a word, cross it out, and then print both word and deletion. (Since the word is inaccurate, it is crossed out. Since it is necessary, it remains legible)" (p. xiv). Sampson (1989) offers further explanation:

> For example, the word 'Being', under erasure, would appear thus: Being and ~~Being~~. What sous rature accomplishes is a strategy of telling us that we both need the term, in order to understand the points being made, and simultaneously should not employ the term…(p. 7, original emphasis)

A *sous rature* approach invites people to become aware of the commonly known and at the same time to deconstruct this knowing. Placing a term "under erasure" indicates that holding onto the term is necessary as we cannot yet live without it but the term is inadequate. The term is thus recognised for its exclusions and limitations, yet at the same time is explored for other meanings or understandings.

In this way, Sampson (1989) interprets deconstruction as a process "to undo, not to destroy", which invites expanding understanding beyond the constraint of dominant thinking by investigating "what lies at the very root of our commonsense understanding" (p. 7). Similarly, Jackson and Mazzei (2012) also describe that deconstruction "is *not* about dismantling and replacing the dominant signifier in a binary with that which has been subordinated (reversing man/woman to woman/man)", but involves an ongoing work of "engagement with the tensions and omissions in such a way as to see how the 'orthodox, dominant interpretation has been produced' (Caputo, 1997, p. 85) without interrogation" (p. 15, original emphasis).

Davies (2000b) offers a further metaphoric interpretation of deconstruction. She proposes to use the verb "*troubling*" to "represent more closely what it is that the deconstructive work can do" (p.14). Her idea of *troubling* means "to agitate or make rough…the seas" (p. 14). She explains why *troubling*:

> …too many readers of deconstructive texts take deconstruction to mean a dismantling that obliterates the binaries and the boundaries between them. Binaries are not so easily dismantled, and deconstructive work often can do no more than draw attention to the binaries and to their constitutive force. For some people, in some readings, deconstructive work may facilitate a different take-up of meaning, beyond the binaries. But this does not undo the continuing force of relations of power that operate to hold the binaries in place. (p. 14)

Metaphorically, troubling denotes a smaller step of deconstruction to trouble the power relation within the binaries as "[b]inaries are not so easily dismantled", according to Davies. Davies (2000a) brackets a word or term as a way to trouble the text to open up more possibilities beyond a singular meaning or story of the word/term. For example, "(be)longing", by bracketing the term in this way, Davies (2000b) attempts "to give special weight to *longing*" (p. 37, original emphasis). Brackets invite readers to read the word twice with hesitation, once with and once without the bracket. This reading allows readers to build a relationship with both the words, such as belonging and longing, and pay attention to the sound and the meanings of the words. The kind of *troubling* in Davies' (2000a) terms, "requires us to take on board contradictory thoughts and to hold them together at the same time" (p. 134). Davies (2000a) argues that "[i]t is in the constitutive force of

discourse that agency lies" (p. 134), and *troubling* makes it possible for agency to be taken up.

Deconstructive thinking offers new openings for my imagination to envisage my thesis as an entry to consider multiple possibilities in responding in situations of suicidal ideation. I especially call on Davies' idea of *troubling* to trouble the binaries by moving back and forth and through the boundaries between binaries to bring forward the constitutive force of discourses at such moments where counsellors and the other people in their stories are overtaken by the force of discourses, which shape their speaking, thinking and practices.

Foucault: Power/knowledge and discourse

In this section, I employ Foucault's (1963, 1965, 1977) ideas of power/knowledge, resistance and "'political economy' of the body" (Foucault, 1977, p. 25), to help in describing the ways in which individual bodies can be punished, trained and kept under surveillance through political and professional regulatory force. After I discussed each concept, I will show its relevance to counselling in the context of suicidal ideation through the application of the suicide legislation (Laws of Malaysia, 2006a), the Counsellor Act 580 (Laws of Malaysia, 2006b) and the Malaysian Counsellor Code of Ethics (Lembaga Kaunselor, 2011).

Power is the central concept in Foucault's work. He is particularly interested in examining how power operates in a "capillary" (Foucault, 1980, p. 96) manner between people and institutions:

> Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application. (Foucault, 1980, p. 98)

Foucault's argument proposes that individuals are the vehicles of power because power is embedded in knowledge, norms and micro-practices of day-to-day interactions between individuals. Therefore, power disperses throughout society and "is everywhere" (Foucault, 1978, p. 93). Power becomes an aspect of an individual's position within a community and relations between individuals. Social

life in this regard comes to be a network of power relations. These power-relations are constantly shifting depending on the strategies adopted by individuals within their interactions such as resistance to the exercise of power. As power is highly interactional and constantly shifting:

> Power is exercised rather than possessed; it is not the 'privilege', acquired or preserved, of the dominant class, but the overall effect of its strategic possession - an effect that is manifested and sometimes extended by the possession of those who are dominated. (Foucault, 1977, p. 26-27)

The position of power is decentralised, and thus the question about who 'has' the power to dominate other individuals or groups does not exist. Capillary power circulates through "a mode of action…it acts upon actions [of others]: an action upon an action, on existing actions or on those which may arise in the present or the future" (Foucault, 1982a, p. 789). In this manner, power presents in multidimension of social bodies in various appearances and shapes, often camouflaged and less recognisable. Individuals, therefore, may not become aware of their subjection to the effects of power.

Foucault (2010) uses the concept of governmentality (p. 4) or "art of government" (p. 6) to describe the role of power in governing the entire populations through employment of the productive capacities of individuals. In other words, governmentality is a form of power to govern the conduct of self and/or others (Lemke, 2002). Foucault's (1982a) idea of "government" (p. 790) is not limited to states politics. Rather "government" includes:

> modes of action, more or less considered or calculated, which were destined to act upon the possibilities of action of other people. To govern, in this sense, is to structure the possible field of action of others…It designated the way in which the conduct of individuals or of groups might be directed: the government of children, of souls, of communities, of families, of the sick. (p. 790)

This form of government includes a wide range of measures that regulate the self and the population. The government of the self takes place when individuals internalise the effects of power to police their own conduct to be consistent with the forms of power implemented by the state (Foucault, 1991), to be part of what Rose (1999a) calls "patriotic duty of the citizen" (p. 145).

Power relations in counselling

Within the counselling relationship, there is an inevitable power differential between a counsellor and client (Guilfoyle, 2003, 2005; Pope & Vasquez, 2016; Proctor, 2002; Totton, 2009). Counselling in Malaysia is positioned as a professional authority by the Counsellors Act and the Malaysian Counsellor Code of Ethics. This recognition renders counsellors as expert with knowledge and abilities to care and support people who come to seek their services. This "role power" (Proctor, 2002, p. 93) of counsellors itself has already situated counsellors in a privileged position to influence the possible conduct of clients. By contrast, clients are often rendered passive objects by counsellors' expertise (Hoyt, 1996). At the same time, the professional codes of ethics and guidelines establish boundaries to limit professionals' power in order to protect clients from potential inappropriate use of power in counselling relationship. This development further presents clients as vulnerable to counsellors' position of power and influence.

Regardless of counsellors' influential position, both counsellors and clients are subject to power relations where both are to influence and be influenced by each other. The counsellors' expert knowledge and skills award them authority to practise counselling, and at the same time to exercise disciplinary power to conduct the conduct of clients (Rose, 1999b). In supporting clients, counsellors draw upon various modes of intervention and care to provide them strategies for governing and disciplining individual bodies. Counselling transforms a client into an object of knowledge and "makes each individual a 'case'" (Foucault, 1977, p. 191), for example through performing a suicide risk assessment. Counsellors apply the knowledge about clients obtained from the assessment to categorise clients – such as high, medium or low suicidal risk – and to develop intervention plans to exercise power in ways that attempt to normalise client behaviour or thought. In facing intervention options, clients may accept or resist. Foucault (1978) considers resistance as an integral part of the operation of power. He argues that "[w]here there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power…[and is] present everywhere in the power network" (p. 95).

While people can never be outside of power relations, the potential for resistance to power may exist. The possibility of resistance appears itself alongside the presence of power, in day-to-day practices embedded within the interaction between people, and with discourses. Foucault (1980) further suggests that "there are no relations of power without resistances" (p. 142). Drawing from this perspective, clients are not *powerless*, they exercise power in the form of resistance (Guilfoyle, 2003).

Biopower

Foucault (1978) uses the term *bio-power* to speak of a mode of power exercised by a state or government attempts to regulate more aspects of human lives, including the births, deaths, reproduction and illnesses of a population. He writes:

> [Bio-power] is a power that exerts a positive influence on life, that endeavours to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations…[with] the function of administering life…to foster life or to disallow it to the point of death. (Foucault, 1978, p. 137-138)

Bio-power is exercised to optimise health and to preserve life of the population through small- and large-scale bio-political mechanisms such as the suicide legislation – Legal Code Act 1997 Section 309 of the Penal Code 574 (Laws of Malaysia, 2006a) – which defines the act of an individual attempts to end his or her own life as an unlawful behaviour. The power of the law shapes how people come to understand ourselves, relative to life and death.

From a legal perspective, the human body becomes the central object of the government and the deployment of power. The human body becomes the 'property' of the state. The body is then, as Foucault (1977) writes, "directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs" (p. 25). The body hence is positioned between applications of powers: the "right of death" and "power over life" (Foucault, 1978, p. 133). Law enforcers such as police and fire-fighters, health professionals such as doctors and nurses, and mental health professionals such as psychiatrists and counsellors, have the duty to protect the life of a person who is thinking of ending his or her life. The law positions these

authorities and professionals to assume temporary ownership of another's body (or life). Through the suicide legislation, these disciplinary authorities and professionals (the 'governors') exercise power on behalf of the state to govern those who consider or decide to end their own lives (the 'governed'). Implicit in this practice of government is the way in which individuals regulate their own conduct in relation to their desire of ending their own lives (see Dean, 2010; Lemke, 2002). An example that shows an attempt to monitor one's own conduct in order to be considered a 'good citizen' is that one seeks counselling to help with the desire to end one's life.

To better manage the suicide phenomenon, the National Suicide Registry Malaysia (NSRM) was set up by the Ministry of Health (MOH) via the Clinical Research Centre in 2007 to study the deaths due to suicide by accessing the legal records and death reporting systems available in hospitals (NSRM, 2009). Bio-power functions through the suicide statistics provided by NSRM to make it possible to regulate mortality. The suicide statistics play a key role in the development of activities or programmes that allow suicide to be monitored closely. Activities such as awareness and prevention programmes, crisis hotline centres, counselling services, free or offer at an affordable fee, are initiated by government, non-profit organisations and local communities to support people who are struggling with suicidal ideation.

While power is exercised in the form of a right to "power over life" (Foucault, 1978, p. 133), Foucault (2003) views death as the limit to power. He argues that "[p]ower no longer recognises death. Power literally ignores death…Death is outside the power relationship. Death is beyond the reach of power" (p. 248). However, advanced medical intervention brings to light the political nature of death by calling into question our understandings of life and death, in particular the time of death and who decides it. As the boundary between life and death is becoming blurred, bio-politics' politics of life cross over to the territory of politics of death, "thanatopolitics" (Agamben, 1998, p. 72). Agamben shares Foucault's belief that human bodies are deeply politicised, but when the care of life becomes the administration of death, he suggests that power extends beyond death (Noys, 2005). As various advanced biomedical technologies are used to care for life, the biological life of human body enters politics and redefines the legal meaning of death from

"cessation of the heart beat and breathing" to "brain death" (Jones & Kessel, 2001, p. 65). In the limit zone between life and death, Agamben (1998) argues, "life and death are not properly scientific concepts but rather political concepts, which as such acquire a political meaning precisely only through a decision" (p. 94). The decisions that have to be made by healthcare professionals and families are about what to do with bodies that are not legally dead. The idea of thanatopolitics is relevant for the analysis in Chapter Ten when I discussed an example of religious discursive practice of preparing a deceased body of a Muslim man.

Disciplinary power

The disciplinary dimension of bio-power uses techniques to discipline individuals' bodies "both as objects and as instruments of its exercise" (Foucault, 1977, p. 170). Such techniques for enhance governance and assure "the ordering of the human multiplicities. . . [with the aim of increasing] both the docility and the utility of all the elements of the system" (Foucault, 1977, p. 218). In *Discipline and Punish: The Birth of the Prison*, Foucault (1977) called on Jeremy Bentham's idea of a prison surveillance design, the panopticon, to illustrate the way a disciplinary society can be produced where control over individuals is perpetually present. A prison with a circular structure design allows prison officers to constantly observe every prisoner in their cells. Under this surveillance system, prisoners are unsure whether their behaviours are being monitored at any particular point in time. In response to the possibility of being under surveillance of an invisible other, prisoners must always police their own behaviour in accordance with the rules of discipline to avoid punishment. Self-surveillance thus occurs as a response to this process. On self-surveillance, Foucault (1977) writes:

> There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze which each individual under its weight will end by interiorising to the point that he is his own over seer, each individual thus exercising this surveillance over and against himself. (p. 156)

Disciplining practice can be achieved without force or violence as prisoners learn to regulate their own conduct according to the ways expected by the prison system. The panopticon signifies a form of power Foucault terms as disciplinary power that operates "to alter behaviour, to train or correct individuals" (Foucault, 1977, p. 203)

into compliant and obedient subjects. The effectiveness of disciplinary power is achieved through hierarchical observation, normalising judgment, and examination (Foucault, 1984). Through these disciplinary mechanisms, individuals are constantly being controlled, trained to perform the expected duties and behave according to expected rules of the discipline, and transformed into useful and docile bodies.

Techniques of surveillance and control have been widely employed beyond prison structure in society. In the context of counselling, the Counsellor Act 580 (Laws of Malaysia, 2006b) and the Malaysian Counsellor Code of Ethics (Lembaga Kaunselor, 2011) are designed to regulate the professional activities of counsellors in Malaysia by setting professional standards for appropriate behaviour, defining professional expectations and preventing harm to clients. The conduct of counsellors is ultimately subject to legal sanction, and a number of punishments are put in place, for instance, removing the name of the registered counsellor from the Register and revoking the practitioner's license in response to professional misconduct (Laws of Malaysia, 2006b, Act 580, Clause 40). These regulations may not be intended to monitor the counsellors' activities as much as to expect counsellors to have the ability to conduct themselves in a professional and ethical manner.

The Act and Codes in this sense form part of the disciplinary systems that attempt to enforce counsellors' embodied conformity to normative behaviour through the techniques of possible surveillance of an invisible other and self-surveillance. This enforcement plays out alongside counsellor education in the production of efficient and ethical, and obedient, counsellors. While counsellors are subjected to the surveillance of the professional body, supervisors, workplace peers, clients, and the wider community; they may become aware and mindful of their own conduct. Stemming from the necessary desire to be accepted and approved by others as a "professional", counsellors regulate their own conduct to align with the accepted standard of conduct through the mechanism of self-surveillance. Drawing from this perspective, alongside subjection to the continuous clinical gaze, counsellors become "the principle of [their] own subjection" (Foucault, 1977, p. 203), and turn the gaze to their own practices. The Act and Codes construct counsellors as both

agents and objects of control. Counsellors thus may become subject to the effects of power without knowing it.

As its worst, the disciplinary mechanism of surveillance and self-surveillance may turn counsellors into passive mechanics (see Foucault, 1977), who accept the "dissociation of power from the body" (Foucault, 1977, p. 138) through the constant subjection of individual forces. This process may lead to the production of "docile" (Foucault, 1977, p. 136) counsellors whose practices become regulated by defensive approaches such as manualised intervention where procedural matters dominate (Ellis, 2004; Pope & Vasquez, 2016). These approaches may leave counsellors feeling confined in a mechanicalised relationship (Marshall & Mellon, 2011) with clients.

Power-knowledge relations and discourse

Power is linked to knowledge in such a way that power functions as a force to produce subjectivities, discourses and knowledges. Foucault (1980) proposes that power "traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression" (p. 119). Power is simultaneously regarded as generative and has a reciprocal relationship with knowledge (Foucault, 1977). Knowledge becomes an effect of power where it is being produced and reproduced within relations of power (Foucault, 1972). Hence, knowledge cannot be thought as neutral because individuals exercise power to produce knowledge.

Power and knowledge are mutually constituted in ways that without knowledge, relations of power do not exist. On this, Foucault (1977) contends that "power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (p. 27). Foucault's argument is that power and knowledge both work together to produce and reproduce each other. The interdependence of power and knowledge forms a concept which Foucault (1977) termed as power/knowledge. Foucault (1980) offers reason for this couplet:

> [T]he exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information…The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power…Knowledge and power are integrated with one another, and there is no point in dreaming of a time when knowledge will cease to depend on power…It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power. (p. 51-52)

In this study, I follow Foucault's conceptualisation of power as power/knowledge when I illustrate how dominant knowledge or practices are being produced, maintained and reproduced in power/knowledge relations:

> These "power-knowledge relations" are to be analysed…not on the basis of a subject of knowledge who is or is not free in relation to the power system; but, on the contrary, the subject who knows, the objects to be known, and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical transformations. In short, it is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power-knowledge, the processes and struggles that traverse it and of which it is made up, that determines the forms and possible domains of knowledge. (Foucault, 1977, p. 27-28)

The couplet power/knowledge has an intimate relationship with the concept of discourse, in which Foucault (1978) argues that "it is in discourse that power and knowledge are joined together" (p. 100). Knowledge forms part of a particular discourse (Burr, 2003). In the Foucauldian tradition, discourses can be regarded 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). To Foucault (1972), "discourses are practices that systematically form the objects of which they speak... discourses are not about objects, they don't identify objects, they constitute them and in doing so, they conceal their own invention" (p. 49).

Discourse constitutes reality, knowledge or practice that is often thought and accepted as truth within a given society. When a particular body of knowledge or practice is accepted as truth within a specific context, Foucault (1980) coins this as a "regime of truth" (p. 131). He argues that power/knowledge plays a constitutive role in the production of a regime of truth:

> Truth isn't outside power, or lacking in power…Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (p. 131)

The interplay of discourses in power/knowledge relations leads discourses to become "more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects which they seek to govern" (Weedon, 1997, p. 105). Discourse in this regard operates as an instrument of power which governs the way a particular topic can be discussed and influence how knowledge is put into practice, as well as who can speak, when, and with what authority (Foucault, 1972, 1980).

Weedon (1997) also suggests a relationship between discourse and the production of subjectivity. Discourses offer subject positions for one to take up or resist. However, Foucault (1972) argues that discourses do not entirely constitute subjects because an agentic position can be taken up to resist or change. This implies that subjects may exist in a state of fluidity by which their subjectivities or identities are constantly constructed and re-constructed through discourses. These ideas have significant implications for counselling, especially in the legal and psychometric of suicidality. I now move on to the next section to present the notion of positioning and agency to offer further understanding about how power relations become the site in which individuals attempt to influence each other.

Positioning theory and agency

As discussed early in this chapter, language is not an innocent tool of communal interaction as when we speak of something, we *produce* knowledge (Burr, 2003; Davies, 2001; Freedman & Combs, 1996). 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 conversation 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).

Positioning theory offers an alternative way of understanding identity construction and its relationship to discourse particularly the ways in which culture and history shape how individuals are invited into and maintain speaking positions in social interaction (Davies & Harré, 1990). Davies and Harré (1990) argue that discourses give shape to speaking by offering particular subject position for individuals to take up. Upon receiving the invitation, individuals can accept, change or reject the position offered. When a subject position is taken up, a subjectivity is produced. Davies and Harré (1999) further argue that:

> A subject position incorporates both a conceptual repertoire and a location for persons within the structure of rights and duties for those who use that repertoire. Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned. (p. 35)

This argument proposes that subject positions shape speaking rights. Taking up a subject position affords one prestige within society in which their speaking are accepted as legitimate. Drewery (2005) suggests that language positions an individual in relation to others. Through the to and fro of conversation invitations, position calls (Drewery & Winslade, 1997) are offered to others to take up certain subject positions. In narrative terms, a position call is "a use of language by one party in a relationship that invites the other party to take up a particular relational position. Position calls structure people's responses and the meanings that are made of them" (Monk, Winslade, Crocket, & Epston, 1997, p. 304).

Individuals engage in a negotiation process to decide whether or not to take up, change or reject position calls offered. 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 positioning, an individual can be discursively constituted as agentic to

accept or refuse to position him or herself in relation to available discourses (Davies, 1990). A person taking up an agentive position is considered as having access to a subject position where he or she has the right to speak and be heard (Davies, 1991). 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). Drewery (2005) argues that a person can only be agentive when he or she is in a network of relationship with others. However, when an individual claims an agentic position, he or she needs to negotiate meaning with others in order to make particular knowledge known.

In this study, 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 therapeutic setting. I pay close attention to the language that counsellors used to explore how discourse(s) interwoven with relations of power/knowledge constitute practices when counselling people struggling with suicidal ideation.

Counselling as an ethical practice: Levinasian and Derridean ethical framework

As I listened to the stories of care and responsibility that the participants told, I was called to grapple conceptually with the implication of their stories. I witnessed how they were responding to their clients in a way that their acts of responsibility at times worked beyond manualised protocols. At first, I was taken by surprise by their acts of responsibility because these were beyond my training experience. I did not pass judgement on their practices, rather I looked to the philosophy of Levinas and Derrida to provide me with a way of understanding what they were doing as a *practice of ethics*.

Levinas's (1969) approach to ethics emphasises the endless responsibility demanded by "the face of the other" (p. 50) when a meeting takes place. This idea

positions counselling as a *practice of ethics*, which transcends and occurs prior to the counsellors' codes of ethics. I use the term 'other' in my study to refer to an individual who is unique in his or her right. The 'other' includes clients, clients' families and individuals who appeared in the stories of the research participants. From the perspective of Levinas, *the Face of the Other* holds counsellors captive to accept absolute responsibility for clients. This commitment is an inescapable demand that holds a counsellor "hostage" (Levinas, 1981, p. 127); it is not a choice or decision that a counsellor can make (see Levinas, 1981). In addition, counsellors are called upon to be open to engage with their clients without prior knowledge or convictions about them. According to Levinas (1969), such openness is a call to the infinity of otherness. In this regard, responsibility for the other is a responsibility for "what does not matter to me" (Levinas, 1985, p. 95). This sense of responsibility goes beyond things that matter to us and in which we have a self-interest based on reciprocity or preference. I use Levinas's idea of responsibility to describe counselling as an ethical practice when responding meaningfully to someone who is struggling with suicidal ideation.

In a helping profession, Levinas's notion of responsibility is not something a counsellor feels towards the other based on manualised protocols of that for which s/he ought to feel responsible. When a counsellor sees *the Face of the Other*, the face makes a call to him or her to ethically respond to it. From a Levinasian reading of responsibility, I came to see a suicide note representing *the Face of the Other* that spoke to a counsellor and he experienced an ethical prompting to help the other by putting the other first (Levinas, 1981).

Building on these understandings of ethics, my analysis of the therapeutic practice in my project is also informed by Derrida's (2005a, 2005b) work on the hospitality of engagement. Derrida's unconditional hospitality welcomes the other regardless of who that other is, and recognizing the potential dangers or risks involved. It follows from this that unconditional hospitality involves a relinquishing of judgement and control in regard to who will receive that hospitality. In this situation, this ethic of inclusion and integration occurs "before imposing conditions on them [clients], before knowing and asking for anything at all, be it a name or an identity 'paper'" (Derrida, 2005b, p. 67). In the spirit of hospitality, counsellors bring their knowledge into the dialogue with their clients. At the same time,

counsellors take a relational position to learn the language of their clients by being curious and reflective in how they speak and construct meaning.

It would be impossible for counsellors to practise Derrida's unconditional hospitality in the context of suicidal ideation, because of limits were set on what was possible to offer as part of the intervention plans to prevent suicide. As part of their professional and ethical responsibility, it is a general obligation for counsellors to observe their professional code and work within the legal directives. Observing these 'rules and regulations' is particularly vital when counselling clients struggling with suicidal ideation as life or death decisions are involved. The idea of opening the door to whoever might come in, Derridean hospitality, offered me a space to understand the dynamics inherent in the counsellors' struggle to weave the 'rules and regulations' with their offering of therapeutic relationship. Through the lens of hospitality, the Derridean nature of invitation guided me to recognise a client's or counsellor's resistance to the power of bureaucratic discourse. I use Derrida's ethics of hospitality to investigate how the social and cultural milieu shaped identities and practices as a counsellor, and their approaches to reposition themselves to offer an 'open door' therapy to clients.

CHAPTER THREE
LITERATURE REVIEW

Introduction

In this chapter, I pay attention to counselling practices in relation to the Malaysian cultural landscape. I briefly review the counselling profession and its development. When I discuss counselling in the context of suicidal ideation, I focus on the challenges and impasses that confront counsellors when supporting clients and their families. I also explore how medical, legal, culture and institutional protocols shape understandings of suicidal behaviours in Malaysia.

The development of counselling as a profession

Counselling as a profession in Malaysia had its origin in the services offered by guidance and counselling teachers at schools in the 1960s, and these services were extended to support people struggling with substance abuse and addiction in the 1980s (Othman & Abdullah, 2015; Salim & Aga Mohd Jaladin, 2005). A significant professional milestone in the counselling field in Malaysia was the establishment of the Malaysian Counselling Association (Persatuan Kaunseling Malaysia, PERKAMA) in 1982. As a move to include international members, the association changed its name to the International Counselling Association Malaysia (Persatuan Kaunseling Antarabangsa Malaysia, PERKAMA International) in 2011 (Tentang PERKAMA International, n.d.). The Association develops and maintains the Malaysian Counsellor Code of Ethics to guide members and uphold a high standard of practice.

A further significant milestone towards establishing counselling as a profession was the development of the Counsellors Act (Laws of Malaysia, 2006b, Act 580) in 1998 to regulate the profession and counselling practice in Malaysia. The Act legalises the position of counsellors and their practices and at the same time protects clients' interests. The Malaysian Board of Counsellors (Lembaga Kaunselor Malaysia) was formed under this Act with the responsibility to implement the Act through the certification and licensing of counsellors. Implicit in the concept of certification is the establishing of the standards of counsellor education training programmes, the qualifications for eligibility to be registered as a counsellor, as

well as the standard fees charged for counselling services. The power of certification and licensing of counsellors requires the Board to monitor applications into the profession and to revoke registration when unethical practice is established (Quek, 2001). The minimum requirements for eligibility to be registered with the Board are: citizen or permanent resident of Malaysia, above 21 years old, and possessing at least a diploma in counselling from an accredited institution (Lembaga Kaunselor, 2012). In order to practise counselling in Malaysia, one needs to first register with the Malaysian Board of Counsellors and subsequently apply for a practising certificate if one wishes to offer counselling services for a fee. This certificate, renewable every two years, authorises a registered counsellor to practise at a specified location.

Counselling as a profession has experienced tremendous growth for the past three decades. This is evident in an increased number of: a) registered counsellors, as of 31 December 2016 there were 7,157 registered counsellors in Malaysia (Lembaga Kaunselor, 2016); b) counsellor education programmes (doctoral training and master's degrees) offered by both public and private higher learning institutions; and c) counselling-related seminars, conferences and workshops on specialised areas, for example family therapy, play therapy, hypnotherapy and crisis management. The areas of mental health, well-being and counselling have also gained greater coverage in social media, the electronic media and the press, which has raised public awareness and subsequently increased the number of people seeking counselling services (Othman & Abdullah, 2015; See & Ng, 2010).

Understanding suicide in the Malaysian context

I now highlight four aspects that contribute to the burden of suicide in Malaysia: judicial practices operate through the Malaysian Law that defines suicide as a crime; religious practices position suicide as a sin; medical practices operating from a scientific-based that view suicide as a mental health problem; lastly, workplace practices operating from a security and financial risk foundation that prefer treatment requiring a crisis intervention.

Suicide and the law

Attempted suicide continues to be regarded as a criminal offence in several countries, including Malaysia, Pakistan, Bangladesh, Singapore, India, Ghana, Kuwait, Nigeria, and Rwanda (Adinkrah, 2016; WHO, 2008). Many of these countries are also former British colonies (Adinkrah, 2016). Despite the United Kingdom having changed the law against suicide in 1961, attempted suicide continues to find mention as an offence under the Penal Statute of several former colonies, such as Malaysia.

From the standpoint of the enforcement authority, Tan Sri Ismail Omar who was the Deputy Inspector General of Police in 2008, stated during a press interview that the official viewpoint of the Malaysian government concerning suicide is that it is a criminal offence that should be deterred like any other crimes. However, he added that unlike other illicit acts, attempted suicide needed to be dealt with delicately, "We [the police] act on it with wisdom and look at the act from many angles, including the root causes and what prompted them to do it as well as if they have mental disturbances. Dealing with people who attempt suicide requires the involvement of many parties, including specialists and psychiatrists" (Naz Karim, 2008). Some examples of punishments for suicide include a 25-year-old Somalian student who was convicted for attempting suicide in May 2012. He was sentenced to two months' imprisonment by a magistrate's court (Lim, 2012). In April 2017, a 24-year-old woman, who attempted suicide, was sentenced to a fine of RM2,000 or three months imprisonment (Bernama, 2017).

The law against suicide is rigorously enforced in the form of police investigations and court judgements. In the event of an attempted suicide, the law calls upon the enforcement authorities (police officer or fire-fighter) and medical professionals (medical doctor or psychiatrist) to assist with the juridical processes. During the process of investigation, police officers interact with families, friends of the individual who attempted suicide and medical professionals who treated the individual to investigate the event. In some situations, attempted suicide as a cause of injury is reported by families as due to accident to avoid police investigation or legal complications (Ong & Yeoh, 1992; WHO, 2012). On some occasions when a death occurs a few days after a suicide attempt, the person's passing will be

attributed to an accident or injury, rather than considered a delayed outcome of a suicidal act (Ong & Yeoh, 1992). In addition, families of this person may not prefer postmortems because of the stigma associated with suicide. When the cause of suicide or attempted suicide can be hidden, statistics derived from police or medical records under-report such occurrences. It is apparent that the meaning of death lies in the hand of a coroner or medical examiner whose decision has the authority to either conceal or "summon the exact truth about the act of taking one's life" (Jaworski, 2010, p. 684). The coroner's report becomes a legitimate statement that influences the statistics on suicide and may have implication for the deceased's family. In this regard, it may be possible to propose that the meaning of death resides in indistinctness, open for alternative interpretations.

The legal implication about attempted suicide may influence an individual's preparedness to talk about his or her struggles with suicidal ideation, for fear that their concerns will be reported to the relevant authorities and he or she can be arrested. In the context of counselling, counsellors have the ethical duty to adhere to the suicide legislation (see Lembaga Kaunselor, 2011, C.1) when clients are assessed to be at imminent risk of suicide and disclose clients' confidential information to families or significant others (Lembaga Kaunselor, 2011, B.2.a). Adherence to this legislation may shape the ways counsellors approach clients and their families to relay such disclosure.

The medicalising of suicide

The medical paradigm has become incredibly influential in the understanding of suicidal behaviour (Marsh, 2010). One of the widespread acceptable 'truths' in the suicide-related research is that mental health problems contribute more than half of suicides globally. I referred to the World Health Organization year 2014 report, *Preventing suicide – A global imperative*, for this claim. WHO, in this report, suggests that mental health problems are present in up to 90% of the all suicides in high-income countries, approximately 60% in some Asian countries such as China and India. This 'truth' has continuously been supported and circulated in academic literature, suicide prevention approaches and media reporting. This further implicates a causal relationship between suicidal behaviours and mental health

problems, and has leads people to gradually perceive suicide as a mental health problem.

In Malaysia, the National Suicide Registry Malaysia (NSRM) reported that there was a total of 328 individuals took their own lives in 2009, and a mental health problem was present in 22% of these deaths (NSRM, 2009). A systematic review of 38 studies about suicide attempts in Malaysia from the year 1969 to 2011 shown that 17% of the participants who attempted to end their lives were struggling with some form of mental health problems (Aishvarya, Maniam, Oei, & Subramaniam, 2014). Another review focuses on studies on suicidal ideation and intent in Malaysia for 14 years from 1997 to 2011, concluded that depression was found to be associated with suicidal ideation and intent among participants (Aishvarya, Maniam, Hatta, & Oei, 2014). The work of Chan, Shah, and Maniam (2012) also suggests that suicidal ideation was present in 75% of psychiatric inpatients with a depressive disorder admitted to the National University of Malaysia Medical Centre from May 2007 to October 2008.

Concern about the role that depression plays in suicidal behaviour is not unique to Malaysia. For example in Taiwan, depressive symptoms were found to be the most common diagnoses in patients who had attempted or suicide (Cheng, Hu, & Tseng, 2009). Research in New Zealand indicates that people who are experiencing suicidal ideation are likely to have one or more recognisable psychiatric disorders (Beautrais, Collings, Ehrhardt, & Henare, 2005). Suicidal ideation was also found to be a predictor of suicide attempts among depressed patients in an American university hospital (Coryell & Young, 2005). A survey carried out by Nock and colleagues (2008) in 17 countries indicates that the presence of mental health problems is consistently a noticeable predictor of suicidal behaviours. They also cite studies that suggest mental health problems are less important in the occurrence of suicidal behaviours in low- and middle-income countries, which are China, Colombia, Lebanon, Mexico, Nigeria, South Africa and Ukraine, relative to high-income countries, which are United States, Japan, New Zealand, Belgium, France, Germany, Italy, the Netherlands, Spain and Israel. For example, more than 90% of those who die by suicide in high-income countries have been diagnosed with a mental health problem (Cavanagh, Carson, Sharpe, & Lawrie, 2003), while low and middle-income countries indicate 60% and 35% respectively (Vijaykumar, 2004).

While the statistics suggest a correlation relationship between mental health problems and suicidal risk, some literature show that not all people who take their own lives struggle with mental health problems and not all people with a mental health problem attempt to take their own lives (De Gioannis & De Leo 2012; Mulder, 2011; Pridmore, 2011; Reinecke & Didie, 2005). However, given the relative dominance of studies that position depression as indicator of the desire to end one's own life, it appears that a "regime of truth" (Foucault, 1980, p. 131) is being produced and reproduced to make claims about mental health problems and suicidal behaviours. As the occurrence of suicide is conventionally understood on pathological and medical terms, people struggling with suicidal ideation are likely to be considered mentally ill by mental health professionals including counsellors (Marsh, 2010; McManus, 2005). This medical approach may be leading mental health professionals to focus their therapeutic intervention on the 'illness' (Marsh, 2010; Pridmore, 2011; Reeves, 2010) itself, for example, referring to diagnostic systems, that is Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, 2013) to guide them in making sense of clients' experience, assigning categories and shaping the therapeutic plan, and/or making a psychiatric referral to clients for assessment, diagnosis and medication.

To further understand this argument about the relationships between suicide and depression, I take a detour into Winnicott's (1963) views on depression:

> Depression belongs to psychopathology. It can be severe and crippling and may last a lifetime, and it is commonly a passing mood in relatively healthy individuals. At the normal end, depression, which is a common, almost universal, phenomenon, relates to mourning, to the capacity to feel guilt, and to the maturational process. (p. 79)

From Winnicott's perspective, being depressed can be viewed as understandable when a person experiences stressful or traumatic situations. Although people may experience severe depressive symptoms, some of the emotional responses may be 'appropriate' or on Winnicott's terms "common, almost universal". However, depression, be it 'appropriate' or severe, was understood as a symptom of mental health problem by the end of the eighteenth century, and since then a suicidal act has been pathologised (Tierney, 2010). The term 'depression' now has a psychiatric meaning in particular based on the Diagnostic and Statistical Manual of Mental

Disorders (DSM, American Psychiatric Association, 2013). Depression according to the DSM-5 is a mental health problem that causes an individual to experience constant sense of sadness, hopelessness and despair, and/or loss of interest in activities once enjoyed. These depression symptoms can vary from mild to severe and may affect an individual's daily functioning and quality of life. With the use of pathologising language, depression becomes an illness. What I want to express here is that depression is not only the result of biological explanations for mental health problems but may be, in Winnicott's (1963) language, "a passing mood in relatively healthy individuals" (p. 79).

The medicalisation of suicide inform individuals' views and interpretations of suicide, and potentially stand in the way of clients seeking professional help (Reeves, 2010). These knowledges and practices shape the way counsellors respond to clients and their focus in the suicide risk assessment and intervention plans (Marsh, 2010).

Suicide and cultural or religious practices

Cultural and religious sanctions also influence understanding the meaning of suicidal behaviours in Malaysia. The worldviews and responses of different ethnic groups concerning suicidal ideation and mental health problems are informed by available cultural traditions, value systems, beliefs, religious practices and guidelines (Clearly & Brannick, 2007; Jahangir, Rehman, & Jan, 1998). The patterns in the suicide rates of the major ethnic and religious groups, noted in Chapter One, indicate a stark contrast (Foo et al., 2012; Kok & Tseng, 1992). All major religions in Malaysia condemn a person who attempts to end their lives with each mentioning the 'punishment' in the afterlife of people who die by suicide (see Colucci, 2012).

In Islam, taking one's own life is strictly forbidden and is viewed as sinful and detrimental to one's spiritual journey. Aziz (2017) maintains that the Quran teaches: "Do not cast yourselves to destruction by your own hands" – 2:195, "Do not kill yourselves" – 4:29; and the Holy Prophet Muhammad's collection of hadith (words) mentions "…whoever commits suicide with something, will be punished with the same thing in the hell-fire" (p. 55). The view that it is a sin to take one's

own life appears to be connected to ownership of the body. A Muslim's body belongs to Allah (God), it is 'on loan' to a person. The body is considered a "'trust' (*amana*)" (Marcotte, 2010, p. 37) that Allah places temporary in one's care (Rispler-Chaim, 2007). Thus, an individual has the responsibility to preserve its wholeness and dignity before it can be "'returned' to Allah in the best possible shape" (Rispler-Chaim, 2007, p. 75). From this perspective, it is regarded as a sin against Allah to take one's own life (Rispler-Chaim, 2007). Historically, there is a practice to not accord funeral rites to those who take their own lives (Kok, 1998).

People with Chinese ancestors in Malaysia may find themselves shaped by English education and subscribe to Western cultures, or assimilated into a Malay national identity (Ting & Ng, 2012). Some Chinese people identify with traditional roots and receive private Chinese education through an independent education system (Ting & Ng, 2012). They adhere to a variety of religious beliefs, mainly Buddhist, Christian and Taoist, with a minority of Muslim. Traditionally, suicide was viewed by the majority of Chinese people as morally and religiously wrong (Tzeng & Lipson, 2004; Xu, 1987; Zheng, Xu, & Shen, 1986). For example, Chinese people who are followers of the Buddhist religion believe that one's soul will pass into a life in the hereafter when one's physical body is dead. If one kills oneself, instead of transmigrating into another life-form, the soul will be punished by remaining in a place of the ten realms of being (Rin, 1975). In addition, taking one's own life is also considered weak, foolish, irresponsible and selfish behaviour (Tzeng & Lipson, 2004; Xu, 1987; Zheng et al., 1986). This belief may be closely related to the interpretation of suicide as a major breach of filial piety (Chinese: 孝, [Xiào]).

Filial piety is central to a Confucian view of ethics and is considered a virtue of respect for one's parents, elders and ancestors (Ames, 2010) as noted earlier. When their parents are still alive, children have a duty to respect their parents, keep their parents from experiencing anxiety or worry about their children, bring honour or a good reputation to family, and provide material support for their parents (Ho, 1996). An act of filial piety also includes taking good care of one's physical body (Tzeng & Lipson, 2004). Bond (1991) further emphasises that "the body with its hair and skin is received from your parents; [one should] not cause it harm" (p. 15). Thus, harming one's body or killing oneself is considered a transgression of filial piety (Chinese: 不孝, [Bù-xiào]) and brings shame to the family (Tzeng & Lipson, 2004).

Filial obligation also extends to the deceased. It is a common practice that on the anniversary of the death and during Qingming Festival (also known as Gravesweeping Festival), descendants will provide 'money', 'clothes', 'shoes', and other material items to the grave of the deceased. These material items are made from paper and bamboo, and descendants will offer these materials to their ancestors who passed away by burning them at the grave or burial ground (Hansen, 1996). The Qingming Festival is when, traditionally, Chinese people would visit the graves or burial grounds of their ancestors. They pray to their ancestors, sweep the tombs and offer food, tea, wine, chopsticks, joss paper accessories, and libations to the ancestors (Kenworthy Teather, 2001). If children die before their parents, parents worry that no one will offer them these items and pray for them after they pass away. Based on this cultural perspective, those who end their own lives and die ahead of their parents passing will be seen as double *bù-xiào* as they have not only damaged their bodies, but also not behaved with filial piety towards their parents in the world of the living and the dead. This belief often leads to a low-profile funeral arrangement and people do not mourn those who die through suicide (Lee & Kleinman, 2005; Tzeng et al., 2010). In addition, those who survive a suicide attempt often experience a sense of losing face (Tzeng & Lipson, 2004), and subsequently believe that their action is considered shameful and/or sinful which has caused their families embarrassment and shame. Tzeng and Lipson (2004) argue that both an individual and his or her family are likely to pay more attention to face-saving (Chinese: 面子, [Miànzi]) in the eyes of others than discussing problems associated with suicide. Both the face-saving and a sense of disgrace or shame (Hu, 1944) about which I wrote earlier in this chapter are highly relevant here. In this regard, suicide is not a solitary act but a collective humiliation or failure that involves the family as a whole (Tzeng et al., 2010).

The majority of the Malaysian Indian population comprises Tamil-speaking descendants of immigrants from southern India who predominantly subscribe to Hinduism. Indian immigrants were brought to Malaya during the British colonial era in the late 19th and early 20th centuries to work on rubber plantations and infrastructural development such as railway and road building (Morris & Maniam, 2001). The Indian population in Malaysia consistently shows a pattern of higher rates of suicide and suicide attempt compared to other ethnic groups (Maniam et

al., 2014). The higher rate of suicide among the Indian population in Malaysia has been found to be related in part to accessibility to the highly toxic pesticide paraquat in rubber plantations where Indian workers are employed (Morris & Maniam, 2001).

A more ambivalent attitude to suicide in Hinduism may be another factor that shapes the higher rate of suicide amongst the Indian population in Malaysia. Vijaykumar (2007) and Venkoba Rao (1975) conducted studies related to Hindu scriptures about attitudes to suicide and they found varying answers, which include permission for some suicides for special purposes. For instance, the suicide of an ascetic or someone who has attained full spiritual enlightenment is condoned in some Hindu religious literature. Morris and Maniam (2001) subsequently argue that the absence of religious prohibition perhaps leads a Hindu person to consider suicide as an alternative way out of life's struggles and challenges. In contrast, Hindu people believe that by living righteously they have a chance to be reincarnated to a higher caste, and by taking one's own life they will be reincarnated to a lower caste or lifeform, such as life as an animal. Hindu philosophy of 'karma' (cosmic justice) and reincarnation mean that life does not end at death, but instead leads to rebirth into another form (Reichenbach, 1990). At funerals, Hindu people use thulasi leaves, often called tulsi or holy basil to confer its health benefits onto the deceased before the next life begins (Simoons, 1998). The deceased will be blessed by the 'thulasi' leaves brought by the mourners which then coupled with prayers with the hope to 'upgrade' the reincarnation of the deceased to a higher caste or lifeform (Ling, 2008). Ineichen (1998) argues that this belief may invite Hindu people to be more tolerant towards suicide.

Social and economic inequalities influence the lives of women within Indian society. It is a common practice for parents or elderly relatives in the family to arrange marriages for their children, and the children, particularly young women are expected to accept the decision (Morris & Maniam, 2001). When dowry expectations are not met, young brides may be harassed by their in-laws' families (Kumar, 2004). Dowry involves a payment in cash or in kind given on demand to a bridegroom's family along with the bride (Kumar, 2004). In addition, married women experience less powerful positions in their in-laws' home and may be subjected to domestic violence (Loo & Furnham, 2013; Morris & Maniam, 2001).

The social and familial pressures on women to stay married in abusive relationships carry an increased risk of suicide for women (Gururaj, Isaac, Subbakrishna, & Ranjani, 2004; Vijayakumar & Thilothammal, 1993). Women who are divorced, remarried or involved in extra-marital relationships are often discriminated against or treated unkindly by their own community (Sharma, Pandit, Pathak, & Sharma, 2013). Some other issues such as poverty, alcoholism, psychiatric morbidity, and frequent portrayal of suicide as a solution to problems in popular Tamil movies could also explain the higher number of suicide among Indian people in Malaysia (Maniam, 2003).

The above explanations show how religious beliefs and cultural norms play a part in contributing to the variation in attitudes towards suicide in Malaysia. On this point, Maharajh and Abdool (2005) suggest counsellors pay attention to the socio-cultural and political aspects of their clients' lives and carefully listen to what contributes to their struggles with suicidal ideation because these aspects may offer insight as well as possibilities of significant coping strategies for their clients.

Suicide and institutions

Organisations or institutions where a counsellor works and practises counselling include schools, universities, corporations, hospitals, counselling centres and non-government organisations. When these institutions are confronted by increasing suicide crisis situations, crisis response protocols are often developed to protect the safety and well-being of individuals who are at risk of suicide. The protocols inform individuals working in the institutions and clients' parents/families on available resources for responding to a crisis situation. The members of institutions often include key personnel, such as management teams, counsellors, security officers and human resource executives. It is also the aim of crisis response protocols to enhance coordinated efforts of these key personnel in responding to people at risk of suicide.

When suicide is dominantly shaped by medical and judicial practices, crisis response protocols for suicide ideation and attempts are mostly constructed through tailor-made policies and procedures that are aligned with medical and judicial practices (McManus, 2005). It is common for crisis response protocols to include

practices to firstly notify the executive management team and contact the families of the individual said to be at risk. The next steps are influenced by the severity of the concern which may include referring the client for specialised diagnosis or to a hospital emergency facility, and/or releasing him or her to the care of the family. Crisis response protocols also involve prevention strategies to assess and respond to suicidal ideation and suicide attempts (Joiner et al., 2007; Suicide Prevention Resource Centre, 2016; The Jed Foundation, 2006). People from all levels within the institution, namely counsellors, educators, actuaries, financial planners, and executives will be involved in developing suicide prevention strategies. These strategies include offering active outreach programmes to promote healthy lifestyles and help-seeking behaviour, as well as guidance and counselling services for those who are in need. Some institutions provide training for key personnel to identify individuals who are at risk of suicide and refer them to an appropriate professional, so that the problem can be detected early and help can be offered in a timely manner (Suicide Prevention Resource Centre, 2016).

From the lens of a risk society (Beck, 1992), crisis response protocols become part of the clinical governance framework that offer assurance and safety to service users (see Freshwater, Fisher, & Walsh, 2015; O'Malley, 1999). The existence of crisis response protocols function to "make risk accountable and calculable as well as compensating for damage in the face of a vulnerable and uncertain future" (Webb, 2006, p. 44). The idea of a risk society (Beck, 1992) suggests a world that increasing become more hazardous and insecure. Beck proposes that a risk society is the effect of industrialisation and modernisation that threaten our daily lives. A risk society functions within a negative logic that emphasises fear of social circulation of bad intention (Giddens, 1999). People living in a risk society may increasingly be concerned with safety, hence experience a growing of uncertainty, anxiety and vulnerability (Beck, 1992). In response to potential risks, people create an atmosphere of risk awareness and establishes new strategies to minimise risk and maintain safety. The notion of risk may provoke institutions to initiate clinical governance through systematisation of the therapeutic process in order to protect client safety and mitigate the cost of business risk.

In addition to risk management, the structured procedures such as crisis response protocols can be on one hand, an appropriate mechanism for an institution to ease

its crisis management. On the other hand, may possibly limit the forms of care received by individual who expresses suicidal ideation. For instance, Reeves (2010) contends that crisis response protocols may influence counsellors in the United Kingdom in their decisions about when and how to disclose clients' potential risk of suicide to clients' families or significant others.

Crisis response protocols position clients as objects of illness who need 'help' to 'control' their own thoughts and behaviours. Counsellors are thus called into a duty to comply with the protocol as a 'good employee', 'professional counsellor' and 'rescuer with authority and responsibility' who has the knowledge to 'save' clients from a potential suicide risk. I draw upon Foucault's (1977) notion of governmentality as a way in which populations are governed through "the conduct of conduct" (Gordon, 1991, p. 2). I introduced this concept in Chapter Two, and it played out in the way that the conduct of counsellors and clients are conducted through crisis response protocols. The protocols operate as a disciplinary mechanism to regulate counsellors' professional conduct, and at the same time has regulatory effects for counsellors to govern their own conduct and the conduct of clients (see Foucault, 2010). When counsellors conform to the protocols, they invite themselves to conduct their own conduct as acceptable employees in accordance with the requirements to keep clients safe. To achieve this goal, counsellors as disciplinary authorities exercise professional power to shape the conduct of clients. The self-government of counsellors in this way functions to subject clients to power via the protocols (Foucault, 2002, 2010; Gordon, 1991; Lemke, 2002).

Counselling in the context of suicidal ideation

Studies on suicidal behaviour in Malaysia are mostly descriptive, focusing on the analysis of suicidal behaviours, methods of suicide, and risk factors (Aishvarya, Maniam, Oei, & Subramaniam, 2014). There is not much research that addresses counselling approaches. Considering this limitation, I refer to the international literature related to counsellors in the context of suicidal ideation to inform this investigation into counselling practice.

A vast body of literature suggests that professional counsellors often encounter a client who expresses suicidal ideation in therapy (for example Granello & Granello,

2007; McAdams & Foster, 2000; Reeves, 2010; Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001). In such a situation, many counsellors and other mental health professionals may experience a range of emotional responses, such as fear, anger directed towards the client, anxiety, guilt, sadness, shock, disbelief, denial, depression, irritability, stress and self-doubt regarding their professional competence (Jacobson, Ting, Sanders, & Harrington, 2004; Reeves, 2010; Reeves & Mintz, 2001; Richards, 2000; Ruskin, Sakinosfsky, Bagby, Dickens, & Sousa, 2004; Sanders, Jacobson, & Ting, 2005; Yousaf, Hawthorne, & Sedgwick, 2002). In addition, counsellors' distress can be further exacerbated by concerns about malpractice and other legal issues when a client takes his or her own life (Bongar & Sullivan, 2013; Reeves, 2010). These emotional responses and concerns, coupled with the uncertainty of client safety, are likely to take a heavy toll on counsellors. These experiences are considered as "occupational hazard" in the profession (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989, p. 294). Counsellors who are exposed to these experiences may potentially be vulnerable to compassion fatigue (Figley, 1995, 2002; Meichenbaum, 2007). Figley (1995) describes compassion fatigue as a state of physical and emotional exhaustion that helpers experience when witnessing "a traumatising event experienced or suffered by a person" (p. 7). Counsellors who experience compassion fatigue may find their ability to feel and care for clients eroded as they continue to attempt to engage and maintain empathetic connections with clients (Figley, 1995).

Counsellors may be prepared to encounter unexpected or crisis situations in therapy. However, when clients express suicidal ideation, the process becomes stressful for many counsellors (Jurich, 2008; Reeves, 2010). On this, Jurich (2008) offers an explanation. The moment a client indicates the possibility of taking his or her life, counselling practice becomes complex in ways that "any word or action [by the counsellor] might be the factor to tip the balance towards the client's life or death" (p. 2). As a client's life is on the line, this experience can position counsellors outside their "normal path of therapy" (Jurich, 2008, p. 2). As a way to minimise making mistakes that may position clients at increased risk for suicide, counsellors become more conscious to scrutinise every move they make in the counselling process. This includes how counsellors talk when assessing a client's potential risk for suicide and informing client's significant others about the risk.

The use of language in the co-construction of suicide risk and safety

The taboo associated with suicide in general and in Malaysia particularly (Azhar, 2003; Foo et al., 2012; Loo et al., 2012; Sudak et al., 2008) may lead clients to take a cautious stance to determine whether or not they can trust counsellors with their concerns. Hence, establishing a sense of safety for clients to talk about despair and suicide is crucial for counsellors, given the risk implications of suicidal ideation. On this, Reeves (2010) suggests practitioners to place emphasis on engagement to develop a client-counsellor relationship which a client feels accepted, valued and respected. Generally, when a client expresses suicidal ideation, it is a standard practice for a counsellor to engage with a client to assess the severity of the suicidal ideation in order to determine whether clients are safe to continue therapy within the parameters of counselling practice, and/or whether clients are in need of alternative mental health care, such as psychiatric services (Reeves, Bowl, Wheeler, & Guthrie, 2004). Assessing a client's potential risk for suicide is viewed as an important practice because it involves concern about potential legal and/or financial implications (Pope & Vasquez, 2016; Reeves, 2010). The suicide risk assessment tools employed by mental health professionals are mainly structured on the basis of a medical model (Hagen, Hjelmeland, & Knizek, 2017; Sommers-Flanagan & Shaw, 2017). Client's suicide risk is often quantified to the rate of 'high', 'low' or 'moderate'. A suicide risk assessment generally is composed of checklists with a questionnaire that guides counsellors to evaluate client's suicidal ideation, intent, plan, and past suicide attempt history. The assessment questionnaire often elicits a yes-or-no response from clients and may not be able to present the full picture of clients' experiences (Brew & Kottler, 2017; Hagen et al., 2017; Sommers-Flanagan & Shaw, 2017).

For assessment purposes, counsellors may need to have basic knowledge of psychological symptoms for discussion in relation to client's suicide potential with relevant mental health professionals (Pope & Vasquez, 2016; Reeves, 2010). Among the diagnostic systems, Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, 2013), a medical model of mental distress, offers psychiatric and symptom-focused diagnoses for most mental health circumstances. DSM diagnoses provide counsellors with options for making sense of clients' experience, and a structure of thinking to guide professionals'

decisions whether clients are in need of psychiatric assessments, diagnoses and treatment. Referring to DSM to describe clients' experiences has become an expected practice for counsellors and other mental health professionals internationally and in Malaysia.

Simblett (2013), a New Zealand psychiatrist with narrative knowledge, argues that the use of DSM-5 often elicits pathologising language to describe individuals who are struggling with mental health problems. Fullagar, Gilchrist, and Sullivan (2007) suggest that diagnostic language may position people who are struggling with depressive symptoms as abnormal, and this description may potentially affect the likelihood of seeking professional help in relation to the stigma associated with mental health problems. In therapy, a pathologising way of assessing suicide risk may on one hand contribute to clarity about symptoms, but one the other hand may contribute to clients experiencing shaming and blaming. Pathologising language may organise how clients make sense of their experiences, and position counsellors in particular relationships with their clients that have limited possibilities for establishing a trusting connection (see Anderson, 1997). Family therapists who subscribe to a poststructuralist approach are concerned that when medicalisation of people with mental health struggles is privileged, the importance of relational aspects of counselling work may be minimised (Strong & Busch, 2013). Simblett (2013) uses Davies and Harré's (1990) and Foucault's (1972) notion of power and resistance to explain the subject positions offered by the DSM discourse, and how this discourse limits the possible actions and responses of practitioners when interacting with their clients. He argues that the greater the certainty of DSM knowledge and practices, the less the possibility of practitioners learning alternatives and expressing professional agency in moment-by-moment practice with clients. Simblett applies a dance metaphor to describe how DSM knowledge and practices can be used to make sense of clients' experience. Simblett identifies DSM as diagnosis through the dance partner and suggests practitioners to adopt a flexible relationship with DSM. They can change their dance movements with DSM from moment to moment in finding ways to best assist their clients. Through different dance positions, practitioners can flexibly weave everyday language alongside the diagnostic language to work collaboratively with their clients to explore how closely DSM descriptions can explain clients' personal experience.

Simblett promotes the practice of holding onto the both/and position to stay open to DSM knowledge and to adopt a relational approach. DSM knowledge is but one way of describing clients' problems, not as definitive and singular descriptions. However, in the mainstream practice, there is often an absence of the fluidity that Simblett's dance metaphor suggests.

Research and clinical experience shown that it is not possible for counsellors to be able to predict with certainty whether or not an individual who presents with warning signs and risk factors may take his or her own life (Jobes, 2016; Mulder, 2010; Pope & Vasquez, 2016; Reeves et al., 2004; Reeves, 2010; Sommers-Flanagan & Sommers-Flanagan, 2015). Thus, making judgements about clients' suicide risk becomes a complex process. Assessing clients' suicide risk by asking them questions according to the assessment checklist is not enough: Sommers-Flanagan and Sommers-Flanagan (2015) argue that *how* counsellors approach their clients with questions may shape how these are answered, invite or close down clients' readiness to talk, and shape the level of client disclosure. Sommers-Flanagan and Sommers-Flanagan (2015) further suggest counsellors adopt a collaborative stance when talking with clients about suicidal ideation or plans. This approach invites counsellors' curiosity about the social and historical origins of clients' problems. A collaborative approach recognises the sense of being overwhelmed and understands the magnitude of the pain experienced by clients. Discussing a topic of suicide can be sensitive for some clients and may be uncomfortable. On this, Jobes (2016) recommends counsellors to apply appropriate pacing when asking clients the assessment questions. The consideration of pacing gives room and time for clients to prepare what they desire to talk about, and opens space for counsellors to establish trust and rapport with clients. Similarly, Brew and Kottler (2017) argue that the interview process does not have to be formulaic. They suggest counsellors adopt an exploratory approach to facilitate the clients' expression of suicidal ideation. For instance, a counsellor might ask, "Is that ok for me to ask, are you considering suicide?" If the client answers affirmatively, a follow-up question can be asked, such as, "Have you told anyone about your desire to end your own life?" This process invites clients to explore further ideas and thoughts of their experience, and may increase the opportunity of clients sharing their concerns (Brew & Kottler, 2017). Fiske (2008) suggests that counsellors who

learn to artfully ask clients about their suicidal experience may likely produce a dialogic exploration with clients. An act of asking that reflects empathy and genuineness often turns the assessment interview into an *exploration* of clients' *problems*, not an *examination* of what's wrong with the *clients*.

There are ways of speaking that reflect respect and sensitivity towards people who are coping with suicidal ideation. Granello and Gibbs (2016) propose that practitioners use "person-first language" (p. 31) to speak about people who are thinking of taking their own lives. For instance, using language such as 'people with suicidal ideation' rather than 'suicidal people'. This form of language conveys a message to clients that they are valued as a person and not as a category of people, as it highlights the individual's dignity and worth, at the same time as it minimises the attention paid to the suicidal behaviour (Beaton, Forster, & Maple, 2013; Granello & Gibbs, 2016). In addition, Silverman (2006) advises mental health professionals to avoid using words such as, 'committed suicide' to describe someone who intentionally ends their lives because of the connotations of illegality, sin and shamefulness. Beaton et al. (2013) propose to adopt the term *ending his or her life* rather than 'committed suicide', as it shows respect for the deceased as well as those bereaved by the death.

As counsellors are not likely to foresee precisely whether or not an individual will attempt to take his or her life, Reeves et al. (2004) urge counsellors to use suicide risk assessment as a means to assist them to increase client safety. The details of suicidal ideation or any plans that clients are willing to share in the assessment interview provides counsellors with a better position to make decisions about how best to respond to and support clients, including making a decision to disclose or maintain clients' confidential information. I explore further in the next section, some aspect of the parenting practices that construct a different practice of confidentiality in the context which involves parental notification.

Confidentiality in the context of imminent threat of suicide

Historically, the concept of confidentiality is shaped by the Western value of individual rights to privacy and autonomy (Meer & Vandecreek, 2002). Information disclosed by clients in therapy belongs to the clients and it is the clients' right that

counsellors protect that information (Bond, 2010; Corey, Corey, Corey & Callanan, 2015; Pope & Vasquez, 2016; Welfel, 2015). Thus, no disclosure should take place without clients' consent. But there are exceptions to this rule (Agee, 2011). The ethical responsibility of confidentiality is inextricably linked to counsellors' decisions about when to disclose relevant information in the interests of preserving the client's life and when to withhold it as a way of respecting client autonomy (Bond, 2010). When a client refuses to consent for the counsellor to notify his or her families or other supportive resources, an ethical dilemma may arise for the counsellor where the client poses a serious risk of potential self-harm (see Agee, 2011). Either the counsellor discloses a client's (confidential) information and increases support for the client, or respects the client's autonomy potentially leaving the client at risk of acting on his or her suicidal ideation. Despite the potential for liability on either side of the ethical decisions, counsellors are advised to emphasise keeping clients safe (Reeves, 2010; Welfel, 2015).

When supporting clients who are at risk of suicide, the Malaysian Counsellor Code of Ethics advises counsellors to protect clients or identified others from serious and foreseeable harm (Lembaga Kaunselor, 2011, B.2.a). Counsellors have an explicit legal and ethical responsibility to take appropriate action in protecting client safety. An aspect of this duty is to disclose clients' confidential information to families or significant others when clients are judged to be at imminent risk of suicide. Confidentiality is one of the aspects that is covered within the Code. It is a client's right that information disclosed in therapy will be held in complete confidence by registered counsellors (B.1.b and B.1.c) unless mandated or permitted to disclose such information. Disclosure is allowed when it is necessary to counter a foreseeable danger of serious harm (B.2.a). In such a situation, counsellors have a duty of care and protect client safety. The Code also demands counsellors to apply the standards related to confidentiality alongside respecting clients' worldview and cultural differences. This point has been clearly articulated in the Code, which speaks to client rights when treating client disclosure: Counsellors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counsellors respect differing views toward disclosure of information. Counsellors hold ongoing discussions with clients as to how, when, and with whom information is to be shared (B.1.a); and to inform clients of the limitations of

confidentiality and seek to identify situations in which confidentiality must be breached (B.1.d).

From a legal perspective, violation of any ethical standard, including confidentiality, is deemed a punishable offence by ethics committees and licensure boards, and consequences can go as far as removing the name of the registered counsellor from the Register and/or revoking the practitioner's license (Laws of Malaysia, 2006b, Act 580, Clause 40).

Making a decision to disclose confidential information remains one of the most challenging question for many counsellors (Pope & Vasquez, 2016; Reeves, 2010). On one hand, disclosure of clients' confidential information is undertaken to ensure that in the presence of risk of serious harm, clients receive optimal care and support. On the other hand, the disclosure may position counsellors in a precarious situation which results in a breach of trust that can possibly lead to irreversible consequences for the therapeutic relationship (Corey et al., 2015). Trust is important in the development of a therapeutic alliance with clients as it shapes clients' willingness to disclose their concerns and experiences (Bond, 2010). One of the aspects that shapes the development of trust in a therapeutic relationship is confidentiality. A therapeutic relationship will be at risk if clients no longer feel safe in what they are willing to share in therapy.

Given the importance that confidentiality has in maintaining a counselling relationship, when an exception to confidentiality may be exercised the Code offers guidance to support the members of the Malaysian Board of Counsellors (Lembaga Kaunselor Malaysia): a threshold of acceptable actions that call on professional knowledge, judgement, sensitive discernment and wisdom to respond with responsible care. For instance, discussing with clients the decision to disclose the suicide risk to their families is seen as a way of respecting client autonomy (Welfel, 2015). This practice invites clients to hear the decision and to discuss with the counsellors any issue that arises. When disclosure takes place as a "joint decision" (Welfel, 2015, p. 133) with clients' consent and involvement, it becomes a collaboration between counsellors and clients who are working towards a therapeutic goal.

Cultural challenges to confidentiality

Cultural practices in Malaysia pose some significant challenges for counselling practice surrounding confidentiality and influence the choices people make when seeking support (Aga Mohd Jaladin, 2013; Sumari & Jalal, 2008). For instance, the practice of clients seeking parental advice may be interpreted by counsellors who, trained in Western individualist models of practice, emphasise individual rights as a client being unable to make decisions (Sumari & Jalal, 2008). On the other hand, the value of 'keeping family problems from outsiders' often evokes individuals' hesitation to bring their own or family issues to outsiders' attention (Abu Talib, 2010; Mak & Chan, 1995). Clients' hesitation in this context is often mistakenly perceived as resistance to counselling (Abu Talib, 2010). Further, families may tend to associate suicidal behaviours with mental health problems that can be traced to the family as a hereditary trait (Ng, 1997). This interpretation obstructs families' willingness to make their problems known to outsiders. Being positioned between keeping family disgrace from outsiders and disapproval of their family for seeking outsiders' help, clients may prefer to remain silent about their problems. Even if they do seek outside help, this will be their last resort, and it is often in a confidential manner or expressing their distress indirectly using a roundabout way of speaking (Abu Talib, 2010; Sumari & Jalal, 2008). I argue that going against the value of 'keeping family problems from outsiders' contributes to clients' hesitating to agree with a counsellor's suggestion to notify their parents about their struggle with suicidal ideation.

In the context of suicidal ideation, counsellors potentially experience an ethical dilemma between "respecting the client's autonomy or seeking to preserve life, either because [respecting the client's autonomy] is a fundamental ethical principle or because [preserving life] is thought to be in the client's best interests" (Bond, 2010, p. 101). The approach that a counsellor adopts is likely to be influenced by his or her position towards suicide (Ellis, 2004). A counsellor who advocates to keep a client safe may become involved in an adversarial struggle situation where a client strives to maintain autonomy as a form of resistance to these practices while a counsellor struggles harder to keep the client safe by employing greater effort to subject the client under close monitoring (Ellis, 2004). This urgency may result in the counsellor acting too soon in alerting the client's family to the risk of suicide,

referring the client for hospitalisation/medication, or releasing the client to the care of his or her family (Reyes-Foster, 2013). When counsellors disclose suicide risk to clients' families, this action may sometimes be experienced by clients as betrayal, leading clients to be more likely attempt to conceal his or her suicidal thought or plans in therapy (Ellis, 2004). This adversarial struggle hence may cause a distance in the relationship between counsellor and client with consequent effects for safety (Ellis, 2004).

For a family who brings up their child with the value that the child's actions reflect on the whole family, receiving a notification from a counsellor (who is considered as an outsider) regarding their child's struggles may contribute to the humiliation of the family. First, their child is expected to be able to cope with difficulties on his or her own by mustering all their resources and consulting family first (Abu Talib, 2010; Baptiste, 2005; Mak & Chan, 1995), and not seek help from outsiders. Disclosing one's concerns to a counsellor without talking to parents first may be seen as disloyalty to the family. Second, the notification may lead parents to be concerned for their adult child and, to experience feelings of guilt and blame for inadequate parenting to support their adult child. This may lead to challenges for counsellors to foster a working alliance with a client's parents without questioning the parents' parenting practices. In light of the high familial gaze for norm violations in order to maintain family honour, clients' families, specifically parents, often demand counsellors to disclose clients' (confidential) information, as they consider this to be their right to the privacy of their children (see Baptiste, 2005; Keshavarz & Baharudin, 2009; Mak & Chan, 1995).

Parental rights, clients and their families' respective values and cultural considerations often positions counsellors in a dilemma whether disclosing suicide risk would help or harm clients. The complexities surrounding confidentiality often produce, in Derrida's (1993) terms, an aporia that confronts counsellors when disclosure is required to prevent an imminent danger to clients. The idea of aporia proposed by Derrida is a dilemma which in the context of counselling Kotzé and Crocket (2011) described as "an impasse where a single 'right' solution is not possible and yet there is a responsibility to take some action" (p. 49). In an aporetic moment, counsellors may experience a state of being 'stuck' where it is not clear

what to do or how to move forward in a therapeutic process, despite of knowledge and skills.

This chapter has reviewed literature emphasising how cultural knowledge and practices in Malaysia shape counselling practices when clients are assessed to be at risk of suicide. I now move ahead to present the research design and process I employed to produce this study.

CHAPTER FOUR
RESEARCH DESIGN AND PROCESS

...as soon as people begin to have trouble thinking things the way they have been thought, transformation becomes at the same time very urgent, very difficult, and entirely possible.

(Foucault, 2000, p. 457)

Introduction

I give an account of my chosen research design to produce my study in this chapter. I begin by discussing qualitative methodology and its contribution to addressing the purpose of my study. This is followed by a description of the research processes that were involved in recruiting participants, and the interview methods for generating qualitative data. I end this chapter with the introduction of the approaches I used to produce transcripts and outline the analysis I used.

Describing the research design

I applied a qualitative research design with a discursive emphasis so that I could invite research participants to talk about their experiences when counselling clients with suicidal ideation. I wanted 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.

Marshall and Rossman (2011) suggest that qualitative researchers inquire about "the everyday life of a setting chosen for study. These researchers value and seek to discover participants' perspectives on their worlds and view inquiry as an interactive process between the researcher and the participants" (p. 30). This form of inquiry aims to generate rich descriptive and relies on the participants' speaking as primary data.

I chose qualitative methodology as it was "less likely to decontextualise the experience and account of participants" (Burr, 2003, p. 149) and because accounts

of counselling practice would offer me the tools to capture the nuances and complexities of experiences in everyday practice:

> Qualitative process studies are highly relevant to the interests of most practitioners, because they help to develop a sensitive understanding of the nuances of the therapeutic process. People who carry out this type of qualitative research also find that the actual experience of doing the research greatly contributes to their growth as therapists. (McLeod, 1999, p. 34)

This political dimension of a qualitative research process invited me to constantly refine ways of interviewing, and to work to develop analytic approaches to penetrate the surface appearances of research participants' strategic responses, such as silence. Following Bondi and Fewell's (2016b) argument for the power of particular examples of practice, I hoped to learn from research participants accounts of particular therapeutic relationships and practice from their professional experience. Through an "experience-near" (Bondi & Fewell, 2016b, p. 30) inquiry, I hoped to engage "in depth with the reality and the lived experience of therapeutic practice" (Bondi & Fewell, 2016b, 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.

Describing the research process

After the University of Waikato's Postgraduate Research Committee and Faculty of Education Research Ethics Committee approved my research (I describe ethical considerations later in this chapter), I embarked on the following processes to approach the relevant parties in Malaysia to recruit research participants for my project.

It is a requirement for a researcher who intends to conduct research in Malaysia to obtain prior permission from the Prime Minister's Department via an official coordinating body known as the Economic Planning Unit (EPU). When I received the approval letter from EPU (Appendix A), I was required to present this letter in person at the EPU office to collect a Research Pass (Appendix J). The Research Pass positioned me as a researcher to do a study with permission from the

Malaysian government to invite potential parties to take part in my project. When I met potential research participants, I showed them the Research Pass.

After approval from EPU, I wrote to the President of the Malaysian Board of Counsellors (MBC) and the Vice President of the International Counselling Association Malaysia (PERKAMA International) to seek permission to recruit counsellors from their membership database (Appendix B and C). With the approval from MBC and PERKAMA International, I then proceeded to invite registered counsellors in Malaysia to take part in my research. I emailed an invitation letter (Appendix D), information sheet (Appendix E) and Participant Reply Form (Appendix F) to them. There were 36 (0.6%) prospective participants out of 5,668 registered counsellors responded to my invitation expressing an interest to take part.

Approaching the research participants: Recruitment process

Malaysia is my research location where I am a registered counsellor. I am familiar with the cultural background, the administrative procedures, and language of communication to support smooth running of the research process. I employed a purposive approach (Ritchie, Lewis & Elam, 2003) to invite participants as it allowed me to apply my own criteria when defining the parameters of the counsellor population. I recruited counsellors who met the following criteria:

- a Malaysian national and registered counsellor with the Malaysian Board of Counsellors;
- experienced in counselling clients who are struggling with suicidal ideation and where there had been a need to inform the clients' families about the suicidal ideation;
- counselled and assisted families to become effective partners in suicide prevention.

In addition to the above requirements, I also considered several aspects. I selected participants from different cultural and religious groups because their worldviews and responses concerning suicidal ideation were likely to be informed by their respective cultural and religious beliefs (Clearly & Brannick, 2007; Foo et al, 2012). As a counsellor myself, it was likely that I might encounter someone with whom I

had worked or known in the past especially as the counselling community was small. In order to avoid such conflicts of interest, I was careful to invite participants whom I held no professional contact with, either as a counsellor, counsellor educator or supervisor. Additional selection consideration was the residence location of prospective participants. Due to time and cost constraints, I focused on participants who were residing in Klang Valley, the home to a large number of migrants from other states in Malaysia. This area comprised Kuala Lumpur, where I was based during data generation, and its suburbs, and adjoining cities, as well as the state of Selangor.

I aimed to recruit eight to ten research participants, and this number was appropriate for this kind of qualitative study. According to Avdi and Georgaca (2007), the number of participants for a qualitative research taking a discursive approach is often small as analysis is very labour-intensive. Upon receiving responses from prospective participants, I followed up with them via email. I emailed 24 prospective participants who did not meet the selection criteria - for reasons such as no experience in counselling a client struggling with suicidal ideation; currently residing outside of the Klang Valley area, thanking them for their interest (Appendix G). Of the remaining 12 prospective participants, I subsequently received the Participant Reply Form from eight of them. I grouped the eight prospective participants who met the selection criteria in "List A", whilst I kept the other four in the waiting list (hereafter "List B") and continued to follow up with them. I then proposed a date and time to meet with the eight prospective participants individually to discuss the informed consent procedures in person when I returned from the University of Waikato to Malaysia.

After I returned to Malaysia, I contacted these eight prospective participants to finalise our meeting dates, times and venues. In a first meeting at a mutually agreed time and place, I discussed the informed consent procedures so that potential participants were cognisant of what my project was about, their involvement and the value of their contribution. I clarified questions they had pertaining to my research and their involvement. I used this meeting time to establish rapport with them. All eight prospective participants agreed to take part. They completed and signed the Consent Form (Appendix H).

Informed consent involved a number of serious ethical considerations in this sensitive area of research. For example, during research interviews, participants might disclose information where a health or life-threatening situation arose that could potentially harm the participants, specific third parties or their clients (see Etherington, 2001). Therefore, I discussed this possibility with participants and I specifically asked them not to reveal such information. Should this happen, I informed them, such information would be excluded from research confidentiality and anonymity, and I would discuss the matter that had arisen with participants and encourage them to report the specific incident to their workplace supervisor and/or seek counselling supervision according to clause A.11 and B.3 in the Malaysian Counsellor Code of Ethics (Lembaga Kaunselor, 2011).

I took action to protect participants' privacy by using a pseudonym. I was also aware that I was asking counsellors to speak about their experiences when counselling clients struggling with suicidal ideation, which in some instances might include stories about their colleagues, workplace, supervisors/supervisees, clients, or clients' families, who had not given permission to have their lives included in a study. I discussed with participants how we might protect the privacy of other people who were at the centre of the counselling process but not present during the research interviews, so that the participants could speak of their professional experience while not risking identifiability of colleagues or clients. I stressed however that although all measures would be taken to protect identities, anonymity could not be guaranteed in research of this kind.

As the research participants were talking about their experiences in a sensitive area of practice, this process might evoke a range of emotional reactions for them (Dahlenberg, 2004; Reeves, 2010; Reeves & Nelson, 2006). It was therefore crucial for me to be aware if participants were struggling with difficult emotions and I would monitor this potential vulnerability by checking with the participants in the moment-by-moment interactions of the interview conversations. If I noticed any sort of difficult emotional responses, I would pause the interview and discuss with participants what they would prefer to do. At the same time, I provided participants with information about appropriate support and I indicated that if the situation arose I would encourage participants to seek supervision. None of the participants took up this provision.

Participants' involvement in the research was voluntary and I emphasised that they had the right, without any reason or at any time, to withdraw their contribution up to three weeks after receiving the final transcripts of the second and final interview. I also informed them that where it was specifically requested by participants that I exclude, from the data, a particular section of the research interview, I would honour the request. I advised participants that they would be free to decline to answer any interview questions. I would turn off the voice recording when a participant wished not to record a particular part of the conversation.

Introducing the research participants

From the prospective participants, I invited eight counsellors to take part in my research project. In this section, I briefly present in Table 1 the research participants' information concerning their gender, ethnicity, religious belief, years of counselling, frequency of counselling clients expressing suicidal ideation and whether or not they receive any formal training related to suicide intervention skills. More detail is provided in the chapters where particular stories are represented.

Table 1: Research Participants' Demographic Information

Name (Results chapter)	Ethnicity/gender (Religious belief)	Years of counselling	Experience counselling in area of suicidal ideation	Professional education for suicide prevention or crisis intervention
Anuja (Chapter Nine)	Indian female (Christian)	Two	Occasionally	Yes
Bahar (Chapter Seven)	Malay male (Islam)	Two	Limited	None
Cheng-Mei (Chapter Eight)	Chinese female (Christian)	Nine	Occasionally	Yes
Li-Na (Chapter Eight)	Chinese female (Christian)	Three	Occasionally	Yes
Mazuki (Chapter Ten)	Malay male (Islam)	Fifteen	Limited	None
Peng-Yu (Chapter Seven)	Chinese male (Buddhism)	Five	Frequently	Yes

(table continues)

Name (Results chapter)	Ethnicity/gender (Religious belief)	Years of counselling	Experience counselling in area of suicidal ideation	Professional education for suicide prevention or crisis intervention
Siva (Chapter Six)	Indian male (Hindu)	Five	Limited	Yes
Umadevi (Chapter Five)	Indian female (Hindu)	Six	Occasionally	Yes

Roadmap to generate research materials

Research interviews: Practical steps

The quality of my research depended on the richness of participants' stories, which they expressed in one-on-one interviews. I used a semi-structured interview approach to invite the counsellors to talk about their experiences. This approach allowed me to narrow down the specific areas that I desired to explore in relation to counselling in the context of suicidal ideation. These specific areas encompassed counselling at the intersection of family involvement in suicide prevention whilst simultaneously being mindful of client's well-being and a counsellor's duty to protect the client. I had developed guiding questions (Appendix I) that served as a base to begin the initial interview (see Kvale, 1996). I emailed a copy of these questions to participants one week prior to each interview.

I engaged with participants in English during the research interviews, but when they used some phrases in another language that I understood, I shifted to that particular language and later translated these responses during the transcription process. The interviews were carried out in a private and adequately soundproofed location agreed by each participant. I audio-recorded the interview sessions using digital devices. After each interview, I manually uploaded the electronic files to my computer and cloud based electronic filing systems for storage and saved them using a password to protect the recording and the participants' identities.

There were two interview sessions for each participant, three to six weeks apart. The first interview session took between 45 minutes to 90 minutes, while the second interview session took 45 to 60 minutes. The goal of the first interview was to explore counsellors' accounts of their responses in the context of suicidal ideation,

especially the experiences in which there had been a need to notify the clients' families about the suicide risk. In the second interview, I followed up on research materials from the first interview and checked with participants about any feelings of discomfort following the first meeting.

I began the first interview by asking questions regarding participants' religious belief, years of practising counselling, frequency of counselling clients expressing suicidal ideation and whether or not they received any formal training related to suicide intervention skills. I used this brief moment to create a relaxed environment into which I could proceed with more open-ended questions. After the first interview was over, I transcribed the conversations and developed follow-up questions for the second interview. During these processes, I came to be aware of the power/knowledge relations as a researcher from an overseas university and how that positioned me in the research interview situations. There might be a risk that research participants would share with me what they thought I wanted to hear. Thus, I sought feedback and guidance from my research supervisors before I sent the transcript of the first interview and follow-up questions to each participant. With my research supervisors' guidance, I re-positioned myself with a new way of inquiry which helped strengthening my curiosity and in turn shaped the conversation with the participants.

Theorising interviewing

My choice of research approach was informed by the poststructuralist and social constructionist perspectives that knowledge is constructed socially (Burr, 2003; Gergen, 1994). Drawing from such a perspective, research inquiry was viewed as an interactive and collaborative process between the researcher and participants in the construction of meanings and realities (see Burr, 2003; Marshall & Rossman, 2011; McNamee, 2012). In this relation, the knowledge and meanings produced in the research conversations were the products of interactions between me (the researcher) and the participants, as well as the historical, cultural and social context within a given time of our interview meetings (see Burr, 2003; Gergen, 1999a). My research was not to discover and define the truth lying 'out there'. Every aspect of my inquiry and the interpretation of the findings of this study were thus a subjective construction which were unique results of these interactions.

As a researcher, I took steps for holding myself ethically accountable when engaging with the participants. I privileged their contributions, valuing the practice expertise they offered. I engaged them from a place of openness and respectful curiosity without understanding too soon in ways that I assumed I knew their experience already (Weingarten, 2003). I formulated respectful curious questioning in response to the participants' replies to "extend [my] not understanding as long as possible" (Weingarten, 2003, p. 198). I hoped to provide the participants more opportunity to story their practices, struggles and challenges. The research interviews thus became a dialogue where the participant was invited to have a conversation about topics that were important to them. This skill, Anderson and Goolishian (1992) refer to as "not knowing" in counselling practice, "entails a general attitude or stance in which the therapist's actions communicate an abundant, genuine curiosity" (p. 29). I worked to bring such an attitude to research interviewing.

During research interviews, I adopted an active listening approach to aid me in seizing the opportunities when *arresting moments* (Katz & Shotter, 1996) arose and inviting a participant into further exploration (Louw, Todd & Jimakorn, 2011). I drew the idea of *arresting moments* from Katz and Shotter's (1996) social poetics reading of language. Katz and Shotter (1996) apply the practice of social poetics in understanding medical diagnostic interviews between doctors and their patients. This practice involves a third person acting as a 'cultural go-between' in these interviews. This person "mediates between doctors and their patients", "open to being 'arrested', or 'moved' by certain fleeting, momentary occurrences in what patients do or say" (p. 919). These *arresting moments* take place when people involved in a conversation are touched by a particular utterance or when something seems to hang suspended or arrested in the gaps between utterances.

The active listening approach invites a researcher to be sensitive to participants' body language, maintaining nonverbal conversational involvement, and asking follow-up questions when he or she senses that there is more to the story told (Louw et al., 2011; McCrory & O'Donnell, 2016; Weger, Castle Bell, Minei & Robinson, 2014; Wengraf, 2001). Nevertheless, it is challenging for researchers to acquire this skill because it requires the ability to stay alert for cues about how to move the interview forward withhold one's biases, preconceptions and expectations in order

to hear clearly what is being said (Minichiello & Kottler, 2010; Wengraf, 2001). The position of not knowing that I took up helped me to maintain my active listening posture to the participants' stories without limiting their stories to my own frame of reference.

First interview: My personal reflection

My research focus emphasised the interplay between a therapeutic focus and counsellors' duty to protect the life of clients and their legal obligation to inform authorities of the potential risk of clients taking their own lives. This emphasis meant that the research interviews could involve ethical complexity in investigating a sensitive professional area where legal considerations directly shaped counselling practice. Prior to interviewing the participants, I prepared myself by exploring relevant theories, philosophies and interviewing methods. In addition, I sought to learn from both my research supervisors and a doctoral candidate whose narrative therapy expertise taught me about the value of genuine curiosity in producing possible new ideas. However, the value of researcher's curiosity did not become apparent to me until I had had my first research conversations with Bahar.

This interview was significant for the research process as I learned much from it. I went to the interview with my own agenda, and in pursuing this did not enable rich accounts to emerge during the encounter with Bahar. I was using a question and answer approach to "soldier[ing] on" (Burman, 1994, p. 51), without giving value to what Bahar was saying. Though I heard Bahar, in hindsight I realised that I had at times stopped listening. Immediately after the interview, I remembered feeling proud of myself for completing the interview and *asking all the questions* in the interview schedule within the time limit. However, when I was transcribing the interview, I became dissatisfied with the interview process and so with the limits that process produced the responses. I sent the first transcript to my research supervisor and we discussed it. In the discussion, my research supervisor helped me to reconnect to my previous preparation on the practise of curiosity. I also realised how familiar discourse in Malaysia had directed me to adopt a modernist/structuralist framework – soldiering on with question and answer – instead of putting into practice the new knowledge about listening with curiosity that I had learned and hoped to apply. Subsequently I reflected on the question of

which paradigm stance I claim as a researcher. The discussion cleared my confusion, which could otherwise have impacted on subsequent interviews.

When I repositioned myself within a social constructionist paradigm, I began to consciously adopt a different way of listening and using language. I applied a more tentative way of speaking. Prior to commencing my doctoral journey, I had limited exposure in my training and education to asking questions in these ways, and through this interviewing process I had found myself embracing a new paradigm that values researcher curiosity. My researcher identity developed into new territory where curiosity guided me to respond to participants' replies. I began to ask questions that could invite rich description of the participants' experiences. I also asked follow-up questions which emerged from close listening to the participants' stories, rather than sticking closely to prepared questions. Instead of summarising, paraphrasing and interpreting, I began to ask questions which offered me opportunities to listen to how participants described being positioned within available discourses which affect them as counsellors in the context of suicidal ideation. For example, I asked questions about how counsellors made sense of their experiences, how they negotiated between contesting discourses, and how they reached decisions that they considered appropriate and which reflected the values embedded in their practice.

Between interviews, I revisited earlier interview audio recordings repeatedly and when I found myself less curious than I had hoped, I questioned why I did that and reflected on my choices. Progressively, I became more aware of my positioning, and by remaining curious with participants' stories I invited them to speak to the sensitive areas where there were contesting perspectives. In looking at my research interview journey, I learned something of what Foucault said about curiosity:

> To me it [curiosity] suggests something altogether different: it evokes "concern"; it evokes the care one takes for what exists and could exist; a readiness to find strange and singular what surrounds us; a certain relentlessness to break up our familiarities and to regard otherwise the same things; a fervor to grasp what is happening and what passes; a casualness in regard to the traditional hierarchies of the important and the essential. (Foucault, 1989, p. 198, as cited in White, 1992, p. 146)

Organisation of the research materials

Producing transcripts

I transcribed all audio-recordings of the research conversations into written form to facilitate the process of analysis. I personally transcribed the interviews as this process offered me an opportunity to gain intimate acquaintance with the interview conversations through repeated careful listening. In addition, the process of listening would also bring the "data alive through appreciating the way that things have been said as well as what has been said" (Bailey, 2008, p. 131). I could *hear* the data against the shaping effect of the theory and philosophy that I studied.

I came to understand transcription as a practice of postmodern qualitative research, taking Denzin's (1995) suggestion to transcribe "cultural texts that represent experience" (p. 9) to get closer to the counsellors' experiences that I was investigating. Bird (2000) asserts that transcripts would not be taken as 'truth' as they cannot accurately represent the complexity of linguistic interaction. Hence, I chose readability over linguistic accuracy in my transcribing process (Winslade, 2003). I checked the transcripts by listening to the recordings again. The completed transcripts were then sent to the participants to check for accuracy and verification of the meanings constructed during interviews.

Approaches to investigate the research materials

This study explored how counsellors were positioned within the ideas and practices of legislation, medical, religion, culture, institution and education that shaped what they could or could not say or do. These ideas and practices were among the many discourses that were in circulation when counselling in the context of suicidal ideation. 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). I present in the next section how I examined the research materials, particularly discourses-in-action, using discursive analysis to understand the constitutive force of discourses that shaped the counsellors' practices with their clients and clients' families.

I discussed in Chapter Two how discourses constitute particular subject positions and offer these positions for people to take up (Burr, 2003; Davies, 2003). When an individual is taking up a particular position, Davies and Harré (2001) argue that this individual will see "from the vantage point of that position and in terms of the particular image, metaphors, story lines and concepts which are made relevant within the particular discursive practice in which they are positioned" (p. 262). Thus, there is an interrelated relationship between discourse and positioning theory. In my analysis, an exploration of the practices of counsellors, clients and their families brought me closer to understand 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, 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 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.

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). Guided by these ideas, I paid close attention to language employed by the research participants in their narratives, looking for the possibility of reading the research materials more richly and with more complexity.

As I first approached the research materials, at times I thought the research participants did not provide clear responses to the specific questions I had asked. I began to question whether I had insufficient material on particular topics for my project. However, when I re-approached the materials and listened to the audio recordings of the research interviews several times while re-reading the transcripts, I experienced a re-connection with the research participants who told me of their work with difficult and complex matters when counselling in the context of suicidal ideation. Even before I began a more theoretically informed discursive analysis, this reconnection brought me closer to the nuances of research participants' responses that I had not previously been attuned to. I became aware that the research participants might respond to my queries in ways that I had not anticipated. This brought to my attention that their speaking occurred through many strategic responses, such as silence, leaving things unsaid, choosing to respond to a different question than the one I gave, or side-lining issues related to a potentially sensitive topic. I became more interested in examining for what purpose these strategies were employed by the research participants in their conversations. I employed new and nuanced ways of listening, hearing, reading, and being excited by the research materials. I was pleasantly surprised by how the steps of revisiting the materials added a "thick description" (Geertz, 1973, p. 6) to stories research participants had told. My experience of reconnection with the research participants led me to think of St. Pierre's (2014) desires for "[researchers'] own experiences of 'being there' with [research participants] in the field, being present, being witnesses in the moment with them" (p. 7).

Through the re-working of the materials, I found myself confronted with materials that could not simply be 'read' at face value. In a narrative approach to counselling, White (2007) argues that people find meaning in their lives through stories and that their lives are multistoried. There could be other alternative stories within a story. In order to *hear* these alternative stories, White (2006) adopts a *double listening* strategy. Drawing on White's ideas of stories and *double listening,* I took a *double listening and reading* action to examine the research participants' stories, combing them for the openings that speak of other practice possibilities than those immediately obvious to me, and for other explanations.

Through the work of *double listening and reading*, I became aware that there might be unspoken voices within the stories told by the research participants in the process of retelling their practice experiences. Listening to and *reading* both *the what was said* and *the unsaid* simultaneously, as well as the interplay between them, offered me an interpretive ground to consider what might be unspoken or spoken in silence. According to Foucault (1972), *the unsaid* can give shape to *the what was said*. I took this claim to argue that what was presented in the research participants' narratives might also be shaped by what was absent. In relation to this, I considered *the what was said* to identify *the unsaid*. While I was moving between *the what was said* and *the unsaid*, I employed cultural knowledge, my socio-political position, and the theories/concepts discussed in Chapter Two, and elaborated in Chapter Five to Ten to guide me in making sense of the research participants' experiences. For example, I followed Mazzei's (2007) approach to interpret *the unsaid* or silence of research participants in their responses to my questions.

Mazzei draws on a Derridean reading of *the unsaid* or silence as productive voice. In this term, the threads of silence are considered as language and part of the "'data', not as absence, lack, or omission, but as positive, strategic, purposeful, and meaning full" (p. 29). Following this perspective, silent data becomes part of the research participants' total experiences. This approach invited me to *hear* silence as a presence rather than an absence as I discussed in Chapter Five. Mazzei's orientation expanded the concept of data and offered me an enriched approach to *read* silence from a multi-dimensional perspective. Mazzei (2007) describes silent data or unspeakable voices as a gift within a gift:

> [The research participants] give us the gift of their narratives and within that gift is the "other" gift that we do not always recognize, or miss through inattention, or negate as unimportant in favor of what we "perceive" as being more important. The gift within the gift is of course that pause—the not said, the reticent breath, the stark silence that transgresses our received notions of data and yet beckons us to identify it as something other than lack, or emptiness of meaning, or simply a distraction on the way to something "more important." Like an unwanted gift for which we feign appreciation but that we cast aside after the giver has taken leave, we leave this gift unclaimed and unappreciated. (p. 27)

In not wanting to leave research participants' gifts unappreciated, I took increasing care with how I listened. As I listened to the spoken and unspoken language that

the research participants used in their narratives, I located a remark that seemed significant. Next, I paused the recording and listened repeatedly to this particular utterance *while* reading the transcripts in order to hear *the "*other*"* gift that was situated between *the what was said* and *the left unsaid*. The gap between these might consist of something that the research participants intentionally excluded due to the presence of a social and cultural gaze; something that could not be expressed or was difficult to voice during the interviews; or some aspects might have been unsafe or forbidden to talk about. I began to 'see' the untold stories that were potentially sitting within the space between the spoken and unspoken. These previously *unappreciated gifts* became hearable and contributed significantly to a richer picture of how research participants navigated their world when counselling in the context of suicidal ideation.

In my search for a suitable conceptual approach to account for voice in silence that appear in the research interview narratives, Jackson and Mazzei's (2012) way of "thinking with desire" (p. 91) offered me a way to make meaning of the silences. Thinking with desire is not about explaining what is desired, but rather it seeks to "understand the interests that produce desire, and the interests that desire seeks to produce and/or protect" (p. 92).

Jackson and Mazzei's (2012) innovative and imaginative approach to data analysis creates a space to make it possible for me to examine what produced silence in the research interview narratives and what the silence produced when discussing participants' practices. Jackson and Mazzei (2012) investigate silences through the lens of Deleuze-Guattarian concept of desire to explore how desire operates to produce "silent discourses…to maintain a status quo…[and] a longing for maintaining a normative and unchallenged (even unrecognized) belonging (status)…" (p. 100). The focus is not on 'why' the participants are silent, or being silenced, but 'how' the silence is being produced by their desire to maintain their current position, by asking "how desire is functioning to maintain sameness and privilege through the production of a silence" (Jackson & Mazzei, 2012, p. 86). They name this form of silence a "*desiring silence"* (p. 86, original emphasis).

Jackson and Mazzei (2012) clarify that desiring silence is not a desire for silence. The desire in desiring silence is a "coming together of forces/drives/intensities" (p.

92) that work to produce silence. This form of silence serves to maintain the current situation, or a collective silent agreement to protect problematic issues. Mazzei (2007) argues that desire enacts "*meaning full and purpose full*" (p. 116, original emphasis) desiring silences and that "[t]hese silences don't just appear or happen out of nothing. They are produced in response to the dominant reality of our communities and our attempt to maintain that which we wish to preserve" (Mazzei, 2011, p. 664). In this sense, it can be a complex decision for an individual to break or maintain these desiring silences.

Jackson and Mazzei's notion of desiring silence offered me a tool to ask "what are the competing forces, intensities, and interests (e.g., privilege, status, the ability to maintain sameness)…[that work] to produce this desiring silence" (Mazzei, 2013, p. 100-101). Through understanding desiring silence, I became aware of how the participants kept silent about certain topics, and I *heard* these silences as their desire to produce or maintain particular results. This approach to the voice of silence in the research materials allowed me to reflect on the data especially when counselling practice was intersecting with institutional policies and procedures, organisational hierarchy, professionality, legality, status, as well as power relations that took place. I learned how counsellors in my study work with and against these forces by enacting silences when talking about their experiences.

The question "How does desire function?" was used to examine for what purpose silence was being produced in the conversations with research participants. I used this question to understand a counsellor I discussed in Chapter Five and the position she took up with the suicide legislation. I was curious as to what silences would be produced from her interaction with the legislation. While I read her struggle to be careful with her use of language when discussing this sensitive topic, I located her desire to maintain her position as a law-abiding citizen as functioning to shape her choice of keeping silent. What the objective was that her silence produced in her conversations is discussed in Chapter Five.

As I investigated the research materials, I experienced situations where I questioned my own knowledge framework in the reading of research participants' stories. Such situations often positioned me in unfamiliar spaces where, according to Deleuze (1989), "we no longer know how to react to, in spaces which we no longer know

how to describe" (p. xi). This challenged me to discern the discourses that played out in the practice. To address this challenge, I was guided by ideas from Foucault (2000): "as soon as [I] begin to have trouble thinking things the way [I] have been thought, transformation becomes at the same time very urgent, very difficult, and entirely possible" (p. 457). Following this suggestion, I called on Jackson and Mazzei's (2012) idea of thinking with theory as I attempted to find possibilities to help me made sense of these unfamiliar spaces. Jackson and Mazzei (2012) introduced a way to analyse qualitative data by putting theory into practice. They invited researchers to "use theory to think *with* data" (p. vii, original emphasis). In their approach, they employed poststructural philosophies and concepts and intertwined them with the interview data by thinking about or questioning whatever they were interested or curious in their research. When both theory and data were being "plug[ged] in" together (p. vii), Jackson and Mazzei proposed that some new understanding might emerge.

Following Jackson and Mazzei I first lifted particular utterances from the research participants out of the research materials to examine them closely. I referred to these particular utterances as *arresting* materials, which I borrowed from Katz and Shotter's (1996) idea of *arresting moments* as I introduced earlier in this chapter. Next, I drew on the theories/philosophical ideas which I introduced in Chapter Two to think alongside these *arresting* materials, asking myself what these ideas offered my analysis of the research materials. For example, as noted earlier in this chapter, I used Foucault's (1972) ideas of discourse, power/knowledge relationship and Davies and Harré's (1990) positioning theory in Chapter Five to explore power relations in counselling, and what subjectivities did power relations produce in different discourses. I also looked into the *arresting* materials from a cultural lens, which I outlined in Chapter One, to offer more possibilities of understanding the research participants' behaviours and experiences. The analyses that I offered in Chapter Five to Ten focused on "specific and particular details, often things that might be overlooked but that, when approached with deep curiosity, have the potential to offer new and important insights" (Bondi & Fewell, 2016b, p. 41). In this way, my study took "a form that honours and fosters [the research participants'] lived experiences of being and struggling to be in relationship to [them]selves and other" (Bondi & Fewell, 2016a, p. 7).

CHAPTER FIVE
WHEN LEGAL AUTHORITY AND CULTURAL BELIEFS ENTER THE THERAPEUTIC SPACE

Introduction

In this chapter I explore an area of therapeutic practice when legal guidelines and cultural knowledge enter the counselling space as a client presents with suicidal ideation. I offer a narrative discursive account from my interview conversation with Umadevi, detailing difficult moments in her practice to invite readers of this study, to take a perspective of thinking about decision-making processes in the context of clients expressing suicidal ideation. In supporting a client, Umadevi was caught in a tense relationship with the suicide legislation, cultural practice, professional code of ethics, and the institutional protocols at her employment context. Umadevi gave my study a unique treasure. She shared with me an account of the very dilemmas that I was interested to study, especially how the law and cultures position counsellors in Malaysia when they counsel clients in situations where suicidal ideation is present. Her contribution is particularly important as she was a counsellor holding a managerial role, with clear dual responsibilities to her clients and management.

The material I use in this chapter is an example that I introduced in Chapter Four, where my analysis benefited from the process of re-listening to the audio recording while re-reading the transcripts. Through this process, I became more intimate with the interview material and I invited myself to actively reflect upon it. It was in this reflection process that I was able to *notice* and *hear* possible implications not directly voiced in the narrative, which helped make alternative understanding of Umadevi's meaning-making available to me. Being a counsellor researching within my own cultural community afforded me ideas regarding the spoken language and the unsaid of the conversations, particularly in terms of recognition of distinctive practice or behavioural references. This position allowed me to examine the implicit messages of the participants' stories in greater depth than would have been possible had I not called on insider knowledge and a shared cultural-political-knowledge. It is through the lens of how legal guidelines position counsellors that I look into how silence that appeared in the narrative can be interpreted.

I begin my focus on Umadevi's practice context which produces a challenge for her to maintain her professionalism as both a counsellor and manager. The dual position presents Umadevi with an ethical dilemma when her counselling responsibility intersects with her legal obligation to inform the authorities about suicide risk in order to protect client safety. The dilemma facing Umadevi was when disclosing the suicide risk to the authorities could potentially result in 'harm' to client and the therapeutic relationship. Next, I explore Umadevi's opinions about the sensitive professional area where legal considerations directly shape her counselling practice. Instead of providing direct answers to my inquiries, Umadevi communicated her thoughts using a range of linguistic strategies, including deliberately self-restrained silence. I apply various theories to unpack the implicit messages inherent in her telling. Lastly, I present a reported situation where Umadevi was positioned between her ethical obligation and cultural discourse that a client brought into the therapy. In the face of Umadevi's aporetic struggle at competing intersections of counselling and culture, I describe how she made possible a safe and trusting sphere for a client using her compassion, care and wisdom.

When law prescribes therapeutic practice

Umadevi, an Indian Hindu woman, was part of a team that provided counselling services to the university's staff and students, as well as the people from general community. Apart from her counsellor duties, Umadevi reported that she also assisted the Centre Manager in the day-to-day operation of the centre. Her administrative role reflected that she was not only in a position of authority and leadership, but also a representative charged with a fiduciary duty of maintaining the organisation's image and good name. In her work duty, Umadevi had two roles: first, as a manager, she was expected to follow the legal guidelines that positioned her to be a good employee and citizen; second, as a counsellor, she had an ethical responsibility to promote well-being and to 'do no harm' to clients (Corey, Corey & Callanan, 2007). In light of her dual responsibilities, I sought to understand how the suicide legislation might have shaped her professional responsibility when counselling clients with suicidal ideation. Umadevi shared her thoughts as follows:

> When a component of the state enters the discussion of individuals, it often bring interestingly the parties closer, because much like how they say, "You should not talk about race, religion or politics",

> everyone that I meet has sort of an opinion about the law…everyone holds an opinion, so it [the law] helped foster a certain sense of unitedness because you can empathise where the client's coming from but if I find that, I professionally find it [the law] harmful, talking about the law, behind the law's back, I am not being a very legal citizen myself.

In her account, Umadevi did not speak directly to my query but I read her response to suggest she was taking up two positions. First, she voiced her desire to be a '*legal citizen*' and Umadevi felt compelled to monitor her own conduct. She remarked, *"[One] should not talk about race, religion or politics*". I turn to Foucault's (1977) perspective of disciplinary power and the invisible gaze to read Umadevi's response in relation to her managerial position. I was curious if the role of normalising judgement (Foucault, 1984) played a part in shaping Umadevi's speaking.

A manager is expected to behave as an obedient employee in maintaining a positive public image for an organisation (Lewis, Goodman, Fandt, & Michlitsch, 2007). In order to make sure that employees' behaviour matches what is needed in the organisation, Umadevi was subjected to institutional gaze. This gaze enacted an institutional expectation that she must not talk "*about the law, behind the law's back*", otherwise she would not be perceived as a good employee. Thus, she weighed or used her words cautiously to convey a message during our research interview that the organisation is following the law. This surveillance by the institution have self-regulating effects (see Foucault, 1977) which I discussed in Chapter Two.

The second position Umadevi took up was to claim an ethical stance to support a client and not cause harm. I read Umadevi's narrative that she wanted to be a good citizen by upholding her legal obligation. However, a moral conflict arose with the supposition that at times adherence to the law and disclose the client's suicidal ideation to the relevant parties might result in potential harm to the client. Performing one's legal obligation involves notifying a client's significant others about the client's intention to end his or her own life. As discussed in Chapter Three, suicide is often understood on pathological terms, and thus, it is very likely for the general public to view people with suicidal ideation as someone with mental illness (Marsh, 2010; McManus, 2005). It is not uncommon that when a person expresses suicidal ideation, he or she may be labelled as "gila" (insane or crazy) in Malaysia,

according to Raja Mohan and Sorooshian (2012, p. 294), and this is the context of Umadevi's practice.

People outside the family may try to avoid someone with mental health problems due to a misguided perception that they are dangerous and violent (Crocker, 1999; Ng, 1997; Ng, 2013). Moreover, people struggling with mental health problems are often told to take control of their behaviours, but are expected to do so without help (Corrigan et al., 2000; Corrigan et al., 2001). When these individuals do not have the capacity or skills to do so, they are often described as failing and defective. Stigma towards people struggling with a mental health problem remains a major challenge in the Malaysian society (Loo & Furnham, 2012, 2013; Ng, 1997; Ng, 2013; Swami, Loo, & Furnham, 2010). As a subject of taboo, a mental health problem carries with it stigma, negative social judgement and shame for individual and families, who risk being excluded and alienated from the community (Azhar, 2003; Loo et al., 2012). Lauber and Rössler (2007) argue that the stigmatisation of mental health problems in Asian context is often more severe as the stigma affects the entire family. Therefore, people struggling with mental health problems may be facing double challenges. On the one hand, they struggle with mental health symptoms, on the other hand, they are experiencing prejudice and discrimination which increases risk of mental health problems. The stigma surrounding suicide/mental health problems thus often leads to the complexity in disclosure of clients' intention to end their own lives.

In light of the stigma associated with suicide, the law creates a dilemma for Umadevi while she attempted to support clients, as the disclosure may potentially cause more pain to clients. The dilemma Umadevi faced is represented by Bond (2002) who writes, "What is ethical may not be legal. What is legal may be unethical" (p. 124). When the practice of Umadevi was subjected to the legal guidelines, she accepted the subject position offered by the law to be a good citizen, but at the same time she also resisted the potential oppressive juridical power:

> I can't change the law if I'm not following it. And if I feel passionate enough to want to change the law and this legislative proceeding, to understand how changes are made, I myself have to put myself into the [legal] system…that's the way I see how I can affect how the system works.

Umadevi's resistance was in a form of observing the law by putting herself "into the [legal] system". Learning to master the law, thus to gain mastery, she must learn to submit to the law. Simultaneously, in order to resist the law, Umadevi must learn to master the law. These paradoxical simultaneous practices come close to questions of mastery and submission suggested by Butler (1995, 1997). Butler (1995) explains:

> The more a practice is mastered, the more fully subjection is achieved. Submission and mastery take place simultaneously and it is this paradoxical simultaneity that constitutes the ambivalence of subjection. Where one might expect submission to consist in yielding to an externally imposed dominant order, and to be marked by a loss of control and mastery, it is paradoxically marked by mastery itself … the lived simultaneity of submission as mastery, and mastery as submission, is the condition of possibility for the subject itself. (p. 45-46)

Butler argues that the process of becoming a subject is a process of submitting to the regulatory order and simultaneously mastering the discourse itself. Mastery can be achieved through repetition of unquestioningly performing self-surveillance to constrain one's action and behaviour. Drawing on this perspective, I would understand Umadevi as repeatedly participating in the process of simultaneously submitting to and mastering the law in order to construct an identity of a good citizen.

Umadevi's approach also relates closely to Foucault's (1982b) suggestion for possible way of working with government:

> We've got to get out of this dilemma: either you're for, or you're against. After all, you can be opposed and still stay involved…To work with a government implies neither subjection nor global acceptance. One can simultaneously work and be restive. I even think that the two go together. (p. 33)

I read Foucault's claim that one "can be opposed and still stay involved" as reflected in the position that Umadevi took up. I was interested to know how Umadevi worked with the law while holding ethical obligation towards clients when a situation called for disclosure of clients' confidential information. The following excerpt presents Umadevi's perspective on this:

> Within this circumstance, am I willing to make that report which would sit on a piece of paper which I am legally expected to do, but which mean that I may lose a life? It is a very difficult decision and therefore shouldn't be made on a salvatory nature.

Umadevi's account addressed the concern faced by many mental health professionals. Deciding whether to disclose information to the relevant parties or maintain confidentiality challenges many counsellors when counselling in the context of suicidal ideation (Jenkins, 2002; Pope & Vasquez, 2016; Reeves, 2010). Making such decisions calls on counsellors' professional judgement as part of the consideration of any potential harm to clients. On the one hand, disclosure without a strong indication of an imminent suicide risk may breach trust which can affect the therapeutic relationship negatively. On the other hand, withholding confidential information when there is an imminent threat of suicide, and a client takes his or her own life, counsellors may be accused of neglecting responsibilities for active suicide prevention (Reeves & Seber, 2010).

Umadevi appeared to consider maintaining confidentiality by talking down her legal obligation to "*a piece of paper*". Her metaphorical language probably suggested ambivalence about performing her legal duty. The collision between the law and ethical obligation produced an undecidable moment for Umadevi as these two conflicting ideas were competing for meaning and action. In this situation, Umadevi attempted to find ways to work with the law alongside counselling while holding onto ethical responsibilities towards clients, the profession and the institution. Umadevi offered a decision-making process to assure measures were in place to fulfil these ethical responsibilities:

> I would consult with, not just the peers in my field, but also peers in other fields like legal field to make sure that I understand what are my responsibilities and also what are the consequences, supposedly what I do actually has a higher chance of harming the client. I would document each stage of the decision-making process before finally making the decision and informing people of such decision.

It was important to Umadevi to seek consultation regarding the decisions she made, and to keep clinical notes that documented her decision-making process in relation to the therapeutic interventions she provided. Umadevi's practices demonstrated not only her awareness of her ethical and legal accountabilities, but also the

standard of care in supporting a client who presented with suicidal ideation. Umadevi's emphasis resonates with the suggestion by prominent practitioners with expertise in responding to a suicidal risk, who argue that consultation and documentation are important clinical practices in avoiding adverse legal action (Bennett et al., 2006; Pope & Vasquez, 2016; Reeves, 2010; Sommers-Flanagan & Sommers-Flanagan, 2015). The use of clinical supervision, peer consultations and working together with experts from other fields is invaluable for counsellors in making informed ethical decisions and valuable feedback regarding the degree to which standards of practice are being met (Corey et al., 2007; Murdin, 2000; Richards, 2000). As clinical documentation may be subject to a subpoena, documenting consultation, recording the care provided by counsellors, and decision-making practices can be helpful to counsellors in the context of a malpractice lawsuit (Mitchell, 2007). Umadevi responded to the law by calling on ethics of care in the form of seeking consultation and maintaining relevant documentation. Her response was in accordance with the code of ethics which requires counsellors "create, safeguard, and maintain documentation necessary for rendering professional services" (Lembaga Kaunselor, 2011, Clause A.1.b, p. 1) and "take reasonable steps to consult with other counselors, or related professionals when they have questions regarding their ethical obligations or professional practice" (Lembaga Kaunselor, 2011, Clause C.2.e, p. 17). This way I argue that Umadevi exhibited how her approach of taking up and resisting the subject position offered by the law to be a good citizen, opened ways for her to work out what options became possible for her clients, as well as for her own practice.

While holding a commitment to act in the best interests of the client, Umadevi went on to emphasise the importance of seeking consultation prior to making an ethical decision:

> I am very grateful not to work by myself. [In a time of urgency], agency's protocols support me by saying, "Do not practise by yourself", so immediately there is always more than one person who is on call. Even having just another person to consult with, consolidate a better decision making than deciding by yourself. I would say that I find myself in a better position than others who work by themselves.

Umadevi spoke about the institution's guiding principle that promoted consultation-seeking among counsellors which shaped her professional practice and

identity. Institutional guidelines operated to shape an active learning subject who was positioned as a responsible counsellor. In this speaking, Umadevi was guided by the institutional discourse to take up an active learner position by taking part in the production of a desirable subjectivity to become a self-governing, self-determining and self-responsible agent for the development of her own learning and competencies. Drawing from this perspective, I look at Umadevi's practice of consultation-seeking through the lens of governmentality (Foucault, 1977).

I consider the discursive practice of consultation-seeking as a technology of the self (Foucault, 1985) in keeping her own practice safe from legal challenge. This practice does not mean that Umadevi attempts to escape from her legal duty, rather it reflects her intention to learn from others in order to stay involved as a good citizen while supporting the client. This technology permits her to take "intentional and voluntary actions by which [she] not only sets [herself] rules of conduct, but also seeks to transform [herself], to change [herself]" (Foucault, 1985, p. 10) into becoming an "ethical subject" (p. 26). In application of a technology of the self, Umadevi acted upon herself to become an *ethical subject* through seeking consultation and receiving support from her colleagues and other experts. In other words, a different subjectivity is being shaped: a counsellor who takes responsible for her own learning, and the one who supports herself in resolving an ethical dilemma.

When the subject of suicide legislation enters between her responsibilities to clients and the institution, Umadevi remained accountable to clients by considering what was possible and what could be in their best interests. She draws upon the Malaysian Counsellors' Code of Ethics (Lembaga Kaunselor, 2011) to guide her in making ethical decisions. She sought consultation and called on the profession's ethical standards to carefully evaluate her therapeutic decisions in order to offer her client responsible practice and care without putting her practice at risk for legal action. I witnessed, through her account, how she maintained a balancing act between different positions as she observed the principle of duty of care.

Umadevi's response to sensitive issues of the law

In reaction to my query about how she positioned herself within the suicide legislation, Umadevi negotiated with the question by enacting a narrative of self-restrained silence (Mazzei, 2007). Her silence was reflected in her way of using hypothetical language such as "*if I find that… if I'm not following it… if I feel passionate enough…*". This way of speaking perhaps suggested that she was dancing on the edge of wishing to voice some ideas, yet speaking hypothetically allowed her to remain tentative about her view regarding the law. Her response is not surprising as it is not uncommon for Malaysian people to speak indirectly, particularly when expressing negative or conflicting viewpoints (Abu Talib, 2010; Gannon & Pillai, 2015).

I became interested in the complexities of her speaking, particularly *what was said*, *the left unsaid* or *silenced* (see Mazzei, 2007). Such silence did not mean that Umadevi did not speak. Umadevi did speak out but chose to respond to a different question than the one I gave to her. In doing this, she either side-lined issues related to a potentially sensitive topic or responded using hypothetical assumptions in her language. Umadevi's response invited me to look into the way I worded my question. I noticed that I, too, had used the subjunctive form of language, "*Can you share how the anti-suicide legislation may or may not shape your practice especially when counselling clients with suicidal ideation?*" This question sounded like I was inviting her to explore this topic on her own terms, but did not require or expect her to commit herself to any particular stance.

I was asking Umadevi to provide information on a sensitive issue of the law. Thus, instead of asking her directly, I deliberately worded my question to open to Umadevi a position that make it safe for her to speak, although I anticipated that I might run the risk of receiving a prefer-not-to-say answer. Then again, why did I feel that this topic would be sensitive for Umadevi and not for the other participants? This could possibly because this is a sensitive research and my insider knowledge of the dual roles as a counsellor and a manager. This is an example where I bring in tentative curiosity which is more useful than a familiar method of direct questioning.

Another possible way of understanding Umadevi's intention to keep silent when discussing a law-related subject is through the concept of desiring silence (Jackson & Mazzei, 2012), which I presented in Chapter Four. Such silence, which Jackson and Mazzei view as potentially productive, is produced by one's desire to maintain one's current position. Law in the Malaysian context is generally understood as going hand-in-hand with juridical power and authority. Respect for authority is part of our culture, thus we become intensely aware that questioning the integrity of the law is a demonstration of disrespectful behaviour. Perhaps for this reason, Umadevi perceived that "*talking about the law, behind the law's back*" would constitute a person as failing to act as a good citizen. When the cultural knowledge and employment context might not have offered much room for Umadevi to discuss her opinion about the law in a public forum, I wonder if the kind of silence she chose to use functioned as a desire to discursively maintain her identity as a good citizen.

When cultural practice interacts with counselling

The discourses of medicine and science have come to dominate how suicide is expressed in terms of an association with mental health problems (Marsh, 2010). This proclamation produces a particular "regime of truth" (Foucault, 1980, p. 131), and continues to shape speaking, thinking, practice and experience, so much so that suicide *is* a form of mental health problem. The shaping effect of such belief relies on the constitutive and productive force of power/knowledge (see Foucault, 1977), and leads to people struggling with suicidal ideation commonly being cared for according to mental health treatment approaches.

At the same time, traditional healing practices for mental health problems continue to be available among many Asian people, including the people in Malaysia (Loo & Furnham, 2012, 2013; Ng, 1997; Ng, 2013; Swami et al., 2010). Mental health problems have featured in the Malaysian folk history associated with the word 'amok'. Amok is referred to as violent or unexplained aggressive behaviour of a person. Malay men may be found *running amok* (Carr & Tan, 1976; Panikkar & Morgan, 2006). People struggling with mental health problems are often believed to be possessed by "uninvited spirits" or suffering an imbalanced amount of "angin" (wind) in the body (Ng, 2003, p. 34) that cause people to feel physically weak and confused. It is a common practice that the families of those who struggle with a

mental health problem seek traditional healing methods to stabilise the wind or "drive out" the uninvited spirits from an individual's body (Ng, 2013, p. 34). Traditional remedies for mental health problems differ among the major ethnic groups in Malaysia. Malay people turn to a bomoh (shaman) (Ng, 2013; Swami et al., 2010); while Chinese people call on a shaman who identifies as sifu or sin-se to serve as a religious medium between the spiritual realm and the human realm (Ng, 2013; Loo & Furnham, 2012); Indian people turn to holy man at the temple, faith healers and exorcists (Laderman, 1988; Loo & Furnham, 2013). For Malay people, mental health problems are often believed to be a consequence of neglecting Islamic values (Haque, 2008).

In this section, I explore the aporia that confronted Umadevi when a client with suicidal ideation decided to terminate the counselling relationship to pursue traditional healing method. Umadevi began her story:

> The client told me that she had talked to her mother about her struggle with suicidal ideation and her mother was concerned about her and decided that counselling wasn't the right therapeutic foundation for her. The client agreed with her mother to seek help from a faith healer.

Counselling, to many people in Malaysia is considered a Western practice of treating mental health problems (Ting & Ng, 2012). While counselling is widely acceptable in Malaysia, there are people who continue to believe in traditional healing practices for treatment of their mental health problems and resist the idea of seeking counselling (Haque, 2008). Their resistance could be partly due to the fear of being labelled as mentally ill due to the stigma associated with seeking counselling (Abu Talib, 2010; Raja Mohan & Sorooshian, 2012). Other reasons include the perception that modern medicine may produce side effects to the body; the medicine may be able to treat the symptoms of the illness but not the cause; more importantly, traditional healing methods are affordable for many people in Malaysia (Haque, 2008). Umadevi went on to express her response following the client's decision:

> I was taken slightly off guard, but later on, I figured that it made sense to me because she was a very filial daughter who would follow the advice of a parent.

Umadevi's understanding of the client's decision derived from the value of filial piety which informs the behaviours of many people in Malaysia in their relationships with their parents and the elders in the family, as I discussed in Chapter Three. The client's response to her mother's decision was regarded as an expectation of filial piety (see Keshavarz & Baharudin, 2009). In this situation, a client's family obligation collides with Umadevi's ethical responsibility towards client safety. This collision produced a dilemma for Umadevi. On the one hand, Umadevi saw herself having a duty to protect client safety, and if she agreed to the client's decision she might have to think of ways to prevent client from harming herself. This thought might lead Umadevi to consider exercising her legal duty to disclose the suicidal ideation experienced by the client. If the disclosure took place, the client might not be protected from potential punitive effects of the legislation and the stigma associated with suicide. On the other hand, if Umadevi disagreed, and used her authority to request the client to continue therapy, she might place the client in between two authorities: obeying her mother's wishes and Umadevi's professional guidance or direction.

In this situation, Umadevi decided to respect the client's decision to perform her filial duty by stepping back from taking up authority position. Umadevi offered her reasons:

> It was far for me to say that counselling is the only way which helps people, of course not, there are always other avenues. That was a decision the client and her mother made to try this modern approach of therapy. After the experience of therapy, they were now decided to explore other traditional healing methods.

Umadevi repositioned herself by maintaining a worldview that both counselling and traditional healing practices were some of the ways that could be used to help people with suicidal ideation. This new positioning made room for Umadevi to distance herself from the effects of the dilemma and at the same time to respect the client's right to self-determination, which might be important for the client in complying with the value of filial piety. Umadevi's response to the client might be understood as responsive to the client's experience of her culture. By being culturally responsive, Umadevi's speech act conveyed respect for the client and her traditional values (see Sue & Sue, 2016; Zhang & Dixon, 2001).

Umadevi's approach to respect for client autonomy did not mean that she relinquished her ethical obligation to protect client safety. She emphasised that:

> I must say I don't think I would do anything differently because there was nothing wrong in seeking traditional healing. It's not like something terrible happened, I'm happy that she came in, I'm happy that she felt that she could come in to have a discussion with me, so I hope it all work out for her in the end.

Umadevi's narrative almost sounds like she was pleased that the client at least turned to a counsellor in person to inform her decision. This final session gave Umadevi a chance to discuss with the client about her decision and maintain a respectful relationship with the client for now and the future. Implicit in her narrative was her hope that this last meeting would leave a positive experience to the client, and the client could consider resuming counselling if traditional healing method did not work out. It appeared that Umadevi's intention in this meeting was to offer a kind of hospitality (Derrida, 2005a, 2005b) to the client and convey a message that the client was always welcome if she decided to continue counselling.

Arising from the client's positioning to take up her filial duty, I became aware of how parenting discourse shaped the client's actions. I suggest that the client was governed by the parenting/cultural discourse to take up a subject position as a filial daughter. Drawing from this perspective, what guided Umadevi in her response to the client's decision was both culturally relevant knowledge, and professional knowledge. Umadevi focused on treating the client with respectful care. To achieve this goal, Umadevi trafficked between respecting client autonomy and a counsellor's beneficent duty to look out for the client's best interests. Umadevi moved away from questioning the client's decision and focused on building a respectful relationship with the client. Umadevi might be hoping that this relationship would serve as a foundation to the client that the door to counselling is always open to welcome her back. Umadevi positioned herself to make wise professional decision to utilise her authority in a way that offer an agentic place for her own practice and the client to move around between competing discourses.

My concluding thoughts

In this chapter, I have shown how Umadevi gave this study the gift of arguing the possibility of both observing and questioning the law and cultural practice. While counselling opens up therapeutic space for clients to talk about their experiences, the law and cultural practices may potentially affect the likelihood of seeking professional help in relation to the stigma associated with suicide. When Umadevi was positioned between professional practice and the law or cultural knowledge, she found herself taking careful steps in her practice. She made attempt to minimise potentially harmful consequences by adopting a stance to respect and submit to the legal requirement and cultural practice, and at the same time resisted these discourses. Umadevi was aware that her resistance would invite certain consequences for her practice as a professional counsellor. It was in space between submission and resistance to discourses Umadevi offered both herself and her clients agency to step outside the restrictive positions offered by these discourses.

CHAPTER SIX
BUILDING THERAPEUTIC RELATIONSHIP

Introduction

In this chapter, I offer a unique story of how counselling theory is applied and embodied in the process of establishing therapeutic relationship with a client whose potential action poses an imminent suicide risk. It is widely argued that relationship-building is one of the most important counselling skills that shapes the success of therapeutic relationships development (Corey, 2013; Daniel & Ivey, 2007; Egan, 2010; Ivey, 2013; Sommers-Flanagan, & Sommers-Flanagan, 2015). In addition, Egan (2010) emphasises the importance of practitioners recognising diversity within cultures and the need to develop approaches which consider "key cultural and personal-culture variables" (p. 52).

I aim to examine the actions Siva took and the values that informed these actions, interwoven with an account of Western counselling orientation. I begin the chapter by presenting an overview of theoretical approaches to counselling, and how they function to shape practices. I end this section by offering a discussion of Siva's counselling orientation. Before I move to discuss how Siva's applied his preferred theoretical orientation to engage with a client he judged to be at imminent risk of suicide, I introduce the background information about the client and what happened that lead the client to be referred to Siva. Finally, I explore through the lens of Weingarten (1998) the small steps taken by Siva in his attempt to regain the trust of the client after the client's urgent request to meet a counsellor was denied by the Intake Officer.

Theoretical approaches to counselling

Counselling theories offer counsellors explanations of human behaviour, and guidance to organise information received from the clients. This information assists counsellors to conceptualise clients' problems and define the counselling goals (Corey, 2013; Hackney, 1992). In the counselling process, counsellors help clients to identify the sources of their problems and together they develop alternatives to these problems (Corey, 2013). On generic terms, the counselling process begins with establishing rapport with a client, engaging a client to explore issues, gathering

information to conceptualise a client's problems, working with a client to develop goals, applying interventions to help client to achieve these goals, and finally preparing for termination of the process (Carkhuff, 2000; Corey, 2013; Daniel & Ivey, 2007; Egan, 2007; Patterson & Welfel, 2000). Typically, how counsellors undertake the counselling process is shaped by the counselling theory that they subscribe to, in defining the nature of a therapeutic relationship, conceptualising client's presenting problem(s), and determining the counselling goals (Corey, 2013; Hackney, 1992).

Counselling theories indeed can be used as a guide; however, no application of theory is effective with all clients (Kottler & Montgomery, 2011; Yalom, 2002). Furthermore, theories can sometimes "insulate [counsellors] from the uniquely magical encounter that often happens during therapeutic sessions" (Kottler & Montgomery, 2011, p. 346). The relationship between the effectiveness of the application of counselling theories and the successful outcome of therapy with clients is not a linear process (Corey, 2013). Jourard (1968), a researcher who pioneered the investigation of self-disclosure in humanistic psychology, proposes that "[p]sychotherapy is not so much a science or technique as it is a way of being *with* another person" (p. 57, my emphasis). A limitation of counselling theory is that it may distill the wisdom of counsellors into standardised and routine procedures for human contact. In relation to this, Carl Jung advises practitioners to, "[l]earn your theories as well as you can, but put them aside when you touch the miracle of the living soul. No theories but your own creative individuality must decide" (Jacobi & Hull, 1978, p. 84).

Siva reported in the research interview that he subscribed to rational-emotive behaviour therapy (REBT). REBT has become established as one of the preferred counselling practices in Malaysia (Mohamad & Rahman, 2011). This Western-inspired theory of helping was introduced by Albert Ellis in the mid-1950s (Neenan & Dryden, 2011). This theory adopts a cognitive-behavioural approach that emphasises how irrational thoughts affect people to the extent of causing psychological disturbance and how these thoughts act as barriers to a happy self-fulfilling life (Najafi & Lea-Baronovich, 2014). This emotional disturbance is not straightforwardly derived from the problems one is experiencing, but rather from the beliefs one has about these problems (Smith, Collard, & Nicolson, 2012). In

other words, the perceptions attached to events are the contributing factors to irrational thoughts, and they are the source of psychological, behavioural and emotional problems (Corey, 2013).

Since REBT proposes that peoples' problems are caused by the beliefs they hold, it is thus the therapeutic aim to help clients identify irrational thoughts about their life events, and to change how they feel and behave when responding to these life events (Neenan & Dryden, 2011). To achieve this aim, counsellors typically employ a disputational technique to directly challenge clients' irrational beliefs (Neenan & Dryden, 2011). In this process, counsellors take the role of an educator to teach the clients how to transform their thoughts into rational cognitions (Corey, 2013). In relation to this role, it is no surprise that REBT counsellors are seen by clients as something of an authority figure. As well, this approach is experienced by many clients as confrontational and they may experience discomfort (Corey, 2013).

In terms of establishing therapeutic relationships with clients, Ellis (1994) acknowledges that Rogers' core conditions of empathy, unconditional positive regard, and congruence, are important and highly desirable, "but they [are] hardly necessary and sufficient" (Dryden & Neenan, 2006, p. 87). REBT regards the relationship as a condition to promote therapeutic work, "rather than being the therapy itself" (Froggatt, 2005, p. 8). For REBT counsellors, clients' cognitive, emotional and behavioural problems are solved by focusing on cognitions rather than spending time on relationship building. In addition, REBT counsellors are cautioned to avoid activities that may "create dependency or strengthen any 'needs' for approval" (Froggatt, 2005, p. 8) from counsellors, which are assumed to be unhelpful in the development of clients' problem-solving skills. However, Ellis does allow for counsellors to modify their interactional skills in responding appropriately to a particular client and in a specific situation (Dryden & Neenan, 2006; Neenan & Dryden, 2011). This flexibility in practice offers room for counsellors to design an interactional approach that they feel will yield more effective responses from the clients.

REBT is described as a time-limited and goal-focused approach. Thus, it makes sense that counsellors embedded in REBT tend to pay more attention to achieving the therapeutic goals. In addition, the structured approach of REBT in general is a

linear process. This model stresses agenda-setting as an important process to ensure both counsellors and clients understand what will be expected of them in each session (Dryden & Neenan, 2011). When REBT counsellors spend time on relationship-building, they may be concerned that some clients will simply not return for subsequent counselling appointments as the counsellors take too long to help them solve their problems (Dryden & Neenan, 2011).

As the philosophy behind REBT views suicidal behaviour as an irrational response to problems, REBT counsellors believe that suicidal ideation experienced by people is the result of irrational cognitions "reflecting the way they view themselves, others, and the world in which they live or may live" (Woods, Silverman, Gentitini, Cunningham, & Grieger, 1991, p. 39-40). Disputing suicidal ideation would be considered paramount when counselling clients who are thinking of taking their own lives. This practice guideline may suggest a focus on disputing a client's suicidal ideation during the first session of therapy. Before I discuss how Siva applied his preferred practice to build a meaningful connection with a client who was deemed to present an imminent risk to him or herself, I introduce a series of actions that took place between the client and the Counselling Centre, and how the client was referred to Siva.

A client with acute suicide risk

Siva, an Indian Hindu counsellor, worked as part of the team in the Counselling Centre at a university. Siva told the story of his experience with an Indian Hindu student who was an existing client of another counsellor in the service. One day, the client walked into the centre and requested to meet a counsellor urgently. He did not have an appointment. Siva described the event:

> He came into the counselling office and stated that he would like to see a counsellor, but at that time the Intake Officer gave him a form to fill in, not knowing that this is a case of urgency because he didn't portray that. He [client] was desperate. So, when an intake form was given to him…he got frustrated and he just wrote on the form saying that, *"I'm fed up, I'm giving up, I'm ending my life"*... and left the office.

The protocols followed by the Intake Officer formed part of the "rules of conduct" (see Foucault, 1988, p. 34) for all employees who worked in the centre. It is a

common practice for institutions to implement bureaucratic systems to ensure the smooth operation of the institutions and the safety of all employees and clients. Such management consists of detailed standard operating procedures for all routine duties that allow employees to understand their roles and responsibilities, as well as to achieve uniformity of the performance of work tasks. This formal system of organisation, on one hand promotes job specialisation and hierarchy of authority within the institution, and on the other hand may leave little room for individual freedom, initiative and creativity, and prevent employees from contributing to decisions about particular actions that need taking. Employees' work functions become more and more mechanicalised. However, employees can recognise problems or tasks which are not in their purview but to which have limited authority to respond.

When meeting this obstacle of the intake system, the client demanded more flexible and respectful services. He pushed beyond the imposed boundary by communicating something that was more urgent than the rules of conduct. He wrote on the intake form: *"I'm fed up, I'm giving up, I'm ending my life"*. The client exhibited a highly agentive act in which he was performing two conflicting ideas simultaneously – one, he wanted to show his annoyance and desperation by just walking away without saying anything; and two, he marked his presence by scribbling his intention on the form. The client seemed to accept the terms of the intake system and at the same time, he questioned it.

Siva described how the client's written note reached him:

> [A]nother counsellor, Rena saw the client's writing on the form. Before the client left the counselling centre, I was alerted. Rena acted quite fast and smart. She took a picture of the note and sent it to me. Therefore, before I came looking for the client, I already read what he wrote. In Malaysian setting, the client is a guy and I am the only male counsellor, so Rena decided to alert me.

When Rena saw the note written by the client, she saw the urgency of the situation. She felt compelled to act as the note called on her ethical professional response towards the client's desperate emotional state. Her response to this call was to take a photo of the note and forward it to Siva via mobile phone.

I turn to Levinas's (1969, 1981) descriptions of the event of encounter with the face of another which requires an absolute responsibility in order to understand Rena's response when she saw the note. In Levinas's philosophy, 'the face' is understood not only as "something present, but as the other's corporeal self-presence, performed by the gaze or appeal we are exposed to" (Waldenfels, 2002, p. 65). Rena did not encounter the client face-to-face and the encounter did not take place in the concrete situation of speech or spoken form, but in a written form. The (suicide) note written by the client became an appeal from a 'face' that "expresses itself" (Levinas, 1969, p. 51). The note became a face that spoke to the counsellor and Rena became a "hostage" (Levinas, 1981, p. 127) to the call to act, that is to accept absolute responsibility to and for the client.

Siva appeared to interpret Rena's action based on the idea that counsellor and client of the same gender are more appropriate. In maintaining a professional duty of care to the client, Rena performed a beneficent act from the position within the Malaysian Counsellor Code of Ethics that invokes a principle of beneficence (Lembaga Kaunselor, 2011, p. IV). In addition, Rena's decision to refer the client to Siva might have been shaped by her knowledge of Siva's suicide intervention skills training that he received during his counsellor education. The reference directly positioned Siva as a counsellor with the knowledge to intervene. Likewise, the training gave Siva the confidence to accept the referral, as he later made clear. Upon receiving the (suicide) note via phone message from Rena, Siva left his meeting to look for the client. He found the client. He described in the research interview what he had witnessed:

> I saw him sitting with his laptop in a space right in front of the balcony. My concern was, it was a first floor and the railing was about one foot away from him. I could see that he was visibly broken down, he had been isolating himself there.

Applying theory with flexibility and creativity

In the account that follows I propose that Siva was informed by his professional judgement to offer hospitality (Derrida, 2005a, 2005b) to welcome the client into a counselling relationship without confronting the client who was experiencing a vulnerable moment. Siva witnessed the client sitting at the balcony, looking "*visibly*

broken down", and he weighed up his options and decided that using REBT techniques to engage with the client was inappropriate:

> [M]y theoretical framework is REBT (Rational Emotive Behaviour Therapy). No doubt I will say as a REBT counsellor, I will definitely clear cut say, "Committing suicide is irrational", but I can't say that to a person who is about to commit suicide, they might not be able to accept it. So, we have to provide them ample space before you can start off with the actual counselling process in these cases [critical incidents].

At that stage, REBT techniques fell outside of an appropriate initial approach for the particular context. Siva spoke of providing "*ample space"* to prepare the client for "*actual counselling*". He made clear how he could offer the client "*ample space*" when he said:

> At that point of time, he didn't need counselling intervention, he needed support to say that things can be better, just hold on for a while. So, if I were to intervene at that moment with counselling, you never know what is the factor that he is planning to commit suicide…maybe his suicidal ideation comes from the belief that nobody is listening to him. So, at that point when I started off with counselling, it meant that I was not listening to him, I was intervening whatever he was doing, so, again I am affirming his stress factors which is "Nobody is listening, this guy is here also to lecture me".

Siva judged that the REBT disputation style had the potential of preventing him from listening to the client, and so the client from participating in therapeutic dialogues. I propose that Siva's approach might be informed by the Malaysian cultural values of courtesy, tolerance, harmony and face-saving in maintaining relationships that I discussed in Chapter One. When interacting with each other, many Malaysian people generally prefer a subtle style of communication to preserve harmonious relations (Gannon & Pillai, 2015). In the Malaysian cultural context, confrontation is considered rude, aggressive, and disrespectful. Thus, to Siva the application of REBT techniques was not culturally appropriate for both himself and the client at that critical moment of interaction. Siva's perspective is perhaps not surprising because the value of the counsellor-client relationship in REBT receives less emphasis and acknowledgment (DiGiuseppe, Leaf, & Linscott, 1993). DiGiuseppe (1996) criticises REBT as failing to take into consideration the situation, event or context that are believed to be one of the sources of these irrational thoughts. He also argues that REBT disregards the role played by

individual differences in people's respective thresholds for submitting to these supposedly 'irrational' thoughts.

It was also possible to understand Siva's actions as sensitive to the "receiving context" (White & Epston, 1990, p. 2) in which the event was taking place. Receiving context is a concept explored by White and Epston (1990) in narrative therapy. White and Epston's work considers the lives and identities of people are shaped by the stories that they create and are created about them. These stories function as the "receiving context" for the events people experienced in their lives, and as a map for people to make sense of their experiences. White and Epston (1990) argue that, "the meaning we ascribe to, any event is determined and restrained by the receiving context for the event, that is, by the network of premises and presuppositions that constitute our maps of the world" (p. 2). I borrowed from the practice of setting a receiving context to offer an account that Siva might have been aware that he could not determine how the client would respond to REBT disputational techniques in a situation because he considered the client to be in a desparate position. Therefore, Siva was sensitive to the receiving context and welcome the client in ways where client could experience being accepted, valued and respected. By not confronting the client, Siva believed that he would be better positioned to be helpful in obtaining an invitation from the client before proceeding. With the influence of Jenkins' (1996) idea of respectful therapy, I interpreted Siva's practice as creating a respectful relationship with the client which involved a process of "knocking on doors and awaiting to be invited in, rather than barging in uninvited (p. 122)…, and then expecting to be welcomed with open arms" (p. 179). With this intention in his mind, there was a possibility that Siva renegotiated the hospitality he could offer the client by calling on Hindu cultural practice that may be differently situated to the individualist cultural context within which REBT has been developed.

Being of a Hindu Indian descent in Malaysia, Siva's practice of welcoming a guest might be shaped by a hospitality principle of "Atithi Devo Bhava" (Kearney & Taylor, 2011, p. 1). This principle denotes that the one who comes to you to be served should be treated as a God. In Hindu culture, where a guest is perceived as the divine, hospitality is thus viewed as the most notable virtue and considered the highest order of responsibility (Tyagananda, 2011). Siva had hoped to calm a client

who had presented with acute suicide risk who had been turned down for seeking counselling without appointment, and at the same time to make space for possible dialogue.

Attention to the use of language in a relational approach

The (suicide) note demanded Siva to respond with care as the possible consequences of an inappropriate or misjudged intervention was possible. The first contact between counsellor and client, before suicide risk assessment takes place, is a crucial interaction in therapeutic relationship building, in particular, for a client to determine a counsellor's competency to offer the support he had sought (Granello, 2010). I focus here on how Siva described his approach to initiate a conversation with the client:

> Well…I just sat down with him, I said, "What's up?" I just started off with a very casual language…I didn't approach him in a way like, "You know, you shouldn't do this, you shouldn't…blah…blah…blah". I don't want to sound authoritative. Instead I said, "Ok, what's up? You want to talk?"…the tone that I used make him not feelling like I gave him any extra attention or special care that he was going to take his own life… it's just like a casual chat…I just spoke to him as a normal person, with that soft and caring tone…by [doing] this I degrade his anxiety, his sensitivity towards suicidal ideation.

In a cultural context where suicidal ideation immediately produces ideas of pathology, there is significance in Siva taking a non-pathologising stance towards this client. Indeed, he used the expression of "*a normal person*" to speak about the client. He then used language that can be seen as everyday and asked the client, "*What's up?*" However, it is not only everyday language but an important therapeutic skill to offer an open invitation to the client to join the counselling relationship. In addition, by using this open and tentative invitational language in his response to an expression of suicidal ideation, Siva showed the client that he was calm, professional and open for a connection.

From the perspective of positioning theory (Davies & Harré, 1990), Siva resisted taking up an authority position, rather he repositioned himself as a participant in the co-construction of the client's stories, actions or new meanings, by inviting the client into a speaking position. Siva's question – "*What's up?*" – conveyed his genuine interest in what the client was going to say or not say. Simultaneously, this

language invited the client to take up an agentic position to discuss any topic he preferred. The client could interpret that he was given the control to tell his concerns at his pace. This was an example of a counsellor who implemented a conversational form of inquiry. Siva explained why he chose this way to initiate a connection with the client:

> I believe these people who have lost their hope and on the brink of thinking of ending their lives, they wouldn't want very formal kind of approach, very professional kind of approach, very unfriendly type of thing. A counsellor should go in with a very casual way of intervening at that point. I would even think of like having two cups of coffee, giving this person coffee, "so you want to jump [from the balcony], why don't we have a coffee first…we talk before you [act]".

Siva took a stance against being confrontational and directive to promote a therapeutic dialogue:

> Clients will feel threaten if counsellor is going to stop what they are going to do, so you don't threaten them. You affirm them first, like, "whatever you want to do, you can wait for a while, let's discuss first". THAT DISCUSSION is the one that is probably going to change their idea to end their lives. The moment you say, "Don't do it", or "What you are doing is wrong, stop it", they will feel like, "this guy is going to stop me" [or] "the idea of suicide is wrong"…They feel threaten.

Siva judged a confrontational and directive approach – '*Don't do it!*' – as partonising and even threatening. Such an approach might express and foster a detached and distanced relationship. A person who makes direct statements such as '*Don't do it*', may be perceived as rude and confrontational in the general Malaysian cultural values, and in some ways may cause the listener experiences of strong criticism or embarrassment.

Alongside his helper position, Siva also took up a position similar to that described by Orbach, "empathic with the suicidal wish" of the client (Orbach, 2001, p. 173). Orbach, a clinical psychologist who specialised in suicidal behavior and suicide prevention, promotes a therapeutic strategy that is based on an empathic understanding that honours the personal perspective of a client who speaks suicidal ideation. He elaborates:

> Being empathic with the suicidal wish means assuming the suicidal person's perspective and "seeing" how this person has reached a dead end

> without trying to interfere, stop, or correct the suicidal wishes. This means that the therapist attempts to empathize with the patient's pain experience to such a point that he/she can "see" why suicide is the only alternative available to the patient… Instead of working against the suicidal stream and trying to instantly increase the patient's motivation to live by persuasion or commitment to a contract, the therapist takes an empathic stance with the suicidal wish and brings it to full focus. (p. 173)

Orbach (2001) clarifies that the notion of empathy with the suicidal wish does not suggest suicide as a mechanism of coping with pain and suffering. Instead, Orbach's orientation is a way of showing respect for the clients' suicidal wish through listening to their stories in an emphatic and non-judgemental way. Listening in this manner allows the clients to feel that they are receiving support and understanding (Orbach, 2011). I argue that such a posture of therapeutic empathy invites Siva to speak the client's language, and at the same time avoid unpleasant struggle with the client regarding suicide subject. When Siva did that, it communicated to the client that Siva was genuinely interested to listen to his concerns. This stance also indicated acceptance to the client, and that Siva saw him as a *person*. In this regard, approaching the client-counsellor interaction with language that indicates openness creates the space for curiosity and collaborative exploration between Siva and the client (see Anderson, 2007).

My point here is that in a life-threatening situation such as this, Siva emphasises the use of casual language in a tentative and open approach to invite client participation. I proceed to show how Siva engaged in co-constructing of what was important to the client through an ongoing process of listening, connecting and responding to the client's body language, written words and meanings.

Small steps to building connection with the client

When the client did not respond to Siva as he attempted to initiate a conversation at the balcony, Siva reported that he did not give up but continued to build the connection:

> I said to the client, "So I assume you are willing to talk, no harm in talking, so shall we talk for a while? I would like to know what's happening." And, the moment I saw his body language, which is like agreeing to that, I said, "Well, this is not a good place to talk because this is a walk-way, why don't we go to the office and talk, it's more comfortable." So, I stood up

> but I saw him hesitated. I insisted and said, "Come on, let's go" and eventually he followed me.

Siva used curiosity, "*I would like to know what's happening*", to invite the client to explore his concerns while simultaneously conveying that the client's story mattered. When the client continued to remain silence, Siva paid attention to the gestures of the client's face or body. He relied on his active witnessing skills to make meaning of the client's non-verbal shifts in body gestures and relate them to the context. When Siva witnessed the client's body language that he interpreted as "*agreeing*" to have a conversation, Siva's experience suggested to him that this was the invitation from the client that he was interested to talk.

In addition, Siva noticed the balcony did not offer privacy for their conversation. In therapy, it is the counsellors' responsibility for the creation of a safe therapeutic environment for clients (Corey, 2013; Egan, 2010). Through the suggestion of a "*more comfortable*" place, Siva offered the client another invitation into a relationship, at the same time he used this opportunity to steer the client away from a potential dangerous situation. While leading the way to the suggested meeting place, Siva encouraged the client, "*Come on, let's go*". Siva judged that the client might need some support and encouragement. He used language in a tentative yet purposeful way to offer words of encouragement that moved the client closer to consider accepting the invitation.

Siva reported that he brought the client into a meeting room as a counselling room was not available at that point of time. In the meeting room, Siva continued to convey his sincerity and sensitivity:

> I brought him to a meeting room and locked the room, and I dimmed the lights, and then I said, "Ok, that's no one here", I just wanted to give the assurance that I am there totally to listen to him…so I didn't bring my phone or I didn't bring anything, just me and my office room's key.

Though a meeting room was not an ideal environment for therapy, Siva took his professional responsibility to attend to privacy. He thoughtfully set up the room by dimming the lights and locking the door to keep someone from walking into the room. Siva intentionally left behind his mobile phone so that he could offer full attention to the client. These small actions that Siva made signified responsible care

and respect towards the client and at the same time, provided, what Winnicott (1964) called, a "holding" environment (p. 231) for the client to feel safe to explore his concerns.

Winnicott (1990), a British object relations theorist and pediatrician, speaks of a holding environment, which consists of the physical and the psychological holding that starts from the moment a baby is held in the mother's womb and continues when the baby is born. He believes that a good enough holding potentially contributes positively to the infant's personal development. Object relations therapists pay particular attention to therapeutic holding that is providing a secure and safe space in therapy. While clearly Siva did not identify himself as an object relation therapist, he set up a climate of 'holding' at work here that offered an environment in which the client felt safe and understood.

The client acted in silence in the entire process. In the meeting room, the client produced a Universal Serial Bus (USB) storage device which contained powerpoint slides and videos. With help from Siva, the client connected the USB to the computer in the meeting room. While the client set up the presentation, Siva patiently waited. The client began the slides and videos presentation without an utterance while Siva sat beside him with occasional questions:

> [The client] had a powerpoint presentation of about 80 slides showing what happened to his life, there was [indication of] suicidal ideation…So I sat down and stayed with him to "listen" to his story presented through powerpoint slides, also a few videos.

Siva reported that the client did not speak during the presentation, but he wrote notes on a paper and passed it to Siva. In this situation, Siva had to rely on reading the client's written notes and body language to make meaning of non-verbal communication:

> There was a lot of guessing because he was not talking. So, I started guessing and said, "Ok, if you feel nobody is listening to you, have you tried everybody? I am here to listen to you, so why not you share with me?" …the communication was all by writing, there were quite a lot of papers, just writing and the slides and all…Every now and then I responded and gave him some feedback but I didn't really dispute his thoughts, all I wanted him to understand was that there was support, there was help…It was quite tiring but it was a soul that we were talking about

> here, so I was there… it was in the evening around 5pm and up after office hours.

Siva honoured the written notes by carefully giving enough time to read them. During the silence, Siva watched the presentation and observed the client. His therapeutic concern and curiosity, in a way, beckoned him to explore the content of the presentation further by asking the client follow up questions. The client then once again wrote on a paper and returned it to Siva. Siva read the note and asked him another follow up question. This process kept on going. The written notes allowed Siva to maintain a connection with the client. Siva became attuned to the client's communication preference and did not exert pressure for the client to speak. Instead Siva accepted and respected the client using silence as a way to communicate with him.

The use of silence for active listening and observation is well documented as one of the basic helping skills potentially leading to rich moments in therapy (Corey, 2013; Egan, 2010; Ivey, 2013). However, the form of silence in this context was not the common pauses or silence in counselling. The occurrence of silence was initiated by the client who preferred to stay silent during the entire counselling process. In response to the client silence, Siva effectively extended the use of silence to create an interpersonal space where both could communicate. Siva remained present in the moment with the client. He used silence as a therapeutic technique to 'listen' attentively to the client (see Egan, 2010). Siva intentionally slowed down his pace to allow for a connection to develop between them. He took time to 'listen' to the client's silence and found the rhythm between 'listening' and responding to the client. In reflecting on his experience, Siva brought to the fore what form of 'listening' he believed the client would expect from him:

> As a counsellor, maybe you can sense that what they are saying is not exactly accurate, but you cannot deny or you cannot just ignore what they are saying at that time. To a certain extent, you might have to listen to it, and…support it by showing that you are there totally to listen because when you deny it, for that person, they will be feeling that this person is not listening. So you have to handle it a bit tactfully, so you must affirm the client that you are there to listen.

Siva chose a posture of being "*there totally to listen*" to the client rather than perhaps "soldier[ing] on" (see Burman, 1994, p. 51) with a list of questions

concerning the clients' history of suicidal behaviours and mental conditions that an assessment perspective might suggest. The act of 'listening' demonstrated by Siva might strengthen the client's belief about how much Siva cared about him. In this example, Siva illustrated that offering the client "dialogical space" (Anderson, 1997, p. 112) required creativity and adequate patience on the part of a counsellor.

In a context where language not only represents the world, it creates our worldviews (Burr, 2003; Gergen, 2009), the client's slides and video presentation became a linguistic device that the client used to communicate to Siva about his concerns. The client's silence was met with a question from Siva and an answer on paper from the client. Together they explored the meaning of client's concerns and suicidal ideation. In this way, ideas, knowledge and actions were formed between them and within their interactions (see Burr, 2003). I turn to Shotter's concepts of joint action (1980, 1984, 1993a, 1993b, 1995) and withness-thinking (2010a, 2010b) to offer me the tools to conceptualise the relationship between Siva and the client.

Shotter (1980) suggests that joint action is "any action in an interaction in which an individual must interweave his actions with the unpredictable actions of others" (p. 32). The action of an individual thus is unplanned and spontaneous without consciously having the reasons for his/her behaviour (Shotter, 1984). Within a dialogic situation, people "act jointly, as a *collective-we*" (Shotter, 2011, p. 2, original emphasis). They "'dance' or…'navigate' towards the common point of [their] dialogue and towards [their] 'positions' in relation to it and to each other" (Shotter, 1996, p. 8) to create a new situation, which is unique to them. In this respect, their responsive thinking, acting, and speaking are joint actions taken in relation to each other. Shotter (1996) writes,

> By reacting to the actions of others our replies are never wholly our own; in being always both reactions to their 'calls' and to the larger circumstances in which they occur they are half 'shaped' by influences beyond our control. Thus, in such 'joint' or 'relational' circumstances, no outcomes can be wholly attributed to the desires or plans of individuals involved, nor can they be attributed wholly to outside agencies. (p. 8)

Shotter (2011) goes on to argue that "[i]t is in these moments of indeterminacy, that the influences of others…can partially at least determine the 'shape' of the 'doings' of individual agent" (p. 3). Within the counselling process, Siva and the client

engaged with each other to produce "an 'action guiding' sense from within their lived and living experience of their shared circumstances" (Shotter, 2006, p. 601). Shotter (2006) calls these forms of responsive actions/behaviours, "thinking-from-within" or "withness-thinking".

Siva took up a position of *being with* the client that resonates with Shotter's (2010a) description of "withness-thinking" (p. 2). "Withness-thinking" involves a counsellor's attempt to form a relationally responsive connection with a client when both of them work together to attend to what unfolds between them (Shotter, 2010a). Siva embodied 'withness' in his practice to give room for "voices to emerge that have often been stifled or withheld" (Hoffman, 2007, p. 70). One, Siva flexibly and creatively refrained from applying his preferred theoretical approach when counselling the client in time of urgency. He was attuned to the client's relational needs and invited the relational dimension into his practice to work alongside his preferred theoretical orientation (REBT). Two, Siva made the therapeutic relationship the primary focus of therapy. He respected the client's available way of being, telling and expression while finding ways to work alongside the client. Three, Siva skillfully used silence, 'listening' ability, skills of conversation and observation to establish a meaningful connection with the client, through which Siva hoped to offer the client an atmosphere to feel 'held' and 'safe' (see Winnicott, 1964) to begin to participate in therapy.

Lastly Siva's curious learner position invited him to honour and witness compassionately what the client was experiencing (Weingarten, 2003). By standing as a compassionate witness to the client's story, Siva positioned himself in the emergent and here-and-now relationship with the client. This meant that Siva's witness process occurred *within* the therapeutic relationship and not from the *outside* as an observer. Maintaining the stance of compassionate witnessing is one of the ways to practise hope with others (Weingarten, 2000). Siva might not have described his actions as I do, that he was doing hope with the client through his witnessing presence. The client might hold many versions of hope, such as hoping the counsellor would listen to him without being judgmental, or hoping that counsellor could help him. I suggest that the kind of hope-related language used by Siva such as, "*I would like to know what's happening*" and "*I am here to listen to you*", created a dialogical space for hope to be practised within their conversations.

Apart from using hope-related language, creating a therapeutic context for the client can be seen as a form of doing hope. In this sense, the practice of hope appeared to have been woven into the care for the client. By doing hope together, counsellors become part of the process by which possible future emerges for the clients (Weingarten, 2010).

My concluding thoughts

Siva's narrative illustrates a number of key discourses competing with each other. These discourses included professional, institutional/bureaucratic as well as cultural discourses. These discourses shaped the interactions within therapeutic space, such as what could be spoken, where and how one spoke, as well as who could speak (see Foucault, 1972). One obvious example was how these discourses shaped the client's access to counselling services and the counsellors' practices in a time of urgency. These discourses function within power relations to produce regimes of truth (Foucault, 1980). Various truth regimes circulated within counselling practice at Siva's workplace. The first regime of truth, the standard bureaucratic procedures produced the guidelines for employees and students who wanted to engage counselling services. The bureaucratic regime functioned to manage and organise the employees' conduct. The employees protected and promoted this standard by ascribing to a particular appointment system. When the client requested an urgent appointment, the Intake Officer followed the guideline. When the urgency of the situation became evident, the professionals with different ethical responsibilities acted outside this particular appointment system. They activated their network of hospitality and relational practices. These steps bridged the space between professional care for the client and the appointment guidelines.

In therapy, Siva was positioned between two opposing regimes of truth: counselling theory and professional wisdom. Siva faced the dilemma of establishing an intervention guided by his particular theoretical approach or spending enough time to build a meaningful relationship with the client. Siva received his counsellor training within the REBT model, which informed him to dispute a client's suicidal ideation. However, Siva judged that it was not a good time to apply this technique. He needed to negotiate between a clearly defined structured approach on the one hand, and counsellor attention to client's needs and the urgency of the situation on

the other hand. Siva used the refined skill of discernment to guide his responses and have the client's best interests at heart. He called on the less-told account of the theory to tailor his practice to the client's capacity for interaction. To skillfully put a theory into practice, Siva employed assessment skills and "in touchness" (Shotter, 2010a, p. vi) with the situation he encountered to develop an approach which was contextually sensitive. Siva's approach demonstrated the recognition of the importance of sensitivity, flexibility and thoughtfulness in the application of counselling theory.

In times of acute suicidal crisis, Siva expertly used language and tone, active listening skill, silence and observing client body language to build a meaningful and trusting therapeutic relationship (see Brew & Kottler, 2017; Fiske, 2008). In the safety of the therapeutic frame, he adapted his own language and tone of voice to attune to the client's level of comfort. Siva used language in a less formal and relaxed way to not only to communicate care but to convey to the client that he did not experience panic or discomfort by the client's suicide disclosure. When they went into the meeting room, Siva thoughtfully set up the room. When the client kept silent in the session, Siva skillfully observed the client's body language, reading client's written notes and asking follow-up questions to make meaning of the client's non-verbal cues. While 'listening' to the client's silence about his life story through the slides presentation, Siva paid attention by reflecting back and clarifying what he saw or read. He respected the client's silence and used silence like a "conversational artist, an architect of dialogue" (Anderson & Goolishian, 1988, p. 383). Siva's practices were actions of welcome and, he was relaxed and open to produce a supportive environment in which the client could share his story in his own pace.

Siva took small steps in getting closer to the client. Siva continued slowly and carefully by attending to, what Weingarten (1998) refers to as, "the small and the ordinary" (p. 3) in conversations with the client, to enable the client to express (in his own way – writing notes) his concerns. Siva demonstrated that relationship building, when counselling client with suicidal ideation, could embody the most caring and effective interventions. These interventions took place without compromising professional responsibilities. Siva taught me that being a conversational artist, an active listener, and a sensible observer are important

counselling skills in shaping how to *be* in the client's world in the context of a client proposing to end his life. He offered hope of new ways of being *with* clients who expressed acute suicide risk.

CHAPTER SEVEN
THE SMALL ACTIONS THAT CONSTITUTE A PRACTICE: NEGOTIATING LANGUAGE AND CULTURE

Introduction

Rapport-building in counselling begins the moment counsellors make first contact with clients (Corey, 2013; Egan, 2010; Ivey, 2013). Clients may need to experience conditions of safety to willingly disclose their concerns to counsellors. Explicitly talking about suicidal experience may be uncomfortable for many people in Malaysia due to the stigma surrounding suicide (Foo et al., 2012; see Sheehan, Corrigan, AlKhouja, & Stigma of Suicide Research Team, 2017; Vijayakumar et al., 2008). It is thus crucial for counsellors to make room for clients to take the session at a negotiated pace (Reeves, 2010). This requires counsellors to resist the tendency of wanting to direct the session with urgency, but instead to approach suicide as a topic when clients are ready to discuss it.

People who have attempted suicide often experience a sense of worthlessness, shame, inadequacy, embarrassment, guilt and worry about how their suicide attempt has affected those around them (Benson, Gibson, Boden, & Owen, 2015; Sheehan et al., 2017). The clients in the stories of two counsellors, Bahar and Peng-Yu whose accounts I include in this chapter had attempted to take their own lives. From a legal standpoint, the clients were considered a criminal (Laws of Malaysia, 2006a). Positioned in this way, the clients were likely to have been subjected to unfair discrimination and the possibility of being treated with less respect by the community in general (see Sheehan et al., 2017). In addition, the stigma surrounding suicide increases vulnerability (Ahmedani et al., 2013; Azhar, 2003; Foo et al., 2012; Loo et al., 2012; Tzeng & Lipson, 2004). The clients might be particularly sensitive, uncomfortable or even hesitate to talk about their suicidal experience. The clients' vulnerability called Bahar and Peng-Yu to be delicate and thoughtful in their approach to engage with the clients to explore their suicidal experience. Bahar and Peng-Yu approached their clients with carefully-sensitively crafted language during risk assessment process. They paid attention to clients' responses and weaved cultural relevance practices into counselling to await clients' readiness to speak of suicidal experiences and despair.

In this chapter, I argue how language plays a constitutive role in the production of knowledge (Burr, 2003; Davies, 2001) about suicidal ideation. As discussed in Chapter Two, Drewery and Winslade (1997) use the term *position calls* to show how language positions an individual in relation to others. Drewery (2005) suggests that "[s]ome forms of speech can reproduce unequal power relations by reproducing the kinds of relationships where one party to a conversation is called into a non-agentive position" (p. 320). Thus, it is crucial that counsellors reflect the way they speak to clients in therapy. Central to this idea is *how* the invitation to engage in counselling is offered by counsellors in the context of suicidal ideation.

I provide vivid examples of the ways counsellors assessed clients for potential risk of suicide that opened up a safe space for conversation about despair and exploration of the questions about living. I show my analysis of the use of language by Bahar and Peng-Yu in assessing suicide risk of clients who had attempted to take their own lives. I first present selected excerpts from the research interviews with Bahar, who practised double 'reading', and asking questions to explore the absent but implicit (White, 2000) with the client about the accounts of life that were located 'outside' of the problem story of the suicide attempt. Next, I continue with the account offered by Peng-Yu to discuss how his own cultural knowledge was woven into the fabric of professional practice as he found ways to carefully negotiate entry to an ongoing therapeutic relationship.

Bahar: "I avoided using the word '*suicide*'"

Bahar, a Muslim man, was a counsellor working alongside a team of psychiatrists in the Department of Psychiatry and Mental Health of a public hospital. Bahar reported that psychiatrists are the first mental health professionals who meet and assess patients/clients. The services offered by psychiatrists involve treatment with medication and/or referral to a member of the mental health team, such as counsellor. After an assessment, if a psychiatrist thinks that it is necessary, he or she may suggest a patient be admitted to the hospital. This is typically for patients presenting with risk of serious harm to themselves or to others. A standard hospital admission often lasts from a few days up to two weeks. In the psychiatric ward, patients will be closely monitored to minimise the risk of harm. Sometimes patients will be prescribed medications to reduce their anxiety or to treat depression (Khoo,

2013). While patients may be required to attend counselling to achieve an optimum outcome, the structures of mental health care practices suggest that the responsibility for supporting people with suicidal ideation remains with the medical health professional.

In the following example offered by Bahar, a young Chinese college student was hospitalised in the general ward for immediate treatment of his injury after a suicide attempt that nearly claimed his life. When a medical doctor had determined the clinical condition of the patient/client was considered "stable" for discharge, it was part of the hospital's suicide post-vention protocols to decide transferring the patient/client to psychiatric ward (Ministry of Health Malaysia, 2014, p. 13). In this decision-making process, Bahar reported that he worked alongside psychiatrists to assess the patient/client for further suicide attempts.

Before meeting the client, it was a standard practice for Bahar to find out as much as possible about the client from the client's Bed Taking History (BTH) file:

> I read the client's background information from the client's BTH file, so that I can prepare myself in term of what I plan to do and what I can tell or say to the client during the session.

Bahar explained that the BTH file consisted of the client's name, age, gender, ethnicity, and some medical records from the psychiatrist and other doctors who were involved in his treatment. Speaking to the importance of cultural context, Bahar continued:

> In Malaysian context, I remind myself that I have to be careful using certain words in therapy because some words may be a taboo to a particular culture or religion. For this client who just attempted suicide, some words might be very sensitive to him, especially the word, 'suicide'. I didn't want to hurt his feelings by using the words, 'suicide' or 'attempting suicide'. I usually use the words 'suicide' or 'attempting suicide' only when the client uses them first. If I use these words first, I am afraid the client may not be willing to disclose more about his experience.

Bahar's narrative indicated that he took responsibility to find ways for the shaping of the therapeutic conversations that would encourage the client to talk about his suicidal experience without leading to a sense of devaluation or condemnation. Bahar did not use the term *suicide*, and I suggest that what is at work here is an

understanding that one person's speaking shapes the experience of another (see Drewery, 2005), and particularly so when the speaker holds a position of authority, in this situation professional authority. Bahar did not know whether or not it was wise for him to use the word *suicide* in the suicide risk assessment process. However, he worked to listen carefully to hear the language that the client used and to pay attention to meanings ascribed in order to inform his own language. Bahar took the lead from the client. When the client made only implicit references to suicide, Bahar did not name suicide in his conversations. When the client made explicit references to *suicide*, Bahar read this as an indication that he too could use this language.

Bahar's way of speaking might be guided by the practice of *budi* in the Malay culture that values courtesy and respect in relationship building (see Ramli, 2013). When meeting someone, a stranger or a person they know, Malay people in general adopt a traditional practice to offer a comfortable and hospitable environment to welcome the person (Mohd. Salleh, 2005). It is also part of the Malay people's culture to engage with an individual to build relationship prior to "getting down to business" (Abdullah, 1996, p. 79). I suggest that Bahar wove this cultural knowledge alongside his counselling practice, as his choice of language spoke of the prioritisation of care and attention to the client-counsellor interaction. In addition, indirectness is a form of communication practised by most Malay people (Mohd. Salleh, 2005). For instance, when making a request, the requester prefers to ask tentatively or to talk around the issue/request as a way of showing respect. This way of communication became visible when Bahar talked about how he followed the lead from the client's language when referring to the subject of his suicidal experience. Bahar's practice could be understood as a sign of respect in his attempt to ask or invite the client to talk about his experience. What appeared central to Bahar's practice was the importance of maintaining relationship with the client.

Engaging with the 'absent but implicit' as a method of suicide risk assessment

Bahar reported that he had learned about the client's suicide attempt and his survival from the BTH file:

> The client was a young college student. This particular situation was special to me because he survived falling from a four-stories building

> which was approximately 12 to 16 metres. In general, people who fell from this height might not survive.

I argue that Bahar attempted to make meaning of the client's survival by calling on his understanding that people with suicidal ideation might be experiencing ambivalence between the wish to live and the wish to die (Gorski, 2016; Reeves, 2010). Bahar recognised this ambivalence and concluded that perhaps the part of the client that wished to live had 'intervened' in the suicide attempt, which saved the client's life. Based on this assumption, Bahar decided to focus on the client's possibility of life-saving rather than the wish to die. This decision perhaps informed Bahar to use curious questioning (see for example McKenzie & Monk, 1997) in his attempt to invite the client to tell the story of his survival through the following question:

> How did you save your life during the fall?

Curious questioning is a way of asking questions, particularly by narrative counsellors (see White, 2007), that reflects counsellors' genuine curiosity and sincerity to learn from clients about their experiences. Bahar might be informed by his knowledge about the issue of ambivalence inherent in the suicidal act, but his question indicated that he was careful to tentatively withhold this knowledge. By paying attention to the client's "reasons for living" (Fiske, 2008, p. 8), Bahar invited expression of ambivalence into the suicide risk assessment interview to help the client reconnect with life.

In response to Bahar's invitation to speak of how he had *saved his life*, the client accepted the position call offered by Bahar:

> The client told me that he regretted his action as soon as he leaped from the building. Before he fell on the ground, at the split second, he used his martial art practice to cushion the fall and saved his life.

The curious question seemed to make room for the client to speak openly and safely about the fall and the skill, which was the martial art practice, that he drew on to save his own life. In this conversation, the client had the opportunity to identify and revisit the moment when he brought himself towards safety. This exploration to

reconnect with life had the potential to lead the client to reposition himself in relation to suicidal behaviour.

A possible way to think about Bahar's focus on a conversation about life-saving rather than life-risking can be found in the narrative therapy concept of "absent by implicit" (see Carey, Walther, & Russell, 2009; White, 2000):

> Often people's hopes and intentions and purposes for their lives, or any other possibilities, are obscured by the dominance of a problem story. Narrative counsellors employ a kind of radical listening that hears a possible duality in what appears at first to be a singular description (White, 2000, p. 36). They are listening for what is **absent but implicit –** that which is not spoken but is the "other side" of what is spoken (see Carey, Walther & Russell, 2009). (Crocket, 2012, p. 474, original emphasis)

I argue that while carefully reading the client's history in the BTH file, perhaps Bahar found what was not named in the problem story but available implicit in the client's surviving the fall was the implicit story about his resistance to dying, a wish to live. This way of engaging the client with a curious question about what was absent but implicit opened a space for a different story to be told. This unstoried experience now had an opportunity to be taken up into the account of the client's life. Through the martial art story, the client asserted that he had done something to save his own life. Such speaking opened up the possibility of developing a sense of agency that the client might also be able to do something about the issues which were challenging to him that had led to the attempt to take his life.

Through engaging in such a conversation, Bahar effectively brought the client to the possibilities of connecting with an alternative more hopeful story. The client stepped into the alternative story about 'reasons for living'. This care to consider the potential for how a conversation might develop calls counsellors to paying attention not only to risk (see Mulder, 2010).

Peng-Yu: "'*Suicide*' is a big…sensitive word…a judgemental language"

Peng-Yu, too, was counselling a student who had been hospitalised after a suicide attempt. He was a Chinese counsellor who worked in a higher education institution. Peng-Yu met the client at the campus counselling service after discharge from the hospital. Peng-Yu reported that the client was diagnosed as suffering from

borderline personality disorder (American Psychiatric Association, 2013). Like Bahar, Peng-Yu showed sensitivity to the effects of language in his concern that the client might interpret Peng-Yu's intention as judging him negatively. Peng-Yu reflected as follows:

> 'Suicide' is a big word…it is a sensitive word. In conversations with a client who had just made a suicide attempt, the word 'suicide' might sound like a judgemental language, which could lead the client to feel guiltier, in particular if the client believed that killing himself was wrong.

Peng-Yu placed a great deal of emphasis on the importance of his actions in building a therapeutic relationship. He explained:

> I need to stay close to the client. I take time to build the rapport. Even though the standard procedure is to assess the client's suicide risk in the first session, I usually will do that after rapport with the client has been established. I will still use the word 'suicide' but use it after the client mentions it first. If I use it in the first meeting with the client, I am afraid the client may not be willing to talk about his experience or concern.

Like Bahar, Peng-Yu took cautious steps to carefully form his language by deciding to follow the client's lead in how to use the word *suicide* in their conversations.

Ménkǎn: The passage to the client's personal space

While Peng-Yu was not talking directly about the social constructionist idea that language is constitutive (Burr, 2003), he might have been guided by ideas that the kind of language he employed constructed the client in a particular way. He gave the questions about suicide appropriate thought and considered the client's response carefully. Peng-Yu went on to explain:

> I preferred not to use the term, 'suicide' in my questioning. I would rather choose to say it in a different manner such as, 'Are you doing something to harm yourself? Please tell me about your plan.', 'Have you thought about not wanting to live anymore? Is that ok for me to ask more about that?'

Peng-Yu approached the client as if he were a visitor waiting to be invited into the client's space (see Swann, Swann, & Crocket, 2013). He replaced the word *suicide* with words that reflected similar meaning but illustrated a thoughtful and respectful way of speaking to seek permission from the client to address the suicide questions.

Seeking the client's invitation to speak, I suggest, is Peng-Yu's respectful and careful way to assess when to enter into the client's personal space. He approached the client with an intention to have a dialogue by "talking with" the client, not "talking to" the client (Anderson, 1997, p. 63). This way of waiting to speak might invite the client into a place of agency (Davies, 1990) to tell his story. Peng-Yu did not take the risk to invite himself into the client's world by taking for granted that he had the right to ask the questions about suicide just because he was positioned as a counsellor.

Peng-Yu's practice reminds me of the cultural meanings of (door) threshold or doorsill (Chinese: 门槛, [Ménkǎn]) in the system of traditional Chinese architecture. A threshold usually forms part of the main entrance door frame in a traditional Chinese house (Harris, 2006). This wooden piece is located at the bottom of the doorway entrance and measures about one foot to two feet in height. In terms of cultural meanings, the height of a threshold represented a family's social status in the ancient time. The higher the threshold, the higher the family status in terms of wealth and political influence (He, 2012).

A threshold takes the position of a divider that separates the inside of a house from the outside world. It serves to enclose, protect and define the house premises, its occupants, as well as the domain of private life. This architectural feature has practical, mythological, and spiritual dimensions in Chinese culture (Komjathy, 2013). From a practical perspective, this wooden plank prevents rain and mud from entering the house (Harris, 2006). In terms of mythology, the threshold functions to keep off evil spirits (Komjathy, 2013). Many Chinese people believe that the threshold protects the house occupants by setting boundaries between the physical and spiritual worlds.

This door feature marks the territories and guarding boundaries of the host and guest or visitor. Before a visitor can enter the house to meet the host he or she first will encounter the threshold. The visitor must step over the threshold upon passing through the doorway (Liu, 1989). This involves lifting the leg, holding the leg high enough to avoid stepping on the threshold. The Chinese culture regards stepping on the threshold is considered impolite and disrespectful as the threshold symbolises the host's back or neck, which may represent the host's or the family's dignity

(Kuzmich, 2015). While holding up his or her leg to traversing the threshold, the visitor watches their step by slightly bowing their head. All these movements bring the act of entry into the conscious thoughts when entering the domain of the host's privacy. The practice of entering and crossing the threshold indicates a gesture of paying respect to the host. This gesture resonates with the Chinese cultural value of being courteous (Chinese: 礼, [Lǐ]). Courtesy is considered a very important etiquette in communication and relationship building for many Chinese people in Malaysia (Fontaine, Richardson, & Yeap, 2002). From this perspective, I argue that Peng-Yu has woven the principle of ménkǎn into the therapeutic process.

Prior to entering the client's space, Peng-Yu stood before the threshold and waited for the client's invitation. When standing at the threshold, Peng-Yu was "in the middle of things" (Jackson & Mazzei, 2012, p. 6) in terms of connecting with the client and having client safety in mind. Jackson and Mazzei (2012) use the architectural feature of a threshold to explain the idea of thinking with theory as a method of data analysis; by putting together the data and theory to work in the threshold to produce new analytical questions:

> In architecture, a threshold is in the middle of things. It exists as a passageway.…Thresholds contain both entries and exits.…therefore the structure itself is not quite as linear and definitive as one might think. In other terms, thresholds can denote excess…The excess of a threshold is the space in which something else occurs: a response, an effect. Once you exceed the threshold, something new happens. (p. 6)

While pausing at the threshold, Peng-Yu endeavoured to find ways to cross over the threshold to enter a space where he and the client could meet. He witnessed the situation and the client with new eyes and ears. He saw and heard the client's story differently. Peng-Yu listened to hear the language used by the client during their interaction; he paid attention to signs that might indicate the client was uncomfortable to take part in the conversation; and he gave careful thought to the language that he used. The movements of traversing a threshold was a step-by-step process which required Peng-Yu's careful, watchful and attentiveness. Through these practices, Peng-Yu created space to respect the client's autonomy, to avoid embarrassment and to invite the client to take up an agentic positioning to enter the counselling relationship. In this process, something new might happen when the

familiar began to be talked about in unfamiliar ways and new meanings were given to the familiar. The 'new' things might become a turning point in the counselling relationship and/or the client's life. In this example, I learned from Peng-Yu how he skillfully interwove language, space and time to invite the client to talk *with* him. In Rogers' (1951) terms, this was an expression, of regarding the client (the host), by Peng-Yu (the visitor), as a person of self-worth; of value no matter what he had done even if legal discourse positioned himself as a criminal. When the client experienced care and respect from Peng-Yu, he might see Peng-Yu witnessing him as a person of value.

Language: The difference that makes a difference

I had shown the accounts of Bahar and Peng-Yu were shaping counselling practice in culturally responsive ways, through the use of language and in carefully negotiating entry to an ongoing relationship with their clients (see Brew & Kottler, 2017; Fiske, 2008). Bahar and Peng-Yu took a stance of patience yet innovative responsive way to what the clients said or did in therapy. They were mindful of "*what*" and "*how*" they talked with the clients about, and "what the *context*" of the talking was (see Andersen, 1992, p. 59, original emphasis). Responding to clients in this way, both the actions or speeches of counsellors and clients were shaping each other's responses in a dialogic way. Their approach to language use was perhaps guided by the 'in the moment' responses to their clients' utterances. In the language of Shotter (1995), Bahar and Peng-Yu acted "responsively 'into' a situation, doing what 'it' calls for" (p. 62). While having client safety in mind, Bahar and Peng-Yu made a discernment when and how to use appropriate language. Bahar and Peng-Yu practiced a relational-responsive (Shotter, 2008; 2010a) way of being with the clients. This form of interaction "involves coming into living contact with an other's living being, with their utterances, with their bodily expressions, with their words, their works" (Shotter, 2008, p. 186). Shotter (2010a, 2010b) refers to this kind of interaction as withness-thinking.

The distinction of language employed by Bahar and Peng-Yu constituted "a difference that makes a difference" (Bateson, 1973, p. 286) which could bring about effects or changes in the therapeutic process. In this context, clients' hesitation to talk about their recent attempt to take their lives or why they did it might be an

indication that the topic was uncomfortable or "too unusual (too painful)" (Andersen, 1993, p. 307) for them to take part in the conversation. Bahar and Peng-Yu reported that their clients might not have been ready to enter into discussion if the word *suicide* was used in conversation before the clients themselves referred to it. When facing clients' hesitation to discuss such topics, Bahar and Peng-Yu actively listened to and observed the clients' body language to notice any hesitation in their conversations and made meaning of what they heard and saw. Through active listening and observation skills, Bahar and Peng-Yu invited themselves to become aware of the clients' readiness to speak of suicidal experiences and despair.

In response to the clients' hesitation to speak, Bahar and Peng-Yu took a relational position to learn the language of their clients by following the clients' lead, or by replacing *suicide* with words that suggested similar meaning. Alongside using appropriate language, Bahar and Peng-Yu weaved their respective culturally relevant practices of – *budi* and *ménkăn* – into counselling to make room for clients' preparedness to speak of suicidal experiences and despair. This practice calls for creativity, respect and patience on the part of the counsellors.

Bahar's and Peng-Yu's commitment towards a sensitive practice have emanated from the dictum expressed in the Malaysian Counsellor Code of Ethics, particularly Section A: The Counselling Relationship in which counsellors are encouraged to develop a sensitivity to diversity issues amongst the people who seek counselling services (Lembaga Kaunselor, 2011). Bahar's and Peng-Yu's practices here are clear examples of how this sensitivity plays out at the level of the individual words they used to discuss the topics of suicide with the clients.

CHAPTER EIGHT
EXTENDING CARE:
RESPONSIBILITY WITHIN COUNSELLING AND BEYOND

Introduction

The cultural practice of maintaining family honour may become a challenge for counsellors (Abu Talib, 2010; Keshavarz & Baharudin, 2009), as it may shape the counsellor-client relationship and the interpretation of confidentiality in therapy. In this chapter, I hold particular interest in the ways in which Li-Na and Cheng-Mei worked alongside institutional protocols to engage in delicate negotiation with clients, clients' families and significant others, to create, in the terms of narrative practice, a community of care (White & Epston, 1990) to work collaboratively in suicide prevention.

I begin the chapter by presenting examples drawn from Li-Na's experience of adhering and at the same time resisting the institutional protocols of referring a client for psychiatric services when he or she expresses suicidal ideation; and inviting a client as a partner to jointly decide what seems to be the best ways to manage confidentiality. This becomes particularly relevant when tension arises between the need to disclose the client's suicide risk to protect their safety and respect for client autonomy. Next, I invite readers of this study into Cheng-Mei's struggles when facing the situation of a client's parents who declined mental health services for their daughter. I investigate how Cheng-Mei persistently maintained a pastoral care relationship with the client and built a support team to work alongside her to support the client.

Li-Na: Standing in the space between a client and the crisis protocols

In this section, I discuss the campus crisis protocols for student suicide that plays a major part in shaping Li-Na's practices, and how she worked alongside the protocols to support clients and their families whose cultures are different than the American culture, where she received her counsellor training.

Li-Na, a Chinese Christian woman, has been practising counselling for three years since she completed her counselling programme in the United States. As a Western-

trained counsellor, Li-Na talked about how the training had shaped her approach in discussing the topic of suicide with clients:

> The training in US taught me to talk about suicide subject openly. I have learned that suicide questions are something that we [counsellors] can just ask the clients directly, it's not something that we cannot ask or avoid asking them. Rather, openly talk about suicide helps the clients to share more. However, the stigma and taboo associated with suicide in Malaysia lead me to be unable to speak openly about suicide without causing people feeling uncomfortable. I adjust my approach to make the process more comfortable for them to share things with me.

Li-Na recognised that the ideas and methods she learned from her education in US might not be appropriate to apply when practising in Malaysia. She tailored her counselling approach to the client's individual culture and preferences. Li-Na's practice illustrated a culturally informed therapy approach (see Pederson, Draguns, Lonner, & Trimble, 2002; Sue & Sue, 2016), which she enacted in accordance with the profession's ethical guidelines.

Li-Na worked as a campus counsellor in one of the private higher learning institution in Malaysia. The institution developed campus crisis protocols for student suicide that offers guidance to counsellors and other relevant people in the response team to respond in a timely and structured way when there is a suicide crisis such as when a person attempts suicide and struggles with suicidal ideation. Li-Na explained that the protocols involved a few steps for counsellors to undertake when encountering with a suicidal crisis:

> After determining the client's suicidal risk, the protocols required another counsellor and/or psychiatrist to confirm the assessment. If the risk of suicide is between moderate to high, the counsellor will inform the client's families. If the families are not around, counsellor may consider the need for hospitalisation to ensure client safety. Lastly, the client's Faculty mentor and/or the Faculty dean will be notified.

I discussed in Chapter Three the functions of crisis protocols for client suicide and I drew from Foucault's (1977) notion of governmentality to understand how the protocols act to regulate the professional conduct of counsellors, and at the same time the conduct of their clients. It was in this idea of the "conduct of conduct" (Gordon, 1991, p. 2) that suggested when Li-Na was "governing the self" in following the protocols, she, at the same time, was "governing" the conduct of her

client (Lemke, 2002, p. 50-51). When Li-Na conformed to the protocols, she was empowered by the institution to use her professional authority, discretion, formalisation, and rule structure to conduct the conduct of her client. In other words, self-government becomes a form of power that governs the conduct of both Li-Na and the client.

When power works in this capillary way, Li-Na was less free (see Foucault, 1977) than she thought, but at the same time, she was much more free than she thought because the protocols offered a platform for her to work in a shared care network. While Li-Na sought to conduct the conduct of the client through the protocols, she, at the same time, experienced the protocols as helpful:

> I see [the protocols] as a shared care which definitely helps support the clients in all different areas. Consulting [other shared care services] actually very important because it will keep us functional. Functioning in a way that we no longer keep having in mind that, ok, this client only tells me this, so I have to keep monitoring. This is a very heavy load for a counsellor…then leading to burnout very easily.

When clients present in therapy with suicidal ideation, counsellors often assume a direct responsibility for clients' conduct because the institutional protocols (alongside the counsellor regulation and code of ethics) require counsellors to take appropriate action to protect client safety. Li-Na expressed that this responsibility is "*a very heavy load*" to be carried by a counsellor alone. Li-Na developed a partnership with the protocols to work alongside her and used this partnership as a mechanism to assist with her own safety and containment of anxiety when a client expressing suicidal ideation. for her to cope with the stress and anxiety (see Reeves, 2010). Li-Na perceived the protocols as benign because she could work in a shared care network, not alone. The protocols opened room for Li-Na to take a more agentic position in her own practice to support the client. Drawing from this perspective, I propose that Li-Na may be provided more freedom than she initially perceived because the protocols make choices available for her. The following example shows how Li-Na offered care to her client while working with the protocols but at the same time resisted it by offering her own way of supporting the client.

Li-Na reported that an Indian student was brought to counselling by his campus friend after the friend found him threatening to harm himself. Li-Na explained what happened in their first meeting when, having concerns for the client's well-being, she took further actions:

> During the risk assessment process, I became aware that the client was experiencing severe depression and he stated that he did not want to cope with it anymore. Furthermore, the client reported a history of suicide attempts. This information indicates that the client was at high risk for suicide. My inner response at that time was, "It is quite serious, I need to pay more attention to him". To confirm my assessment, I get my colleague to assess him as well, we feel that we need to refer him for psychiatric assessment.

In relation to the outcome of the risk assessment, Li Na's professional knowledge prompted her to take up an "active intervener" (Danto, 1991, cited in Colt, p. 320) position, which I elaborate further in Chapter Nine. To offer additional support to the client, Li-Na suggested to the client for a psychiatric assessment as per the crisis protocols. Li-Na approached the client in the following way:

> When I made a referral for psychiatric service, the client was quite receptive of the idea that he recognised he has a problem and he needed help but he didn't know how. I offered to take him there [to the hospital], so I personally brought him to the hospital and we saw the psychiatrist, and he was diagnosed with depression and prescribed medication for it.

In such a time of urgency, Li-Na personalised the referral process by offering the client to accompany him to the hospital. While in the hospital, she was there together with the client when he registered himself as a patient, she waited for his turn to meet the psychiatrist, sat with him while the psychiatrist assessed him, waited with him to collect his medication, and when everything was over, she went back to the campus together with the client. In a situation where the protocols and its relational power prescribed the counselling relationship, Li-Na demonstrated a highly agentive act in which she accepted the protocols and simultaneously, she resisted the protocols by choosing her own way to show her care to the client: to be there all the time waiting patiently in line with him at the hospital. Li-Na strove to stay present with the client, not just as an observer, but a "fellow traveller" (Weingarten, 1998, p. 4) resonating with the client's emotions to keep the client feeling safely *held* (see Winnicott, 1964) and supported.

Negotiating confidentiality and disclosure

For Li-Na, the issues of confidentiality and disclosure became more complicated when the protocols expected her to inform clients' families of the suicide risk and clients refused. Li-Na viewed that it was necessary for her to discuss with clients the issues of confidentiality and disclosure up front before they agreed to counselling. It was Li-Na's practice to spend time with clients to discuss these issues during the informed consent conversation:

> The culture in Malaysia values the parent involvement in their children education and lives, so informing parents is important. As I go through the informed consent with clients, I make a point to spend a little bit more time on the confidentiality issue to let them know when I cannot ensure the confidentiality, it is for their safety, for the benefit of making sure that they are safe. By preparing them earlier prior to beginning of counselling, their acceptance is no longer shock or surprise because they know that this is part of the procedure that they had agreed to it earlier.

Li-Na offered clients great detail to ensure they had a clear understanding of the therapeutic process and knew what to expect. She particularly informed clients about the need to notify and involve family members in the counselling process in the context of imminent danger. Through this practice, Li-Na invited clients to take up agentic positions in deciding whether or not to give consent to accept conditions of entering the counselling relationship. In telling clients about her ethical and legal obligation to notify families when clients' lives were at risk, Li-Na took time to offer elaboration on the steps she might take to promote client safety:

> To help them understand more, I emphasise more and give example. I will let them know, "Whatever we discuss here is private and confidential, however there will be some limitations that I would want you to take note of, for example, let say if your life and safety is at risk, like if you are very depressed and you feel like you don't want to live anymore, you want to kill yourself, that is the time that I cannot keep this information as confidential, I will inform your families". I will keep emphasising that it is my aim to help them to protect their safety.

Li-Na's practice of discussing thoroughly confidentiality issues with clients signifies respect for clients' dignity that they are valued and respected members of the therapeutic alliance.

Parental notification

In Chapter Three I addressed legal obligation and ethical standards in relation to informing clients' families when clients were judged to be at imminent risk of suicide. Li-Na's story continued with the same client that she mentioned above. Upholding the ethical standards, Li-Na began the process by asking the client's permission to contact his family members about the suicide risk. Li-Na described the client's response when she approached him with this request:

> When I told the client that I needed to tell his mother about it [suicidal ideation], he was very resistant to the idea and in a panic mood, he responded, "I can take care of myself, I'm ok now."

The client's response is expected as the act of disclosing personal problems to an outsider and seeking outside help may be culturally intolerable for the client and his family. Despite the resistance, Li-Na continued to persuade the client:

> I explained to him that his safety was important, and then I empathised with his feelings, "It must be very scary for you if your parents know about this. It's important for your family to know what's going on because they are the people that you will receive support with for a long time and your wellbeing will be taken care by them. Even though it may be very scare that you parents know, but I still need to inform them, it's my duty and also part of our rules that I have to do so."

In her attempt to persuade the client, Li-Na practised and imparted the skill of empathy in the therapeutic relationship while standing alongside her professional duty. With reference to how the practice of family honour shapes the lives of many Asian people, Li-Na came up with careful language to make it possible for the client to interpret the parental notification as an act of care. Li-Na took the next step to further negotiating with the client:

> The client begged me not to call his parents (mother) as they live quite a distance from the client. I did what he felt comfortable first instead of going to the very tough one, which is his Mom. [The client] agreed to talk to his cousin first…and then later on, the cousin helped to invite the mother to join them…He called the cousin, and invited the cousin for a meeting. Having his cousin to be with him now and talking to the Mom later was actually bearable for him.

While the act of seeking professional help is encouraged in mainstream American society, Li-Na observed that this practice was considered unfamiliar and not a preferred practice to many individuals and their families in a Malaysian context. Seeking professional help outside of the family is perceived as in opposition to family honour (Abu Talib, 2010; Almanzar et al., 2014; Keshavarz & Baharudin, 2009; Mak & Chan, 1995; Meer & Vandecreek, 2002). Li-Na could see the client's fear and concern if his family had to receive the notification from Li-Na, as she was a stranger and an outsider. The fear and concern may be connected to the risk of being abandoned or disowned and loss of familial support (see Baptiste, 2005; Conrad & Pacquiao, 2005). The client might be anticipating condemnation from his family for having not lived up to the family values and expectations. These aspects offer some of the multiple explanations as to why the client opposed Li-Na's decision to inform his family. When the client's resistance became apparent, Li-Na was flexible and willing to negotiate disclosure. She offered the client options to choose his next closest sources of support within his family. In this way, Li-Na practised responsible care and supported the decision of the client to postpone parental notification until he was ready to do so, supported by another family member.

By being mindful of the cultural values of 'keeping problems within the family', Li-Na felt that it was important for her to be mindful when engaging the family in therapy. Li-Na explained how she planned with the client to approach his family with the news:

> I suggested to the client to call his own family, so that family didn't get it from a stranger of what's happening to their son. Prior to informing the family, I briefed the client how to approach them, "Maybe you try to tell your parents about your struggles, even you don't say that you are suicidal is fine. You say that you are very depressed, and then later on we can continue from there when we meet them face to face."

Li-Na was aware that the parents might be sensitive when hearing the news regarding their child's struggles from an outsider. In contrast, receiving the news from their own child might invite the parents to be alerted that their child was experiencing a problem and needed help. By suggesting the client to inform his parents, in a way acts like the client is consulting his/her parents when facing problems in life. This strategy honoured the culturally appropriate practice.

Cheng-Mei: Working with a client whose parents declined mental health services for their child

Reeves (2010) argues that many counsellors know that the quality of parents-counsellor relationship plays a key role in suicide prevention. However, engaging parents in a therapeutic setting can be challenging, in particular when working with parents who are resistant to or refuse mental health services for their child. In this section, I investigate how Cheng-Mei built a support team to work alongside her when a client's parents are not interested to participate in therapy and refuse services for their child.

Cheng-Mei is a Christian Chinese woman, who worked as a campus counsellor in a private higher learning institution. Cheng-Mei reported counselling a young Indian woman student. The client was distressed and anxious but not feeling suicidal in the early meetings. She was later diagnosed by a clinician psychologist as suffering from both depression and anxiety symptoms (American Psychiatric Association, 2013). Cheng-Mei described the client's situation that called for parental notification:

> It was important for me to inform the client's family because the client told me that, "I stay alive because my parents are there for me, if they are not, I would already kill myself."

When imminent danger of serious self-harm became apparent, Cheng-Mei reported that the institutional protocols expected her to inform the client's family members of the suicide risk. She made a clinical judgement to discuss with the client to obtain her consent to inform her parents about the suicide risk. With the permission from the client, Cheng-Mei reported that she contacted the client's mother and informed her that her daughter was experiencing depression and anxiety symptoms, and struggling with suicide ideation. Subsequently, Cheng-Mei followed up with the client about the matter and was told that the client's mother had called her and they planned to meet up with the clinical psychologist and Cheng-Mei. Cheng-Mei reported that she later received a phone text message from the client's mother saying that,

> I have talked to my daughter, it's settled, thank you very much.

With this update, Cheng-Mei thought the client received relevant familial support and things went well. However, when she followed up with the client after the semester break, the client told her:

> My mother thinks that my problem is that I didn't talk to people, and it is me who needs to change, not for me to seek help from the counsellor, clinical psychologist, doctor or take medication, I need to cope on my own.

To many Asian people, in particular Indian communities, family is their primary source of support (Abu Talib, 2010; Baptiste, 2005) and some may not view psychological services as a credible source of help (Bhargava, Kumar, & Gupta, 2017). Therefore, it is not surprising that Cheng-Mei received this form of response from the client's mother. Upon hearing this response, Cheng-Mei said:

> I offered the client to continue meeting her, but she said "Never mind, I will go back to the clinical psychologist". I was thinking, this is a good idea, it is fine as long as she seeks help. However, the clinical psychologist is a private practitioner and it is not cheap. Later, when I checked with the client, she told me that she couldn't afford the service. So she didn't see the doctor, stop medication, stop seeing me too, and everything.

In consideration of the potential risk of being disowned or abandoned by family (see Baptiste, 2005; Conrad & Pacquiao, 2005), it was possible that the client attempted to resolve her problems on her own. She might believe that by submitting to her mother's directive, she could maintain harmonious interpersonal relationship with the family. Being culturally appropriate, Cheng-Mei did not compel the client to continue counselling. Instead, she continued to exercise some form of pastoral care to maintain a consistent stance of caring and availability. Occasionally, Cheng-Mei initiated brief conversations with the client to find out how she was coping whenever she spontaneously met her on campus. Through this pastoral care, Cheng-Mei observed:

> The client was still tense, still not very well. Because all this while, she told me she stopped seeing mental health professionals because her mother said she should try to change, she said, "I did try but I realised it wasn't working".

Out of this continuity of care, Cheng-Mei said one day she received a phone call from the client:

> It was a Sunday evening, the client was very stressed, very tensed and she was crying and said on the phone, "It feels like I just want to die". I didn't have a good feeling, I know that I couldn't just do it over the phone, so I invited the client to meet me at the university. And she said this one thing, "You will do that for me?" It sounds like the client has this idea that a lot of people don't do thing for her. She agreed to meet at the university. While I made the journey there I was hoping and praying hard that she will be ok. It was almost 8pm when we met.

I argue that Cheng-Mei's gentle persistence in maintaining a pastoral care relationship with the client encouraged the client to call Cheng-Mei when she could not cope with the distress anymore. Cheng-Mei described what took place when they met:

> I let her talked and cried. After she was calmer, we went through the safety plan, we completed the plan and signed it. I was very tempted to tell the mother again, but she strongly insisted not to, "Don't tell my Mom because there is no point, they will just scold me." But she agreed with me to tell the Faculty mentor about her situation. I support her decision for now, at least she was willing to talk to her mentor.

The dilemma for Cheng-Mei was in having to work without parental notification of the suicide risk in attempting respect for client autonomy and to respond where there was a renewed concern for client safety. This might be a difficult decision for Cheng-Mei as it was culturally appropriate for the client to respect her parents' decision, but to Cheng-Mei, the client might be suffering due to the decision made by her parents. Parental notification at that moment would not have helped and the client did not prefer it. Cheng-Mei explained:

> This one was really a situation where the parents just scolded the child for being depressed. The client said her family didn't believe and understood depression. The family thought it was because she was childish and she did not believe in herself. I feel very sad for this particular client, but I am also very encouraged by the way the client trying to help herself.

Inviting a guru-chela relationship into the counselling process

Culture shapes the interpretation of mental illness experience, modes of coping and help-seeking behaviour (Sue & Sue, 2016). The stigmatisation of mental health problems may lead parents trying to conceal their child's struggles in order to protect family reputation (see Bhargava et al., 2017; Chentsova-Dutton, Ryder, &

Tsai, 2014). As the client did not want to inform her parents, Cheng-Mei made active efforts to engage the client in both therapy and community support:

> I scheduled frequent therapy sessions for the client. At the same time, I informed and engaged her Faculty mentor to care and support the client. Her mentor was very good. As the mentor shared the same culture with the client, he/she helped the client to see the family situation from a different perspective. As the client told me that she was experiencing persistent sadness, I suggested a psychiatric referral, and the client agreed. Our institution has a policy to help students who cannot afford psychiatric treatment. The institution will pay the fee for their first treatment. So for this client, I made arrangement for the institution to pay for her first treatment and she paid for follow up treatments.

Cheng-Mei began to build a community of care (White & Epston, 1990) to continue supporting the client. This practice seems appropriate for the client who places great value on the importance of relationships and obligations within the family and society. For example, inviting the client's Faculty mentor in the counselling process resonates with the traditional *guru-chela* (teacher-disciple) (Neki, 1973) or *guru-shishya* (teacher-student) (Raina, 2002) relationship in the Indian context. The *guru-chela* relationship was proposed by Neki (1973) as a culturally relevant interaction model for therapeutic relationship when counselling Indian people.

In the Hindu tradition, a *guru*, being a teacher and a spiritual preceptor, is a highly respected member of the Indian community. *Guru* is positioned to "*show the way* and to transmit the value of his experience to the disciple" (Mlecko, 1982, p. 58, original emphasis). The nature of *guru-chela* (teacher-disciple) relationship is thus a direct interaction between the client and her Faculty mentor. In a *guru-chela* paradigm, the Faculty mentor re-introduces the principle of self-discipline to the client where harmonious relationship between the client and her family can be preserved (see Kumar, Bhugra, & Singh, 2005; Raina, 2002).

The practice of direct guidance which is embedded within the *guru-chela* relationship is more likely to be acceptable by the client (or may be later by the client's parents) and makes the act of help-seeking more tolerable. Indirectly, the client may be seen consulting a "teacher, counsellor, father-image, mature ideal, hero, source of strength" (Mlecko, 1982, p. 34), rather than an outsider. In a society where the culture of interdependency among its group members is valued,

consulting a Faculty mentor now seemed to be a 'right' thing to do because of the association with 'teaching' – a kind of *guru* status. While the act of help-seeking itself produced additional stress and anxiety for the client, inviting a Faculty mentor into the counselling process was perceived as a culturally appropriate practice.

Cheng-Mei described how she worked closely with the Faculty mentor to support the client:

> We will update each other within the boundary of confidentiality and what's important that can be informed if it is within the agreed informed consent. Secondly, we do keep in touch with one another about whether the client is coming to see us or not, to follow up…so we know the client is seeing one of us. I am aware that the Faculty mentor cannot play the role as a counsellor, so we play a different role. I will facilitate her feelings whereas he will guide her study.

The active roles played by Cheng-Mei and the Faculty mentor promoted a sense of connectedness which might function to minimise the client's isolation. The sense of connectedness supported the client's willingness to communicate her concerns to others (see Centers for Disease Control and Prevention, 2008; Sane Australia, University of New England, 2014):

> For the first time, I hear hope in her. The client is now more positive and willing to open up herself to talk about her concerns, her coping skills are improving slowly.

Through a re-interpreted mentor-mentee relationship, Cheng-Mei created a forum for dialogue between the client, counsellor and Faculty mentor so that an understanding of distress that was closer to the client's experience was achieved. Cheng-Mei formed a small alliance with the Faculty mentor, the institution (finance department that sponsor the client's first psychiatric treatment) and the psychiatrist to support the client.

My concluding thoughts

These two brief accounts of Li-Na and Cheng-Mei offered a different view concerning instituitional protocols in how the protocols positioned counsellors and limited their practices. Their works demonstrated how they were active in their negotiation of their therapeutic practices in response to the protocols. In a situation

where particular counselling interventions were seen by the clients and their families as devaluing their cultural beliefs and practices, Li-Na and Cheng-Mei continued to use the iprotocols to guide their practices. However, they called on flexibility and creativity to adapt the protocols to the particularity of a specific client. They delicately worked with the clients to co-construct preferred ways of approaching counselling interventions. Their approaches spoke of respecting client knowledge of their culture, family and personal preferences. At the same time, they took up responsibility for their professional and institutional values and protocols, and acted on behalf of safety.

CHAPTER NINE
PRACTISING HOPE WITH A CLIENT

Introduction

In this chapter, I present a complex example of Anuja's counselling work with a client who threatened to take her own life in the session. I also explore the question of touch in counselling practice in a life-threatening situation.

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 suicidal ideation (Benson et al., 2015; Maple at 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.

I theorise Anuja's exposure to suicide by using Weingarten's (2000, 2003) work on witnessing experiences. I also engage feminism's personal-political-professional philosophy (see Blackmore, 1999; Bondi, 2004; Crocket, Kotzé, Snowdon, & McKenna, 2009; Hooks, 2000) to understand the possible effects of Anuja's lived experience in shaping her practice. The chapter first focuses on Anuja's account of her lived experience, and then 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 her lived experience can be valued in offering substantial support for those who speak suicidal ideation.

Anuja's lived experience of suicidal behaviour

In the research interview, Anuja recalled witnessing her mother's repeated suicide attempts when she was a young child:

> I have seen my Mom attempted 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.

Cerel, Jordan, and Duberstein (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 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). In addition, to avoid being stigmatised by wider families, friends and society, Anuja kept silent about the events in her family as others have done (see Foo et al., 2012; Sudak et al., 2008; Tzeng & Lipson, 2004; Witte, Smith, & Joiner, 2010).

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 experience 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 act in response to what one witnessed. The quadrants range from being an (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 traumatic event and has the knowledge and skills to help oneself and the other. By contrast, people who find themselves in Witness Quadrant 4 tend to experience distress more intensely. This quadrant may speak of Anuja as a child who, in the language of Weingarten (2003), was "haunted by experiences in which [she was] painfully aware of what needed to be done, but felt helpless or lacking in resources or expertise" (p. 98) to support her mother and herself. 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.

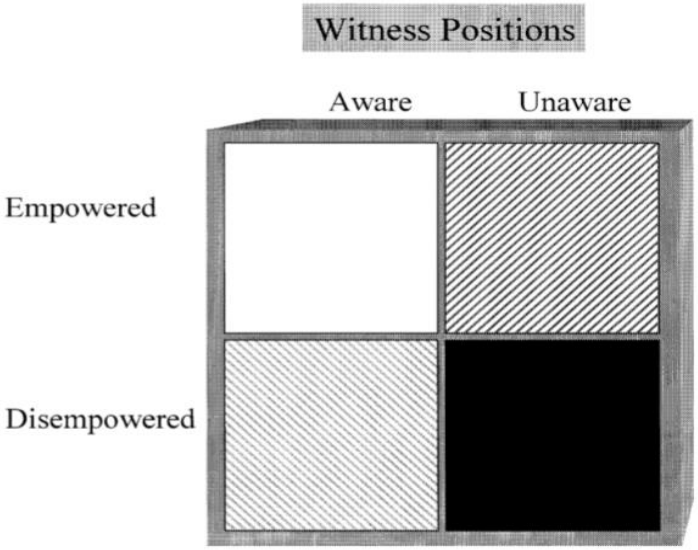

Figure 1: Witness Positions
Adapted from Witnessing, wonder, and hope (p. 396), by Kaethe Weingarten, 2000, Hoboken, NJ: John Wiley and Sons. Reprinted with permission.

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 affect the life of an individual and others. Perhaps this idea might help in understanding the second aspect of Anuja's personal story.

Anuja's own experience of an attempt to take her life

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 of "*value life*" and "*understand other people"* could provide her with skills to support others in counselling.

Shifting the witness positions

In this section, I discuss the shifting of Anuja's witness position through this personal journey from self-witnessing, to witnessing others, to compassionate witnessing. Weingarten (2003) explains that one can witness oneself by becoming:

> aware of what has happened to us – witnessing ourselves as victims, and we can become aware of what we do to others – witnessing ourselves as perpetrators. More able to witness ourselves in these roles, we will better be able to witness others in each of these roles as well. (p. 152)

Weingarten's explanation suggests a relationship between self-awareness and meaning-making in the development of capacity for self-witnessing. I propose that Anuja developed her capacity to witness herself – first as someone who attempted to end her own life. However, after she survived the suicide attempt, she made it clear that her very existence proved there was a productive life for her. Secondly, Anuja was a witness of her mother's repeated suicide attempts. She asserted that, "*if I grow up, I do not want to do the same thing*" as her mother. In the process of self-witnessing, Anuja made room to explore her decision to live and in this exploration, she took small steps to resist further suicide attempts. In a position of empowerment, Anuja was able to keep herself safe when she was experiencing suicidal ideation again, and she could do the same for others in similar situation. This process invited her to the possibility of a different witness position as I elaborate below.

On the terms of Weingarten's (2000) account of witness position, Anuja moved from an aware but disempowered position (Quadrant 4) to aware and empowered position (Quadrant 1). In this new witness position, she was able to identify how she could engage and respond more agentively and effectively. Weingarten (2003) proposes that when one becomes an aware and empowered witness, one is called

into the posture of compassionate witness of others. She asserts the idea that "witnessing others with compassion needs a solid foundation of witnessing the self" (p. 224). In this way of thinking, Anuja's self-witnessing invited her to witness what happened to her mother and others as a compassionate witness. Anuja's journey resonates with Chödrön's (2008) writing about cultivating compassion:

> Compassion is not a relationship between the healer and the wounded. It's a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognise our shared humanity. (p. 74)

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 inviting a client to do hope together in suicide prevention efforts.

Anuja, an Indian woman, had practised counselling for two years after completing her counsellor training. She worked in a private university as a student counsellor. When counselling clients struggling with suicidal ideation, Anuja offered flexibility in the frequency of appointments and took initiatives 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 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 struggled with depression and suicidal ideation to work out a plan to take his or her life (Berk, Grosjean, & Warnick, 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 personal mobile phone number to clients could be associated with Beck's (1992) idea of the risk society which I discussed in Chapter One, that is 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 number 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 the 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 personal mobile phone number. She circumvented this regulation of not providing personal mobile phone number 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 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 Psychiatry Department or the police to rescue the client from harming herself. On the phone, Anuja engaged in conversation with the client and gave her the space to speak. The step of providing the client a space to speak can be interpreted as taking a socio-political stance as described by Monk and Gehart (2003). This socio-political stance becomes visible when I consider how a young Indian woman can be positioned in her family.

Traditionally, the Indian family system adheres to a patriarchal culture. Despite the influence of Western culture and the processes of modernisation, women in Indian families are often expected to accept a position subservient to male members (Nath & Nayar, 2004). Indian families are usually large and family relationship is important in Indian society (Chadda & Deb, 2013). Often a family structure, identified as "joint family" may include more than one generation living together in a common house or nearby in the same neighbourhood (Chadda & Deb, 2013, p. S301). The male members in the joint family are expected to financially support the women and children. They are also responsible to make decisions about almost all aspects of the lives of their children, including the areas of study, career and marriage (Chadda & Deb, 2013; Nath & Nayar, 2004). Sons are generally highly valued as they ensure the lineage to continue and maintain family values. Daughters can provide an extra burden to the family because the parents have to pay large dowries for their marriages (Kapoor, 2014; Nath & Nayar, 2004). Purity and chastity are generally important values held by and for Indian women (Sayed, 2016). Therefore, the conduct of the daughters is often monitored with stern discipline as the value of their chastity is associated with family reputation (Kapoor, 2014; Sayed, 2016). In Anuja's story, the client was struggling with borderline

personality disorder. An additional surveillance might have been invited with such a diagnosis. The client thus was even more likely to have become an 'object' (see Foucault, 1977) of her family's care. The position of being under surveillance might have restricted her freedom to move around or take initiatives on her own. As an Indian woman, Anuja would probably has some ideas regarding the limits and constraints of a young woman's life within the society. Counteracting these cultural restrictions, Anuja took up a socio-political therapeutic stance (see Monk & Gehart, 2003) by offering a safe space and inviting the client to take up a position to speak in therapy.

Anuja made room for the client's voice through listening attentively to her story in 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 show below. 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" which 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/hold such hope, the basis for co-creation of hope is that a counsellor can do/hold hope on behalf of the client (Weingarten, 2010). I go on now to illustrate how Anuja can be seen to do/hold hope for the client.

Through the phone conversation, Anuja heard the presence of hopelessness in the client's speaking. 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*", "*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 care 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 towards 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 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 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 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 pointed a knife at her own wrist. One was the witnessing of 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 determining the appropriateness of touching clients. A hug between members of same gender probably receives less scrutiny from the public and professional gaze in a 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 *do* 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 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 for 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 the witnessing of her mother's repeated suicide attempts. Anuja could have been recruited by 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.

A further question that is raised here is the question of touch in counselling practice. Touching in a counselling relationship may take many forms from handshake to an embrace. The ethics of touch has been broadly discussed among mental health professionals. In North America, touch is considered an intimate, complex and powerful non-verbal mode of communication (Zur & Nordmarken, 2016). On the

one hand, touch can communicate approval, reassurance, safety and security; support, consolation, care, comfort and concern when dealing with intense emotional experiences. On the other hand, touching in counselling may be considered by many professionals as an inappropriate breaking of professional boundaries (Pope & Keith-Spiegel, 2008; Zur & Nordmarken, 2016). Physical contact often produces different meanings in different cultures (Sue & Sue, 2016). Touching norms may vary according to attributes such as gender, age and individual experience. In light of these many possible interpretations of touch, counsellors in North America are advised during training that any physical contact with clients should be approached with considerable caution (Pope & Keith-Spiegel, 2008; Pope & Vasquez, 2016; Zur & Nordmarken, 2016) and that counsellors should be aware of clients' possible cultural interpretations to touching behaviours (Sue & Sue, 2016).

In Malaysia, each ethnic group has a different practice for how to use (or avoid) touch. In general, Malaysian people are considered a gender-conscious society. Touching between strangers and members of a different gender, such as a handshaking, is uncommon (Puniamurthy, 2000). In greeting a guest, handshaking is acceptable among men. However, if a man is introduced to a woman, it is appropriate to wait for the woman to offer her hand first. If she does not offer her hand, a man can bow as a substitution to handshaking (Munan, 2008). In addition, Muslim people use their right hands to eat and shake hands with others. To the Muslim people, the right hand is considered noble and honoured. Touching anyone with the left hand is considered inappropriate (Puniamurthy, 2000).

In the counselling profession, the Malaysian Counsellor Code of Ethics does not explicitly address the appropriate use of physical contact between counsellor and client. The words 'touch' or 'physical touch' are not mentioned in the Code of Ethics (Lembaga Kaunselor, 2011). The Code focuses on *what not to do* but does not define acceptable standards to direct the physical contact between counsellor and client. In the absence of explicit guidelines, counsellors may call on the cultural practice of touching or non-touching behaviour to lead them in the issue of touch ethics. In this manner, the ethics of touch lies in the ethical principle of non-maleficence – 'do no harm'. It is the responsibilities of counsellors to consider their intentions and the potential effects of their actions.

Another barrier to touch in counselling is associated with Beck's (1992) concept of the risk society. People may sexualise forms of touch in a risk society (Marshall & Mellon, 2011). Touch practice in this sense is often regarded through a lens of suspicion. Many practitioners set their own practices that they considered 'appropriate' to avoid being suspected or accused of a sexual interest in clients. One of the ways is to divide the body into acceptable and non-acceptable touch zones. For instance, in North America a brief and non-erotic touching on the hand, back or shoulder is the area of 'appropriate' touch that Zur (2007) believes can convey a caring and supportive message to the clients. Another way is to adopt a 'don't touch' approach (Zur, 2007). However, Zur and Nordmarken (2016) argue that the practices of counsellors limiting their touch behaviours or taking up a 'don't touch' position may perhaps prevent counsellors reaching out to clients at a crucial moment to offer care and comfort. The fear of being suspected or accused of touching the client inappropriately may have invited counsellors to interpret touch intervention driven by their desires to prioritise self-protection over client protection.

I turn the Foucault's (1977) explanation of surveillance mechanism to understand the work of power in relation to the issue of touch in therapy. The discourse of risk and counsellor-self-protection construct an atmosphere in which 'do no harm' to clients defines touch as risky and acts of counsellor-client touch as suspicious. When a discourse of ethical touch is overshadowed by an unethical touch discourse, counsellors are positioned as objects of distrust who are of risk to clients. Counsellors may be exposed to disciplinary action or at risk of litigation. When a counsellor touches a client, the discourse of touch as risk becomes a "regime of truth" (Foucault, 1980, p. 131) that provides "rules, opinions and advice as to how to behave as one should" (Foucault, 1985, p. 12). In this regard, counselling practices become regulated by approaches where risk assessment procedures are prioritised in order to mitigate potential risks for practitioners. This regime of truth may leave counsellors confined in a mechanised relationship with the clients (see Marshall & Mellon, 2011) that limits the opportunity to develop warm and meaningful professional relationships.

In responding to the panoptic gaze of numerous others, such as parents, other counsellors, supervisors, counselling authorities from the Malaysian Board of

Counsellors, counsellors in Malaysia learn to become the subject of their own surveillance. They engage in self-disciplinary practices such as regulating their touch behaviours with clients. This self-surveillance perhaps can turn a counsellor into something of a passive mechanic (see Foucault, 1977), who accepts the "dissociation of power from the body" (Foucault, 1977, p. 138) through the constant subjection of individual forces.

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 witnessed Anuja 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 of care to 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. Her 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 judgements 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 witnessing 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 ways 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 account for the kinds of knowledge one acquires from past experience 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. This feminist value positions Anuja's personal experiential knowing *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 knowledges counsellors bring into therapy, including counsellor-derived knowing from past experiences. The feminist idea of the interrelationship of personal-political-professional encourages me to take responsibility to bring the politics of lived experience into my counselling practice, learning and teaching. 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 aware and empowered (Weingarten, 2003). Through this witness quadrant, students may become aware of the influence

of their personal experiences on counselling practices, and call on appropriate application of these experiences.

CHAPTER TEN
DEATH, POWER AND THE BODY

Introduction

In this chapter, I aim to explore the understanding of a human body from an Islamic perspective in the context of a death by suicide. I explore issues that arise in reference to meanings that are associated with a body to reflect on social and religious interpretations and the body's significance as the object of power relations. I present an example drawn from Mazuki's experience of witnessing the dilemma faced by body washers at the mosque and the practice of a religion officer who consented that the washers to prepare ''ghusl' for a deceased body of a Muslim person who took his own life. This episode took place before Mazuki became a professional counsellor.

Mazuki's story contributes to this study through what he had learned from this personal encounter at the mosque and how it had shaped his future professional practice as a counsellor. The experience taught him to practice respectful caring for people who express suicidal ideation. In his current practice, he called forward the idea of '*bersangka-baik'* (positive thinking) to offer a compassionate care to the bodies and lives of people who took their own lives, without judging them. For an individual who struggles with suicidal ideation, Mazuki undertook the responsibility on behalf of an individual to care and respect his or her body. At the same time, the responsibility to hold an individual accountable for his or her own action lies with Allah on the Day of Judgement, suggested Mazuki. In the face of experiences of uncertainty, Mazuki learned from the Senior Religion Officer that he had the responsibility for ethical practice in counselling to, in Bauman's (1998) words, "take *responsibility for one's responsibility*" (p.17, original emphasis).

I begin the chapter with an investigation of Islamic perspectives on the human body, followed by an account of the experience encountered by Mazuki, with multiple perspectives on religious practice when there is a death caused by suicide in the Muslim community. In particular, I explore the complexities of shifting relations of power between competing ideas within religious practice and moral questions, as well as the moral deliberations that arose as a result. Next I present philosophical

understanding of how power is manifested and deployed over a body from the lenses of Foucault (1978, 2003) and Agamben (1998). In examining these systems of thoughts, I mobilise Levinas's (1985) ethics of care in *the Face of the Other* to understand the action taken by religious authority when coming to a face-to-face encounter with a body of the deceased.

The human body from an Islamic view

Islam is constitutionally the official religion of Malaysia. All Malay people subscribe to this faith and aspects of their lives are governed by Islamic laws (Lipton, 2002). Religious practices function in the social control of the human body and offer definitions and interpretations relating to the human body (Hoffman, 1995; McGuire, 1990). These definitions and interpretations shape the understandings of human existence and in turn, influence position towards the human body, in particular a body of the deceased which is the main focus of this chapter.

To followers of Islam faith, bodies belong to God (Allah) (Hamdy, 2012). Islam considers the body as a gift from Allah (Aramesh, 2009) that is "temporarily entrusted to us as a 'trust' (*amana*) from God" (Marcotte, 2010, p. 37). Hence, it is a consensual principle in the Islamic jurisprudence to respect and care for the health and well-being of the physical bodies (Hoffman, 1995). The body remains sacred even in the time of death. Islamic law offers a comprehensive burial practice for its believers to treat a deceased human body with respect and dignity. There is a requirement to bury the deceased on the day of death or the following day if death occurs late. This practice is one of the ways to respect the body by making haste to prepare the body for burial before the body begins to decompose (Kramer, 1988; Ross, 2001).

Burial preparation

Funerals in Islam follow specific procedures, but regional customs practices vary (Braswell, 2000). Generally when a Muslim person dies, the body will be covered by a piece of cloth with the mouth and eyes closed, and the feet tied together (Kramer, 1988). Next, the body will be transported to the mosque for burial preparation. In the mosque, the body will be ritually washed and shrouded in a

procedure called ‘Ghusl’. The body is washed respectfully with clean and scented water. The washing begins with the hands, arms, mouth, nostrils and feet (Ross, 2001). The people who wash the body, ‘washers’, commonly consist of adult members of the immediate family or other Muslim people within the local community, and of the same gender as the deceased. Once the body is clean and dry, the body will be given ‘Kafan’, which is to be shrouded in sheets of clean white cloth (Kramer, 1988). The shrouded body will then be carried with great care and gentleness to be put in a coffin for funeral prayer.

The funeral prayer is usually performed by the prayer leader (Imam), and attended by the deceased’s families and members of the community. The mourners pray alongside the prayer leader to plead to Allah to forgive the sins of the deceased (Kramer, 1988). After the prayer, the coffin will be transported to the Muslim cemetery for burial, and only men of the community accompany its journey. The coffin is usually carried by men on their shoulders. At the gravesite, ritual prayer is performed once more before the deceased is laid in the grave. The body is carefully lowered into the grave facing towards Mecca, the Muslim holy city where the Holy Prophet Muhammad is believed to have been born (Cakmak, 2017). It is also a common practice within Islamic faith that the body is removed from the coffin and buried only in a shroud (Kramer, 1988).

These and other rituals and practices are clearly meant to preserve the dignity of and bestow respect on the body. These comprehensive procedures constitute the rights of the dead, and at the same time, the obligations of the living to take care of the body with respect and gentleness. Religious knowledge thus informs and shapes the body, and becomes a means of discipline of the self and the body (Carrette, 2000). The story told to me by Mazuki is embedded in such practices.

Suicide is a sinful act in Islam. However, Muslim scholars differ as to whether a funeral prayer should be performed for an individual who died by suicide. It is narrated in a hadith of Sahih Muslim that the Holy Prophet Muhammad declined to perform a funeral prayer for an individual who died by suicide, but he did not forbid his companions from performing the prayer for this man (Aziz, 2007; Halevi, 2007; Sabry & Vohra, 2013). This practice of the Holy Prophet Muhammad was later interpreted by most Muslim scholars as an act to discourage others from ending their own lives. From the viewpoint of the Holy Prophet Muhammad’s sunnah

(action or behaviour), his actions may be seen as ambiguous. First, not to offer the funeral prayer for one who has committed suicide because of his/her sin; second, a possibility for forgiveness, and to allow others to perform the prayer. According to the majority of Muslim scholars, all funeral rites should be offered to all Muslim people even if a Muslim person is guilty of grave sins and crimes (Cakmak, 2017; Degirmenli, 2013; Halevi, 2007).

Mazuki's encounter with a deceased body

Mazuki is a Muslim counsellor and was a doctoral student at the time of research interview. He recalled a set of events which occurred prior to his practice as a professional counsellor. At that time, he was a Welfare Officer attached to an organisation. He reported that he was assigned to use a hearse to bring a body of a Muslim man, who had died by suicide, from the hospital to the mosque. He began the story:

> As instructed, I brought the body from the hospital to the mosque. But due to the practice of the Muslim people, the Muslim people believed that a Muslim person who committed suicide, he is no longer a Muslim. It is like you are being expelled from your religion.

In this account, Mazuki spoke in general about the religious framework that shaped his knowledge about how Muslim people reconciled with a death caused by suicide. A Muslim person who takes his or her own life, is seen as having violated the sanctity of life entrusted to him by Allah (Braswell, 2000; Cornell, 2007). His or her death is not considered to be in accordance with the principles of a good death from the Islamic perspective (Tayeb, Al-Zamel, Fareed, & Abouellail, 2010). This person takes on the consequences of a major sin, and is thus subject to tremendous punishment in the Hereafter as a result of his or her action (Aziz, 2007; Cornell, 2007). On the basis of this teaching, many Muslim people are of the opinion that an individual who takes his or her own life should not remain a Muslim person, and thus deserves no burial rite that applies to other Muslim people who are considered to die a good death in Muslim society.

Muslim people believe that their lives constitute trials and tests, thus life struggles or difficulties are considered a gift from Allah (Hoffman, 1995). Muslim people are expected to exercise patience and endure the suffering to the best of their abilities

(Cornell, 2007). When experiencing life difficulties, Muslim people are prohibited from ending their own lives in order to escape affliction but are expected to turn to Allah for help and guidance. A Muslim person who expresses a wish or intention to take his or her own life would be considered weak in the faith (Cornell, 2007). In relation to these perceptions, Mazuki illustrated the dilemma facing the washers when performing the washing:

> The situation was that this particular body was a body of a Muslim person who committed suicide. The body was already in the washing area, but all the washers just stood some distance from the body. They were reluctant to do it. The dilemma was: should we bathe his body? Was the deceased still considered a Muslim?

The dilemma experienced by the washers which Mazuki witnessed can be understood in terms of the discursive conflict produced by their religious teaching and practice because the deceased had committed an act which called into question his status as a Muslim person.

The practice of '*bersangka-baik*' (positive thinking) as a way to express ethics of care

When there is uncertainty in relation to religious practices, Muslim people refer to the Quran, which is the central religious text of Islam, as their main resource for guidance. In addition, they can also consult the Holy Prophet Muhammad's collection of *hadith* (words) and *sunnah* (behaviours); the religious scholars' knowledge, such as *ulama* and religious teacher; and individual's mind or inner voice (Rahman, 2017). *Ulama*, a word used to denote a "learned man", is commonly employed to refer to "religious teachers such as Imans, Muftis, Qazis and Maulawis" (Hughes, 1973, p. 13-14). *Ulama* carry the duty to study the knowledge of religious scriptures, and to teach and guide the members of the Muslim community in religious affairs. On the *hadith, ulama* are considered "the heirs of the Prophets" (Takim, 2006, p. xi). In association with this "heirs tradition" (Takim, 2006, p. xi), *ulama* often held in high respect and positioned as authority. Thus, the members of the Muslim community are expected to respect and obey the directions or teachings of the *ulama*.

When the washers in Mazuki's story faced with the question of performing the washing for a person who had died by suicide, a religious authority became one of

the reference resources for them to seek guidance. The washers sought consultation from a religious scholar, Senior Religion Officer who was present at the mosque. Upon hearing the washers' uncertainty, the Senior Religion Officer took the responsibility that they called him to:

> The Senior Religion Officer advised the washers, "Our teaching also taught us to always practice '*bersangka-baik*' or think positively towards the other. Do not judge how he died, we believe that he is now passed away and it is our obligation to make sure that his body is properly washed, shrouded, prayed and buried."

In his explanation, the Senior Religion Officer drew on a spiritual term from the Quran, called positive thinking or '*bersangka-baik*' in Malay language to support his decision of allowing a funeral prayer for the deceased. This practice can be found in the Quran Surah al-Hujurat, 49:11 (Ahlulbayt Organization, 2014). Islamic sources define the practice of positive thinking as '*husnu'l zann*' in Arabic. Yucel (2014) describes this practice as an honourable mental attitude that "encompasses good intentions, thought and action towards God, the universe and human beings. Moreover, it also carries the meaning of optimism and of holding good opinion and thinking well about others" (p. 101). Islam deems it to be a religious duty for its believers "to view people and events with good intentions, both to see and interpret the circumstances as positive wherever possible" (p. 102). Muslim people are encouraged to practice this attitude in their daily lives.

From an Islamic perspective, the practice of positive thinking is one of the rules of conduct that can potentially prevent accusing others of doing something wrong or bad (Yucel, 2014, 2015). In addition, thinking positively towards the other is believed to promote human connectedness as well as to maintain a spirit of unity among people (Yucel, 2014; 2015). However, it may be difficult to maintain '*husnu'l zann',* in particular when a person is doubtful of what he or she would believe and is unable to withhold judgments of another person or situation. The sense of doubt and judgment may invite an individual away from positive thinking and move him or her closer to negative thinking, which in Arabic is called '*sui zann*'. The Quran, Surah al-Hujurat, 49:12 (Ahlulbayt Organization, 2014) encourages believers to stay away from '*sui zann*' for it "can lead one person to breach another's privacy in order to find out or confirm negative prejudices, and further lead to gossip or slander which can gradually increase disorder, major

divisions and even conflicts between people" (Yucel, 2014, p. 104). The intention behinds positive thinking reflects a loving and compassionate attitude of care between people that encourages them to continue moving towards positive ends.

Holding on to the idea of positive thinking, the Senior Religion Officer went on to explain to the washers:

> We practise the principle of thinking positively, do a good deed, do not think about other things, just do what we are supposed to do. Don't judge how he died, it is Allah's responsibility, it is not our responsibility. Our responsibility is to make sure that his body receives proper treatment as a Muslim person as per what we have been taught in our Islam teaching. So, we do our responsibility, don't think about Allah's responsibility.

The Senior Religion Officer suggested to the washers to distinguish the responsibilities, towards the deceased, of religious practitioners (here this means the Senior Religion Officer and the washers) and Allah. As for the sin that the deceased had committed, it will be for Allah to decide and it is not for the religious practitioners to approve or disapprove of what he had done, "if He wills, He will punish him and if He wills, He will forgive him" (Abdul-Rahman, 2003, p. 163). The Senior Religion Officer might also be guided by the teaching of Ahl al-Sunnah wa'l-Jamaa'ah's summaries of belief, which claim that a Muslim person who dies by suicide does not become an infidel; he or she remains a Muslim person, and thus is subjected to burial rituals and practices that apply to deceased Muslim people (Braswell, 2000; Cornell, 2007).

I interpret that when the washers referred their uncertainty to the Senior Religion Officer, he was positioned in competing discursive practices: the Islamic teaching about the ownership of the body; a deceased body of an individual who, from the religion perspective, had committed a sinful act; and the washers, who were uncertain whether this individual deserved a proper burial ritual. In this position, the Senior Religion Officer took the lead and shoulder the responsibility to explain to the washers why 'ghusl' should be prepared for the deceased body. The Senior Religion Officer not only called on the knowledge of the Islamic scholars but he took up the value of positive thinking to invite the washers to an alternative way to reconcile with a death caused by suicide. The notion of positive thinking invited the washers into another position, which was to respect and care for the whole embodied person. I propose that the Senior Religion Officer viewed himself as

having a responsibility to use his authority through his advice to the washers, to respect and care for the deceased body as required by the Islamic law. His action can be read as taking "*responsibility for one's responsibility*" (Bauman, 1998, p. 17, original emphasis).

Following the advice from the Senior Religion Officer, Mazuki reported that the washers took up the task to prepare the body for 'ghusl', accepting the call from the Senior Religion Officer into the position of "*thinking positively, do a good deed*". I also draw on Foucauldian concepts of discourse, power/knowledge and subjectivity to interpret how, in an expert position, the Senior Religion Officer has more space to speak and act than others in offering religious guidance, while the washers were expected to accept the teaching, follow what was being advised, and not to question the Senior Religion Officer's knowledge and responsibility. Foucault (1977) conceptualises this as governmentality, by which both the Senior Religion Officer and the washers are positioned to submit to disciplinary power.

Foucault views religion from the controlling aspect of religious knowledge, by which power can be exercised to produce the 'truth' and discipline of the self and the body (Ghatak & Abel, 2013). In this respect, Islamic culture operates like power from a Foucauldian perspective, permeating social relations to maintain and regulate practices and traditions of Muslim societies (Ghatak & Abel, 2013). The constant practising and training of bodies will subsequently produce a disciplinary system or norm that shapes the way in which people act, think and speak. Over time, these systems become so deeply rooted in the social body that people learn to discipline themselves and behave in expected ways without any coercion from others. Disciplinary power in this sense positions both the Senior Religion Officer and the washers respectively under religious gaze and subsequently leads them to perform particular action(s), or be subjected to the risk of being questioned or disciplined by the absolute authorities of their religion and the Muslim community at large.

Moved by the gaze of the dead

In a situation where the religious law and moral/ethics of power construct religious practices, the Senior Religion Officer chose to open up a moral space by calling on the practice of positive thinking to respect the body/dead. I now turn to an analysis

informed by Derrida's model of mourning and Levinas' views on responsibility to further understand the Senior Religion Officer's practice.

Derrida (1995) argues that one's death is irreplaceable and it yields a sense of responsibility: "It is from the site of death as the place of my irreplaceability, that is, of my singularity, that I feel called to responsibility" (p.41). The responsibility towards death is about respect for the Other that connects the relationship with the deceased and invites new possibilities of practice in the community:

> The Derridean model offers a respect for the (dead) Other as Other; it allows agency to the mourner in the possibility of an ongoing creative encounter with the Other in an externalizing, productive, future-oriented memory; it emphasises the importance of acting out the entrusted responsibility, which is their legacy to us; it upholds the idea of community and reminds us of our interconnectedness with our dead (Kirkby, 2006, p. 469-470).

In *The Work of Mourning*, Derrida (2001) presents a series of eulogies for his close friends, through which he bears witness to the uniqueness of the friendships as he grieves over their loss. What emerges in this work is that he views "mourning as an ongoing conversation with the dead who are both within us and beyond us" (Kirkby, 2006, p. 461). Derrida (2001) spoke of the gaze of the dead Other when he wrote in the eulogy for Louis Marin in *By Force of Mourning*, a chapter in *The Work of Mourning*:

> Louis Marin is outside and he is looking at me, he himself, and I am an image for him…He is my law, the law, and I appear before him, before his word and his gaze…we bear in ourselves the gaze that Louis Marin bears on us…This gaze is his, and it will always remain his…In us, there where this power of the image comes to open the being-far-away…Its power of dilation gives it its greatest force in the mourning of the absolute of "force". (p. 160-161)

Derrida describes the gaze of the dead Other as law and power that "look at us with a look that is a call to responsibility and transformation" (Kirkby, 2006, p. 461). On these terms, as the body of the deceased appeared before the Senior Religion Officer, the body 'gazed' into the eyes of the Officer and called him to submit to the "force" (Derrida, 2001, p. 161) of his gaze to act responsibly towards him.

Derrida's idea of ethical obligation towards the Other has an important connection with Levinas' concept of responsibility. Levinas's idea is associated with the

original responsibility of the religions of Judaism and Christianity, and he views other religions as a threat to this originality (Butler, 2005). In the context of my study, it is not my intention to call on Levinas's concept of responsibility to question the Islamic approach of ethical responsibility. I bring Levinas's idea of *the Face of the Other* to offer an understanding of religious practice in respect of the dead. I use Levinas's concept of responsibility to explain that in the moment of seeing *the face* of the body, *the face* demands an endless responsibility to his or her needs.

Levinas contends that human relations begin at the encounter with *the Face of the Other* and this relationship is an ethical relationship which is governed by ethical responsibility (Beavers, 1990). Levinas (1985) describes the encounter with *the Face of the Other* in *Ethics and Infinity: Conversations with Philippe Nemo*:

> You turn yourself toward the Other as toward an object when you see a nose, eyes, a forehead, a chin, and you can describe them…The face is exposed, menaced, as if inviting us to an act of violence. At the same time, the face is what forbids us to kill… The face speaks. It speaks, it is in this that it renders possible and begins all discourse.... The first word of the face is the 'Thou shalt not kill.' It is an order. There is a commandment in the appearance of the face, as if a master spoke to me. (p. 85-89)

Levinas (1985) connects "responsibility" and the "Other", by which he maintains that the human face calls us into serving the Other. It is here that Levinas' ethics of care in *the Face of the Other* offers the possibility of yet another understanding to the action of the Senior Religion Officer. His coming face-to-face with the body, the body/face of the deceased exposed humanity's intrinsic value and the need for a relational perspective. The body/face of a deceased Muslim man called forth an ethical response from the Senior Religion Officer to "condition the laws and establish justice" (Levinas, 1985, p. 89). The Senior Religion Officer became, in Levinas's (1981) claim, a "hostage" for the body/face (p.127).

The moment of seeing the body/face of the deceased, the body/face demanded the Senior Religion Officer to greet him without prior knowledge or convictions about him. This moment of unknowingness might invite a moment of vulnerability for the Senior Religion Officer. In this regard Butler (2005) suggests that ethical engagement involves:

> risk[ing] ourselves precisely at moments of unknowingness, when what forms us diverges from what lies before us, when our willingness to

> become undone in relation to others constitutes our chance of becoming human. (p. 136)

It was in this moment of unknowingness that the Senior Religion Officer made himself vulnerable and took the risk of opening up new possible ways of thinking or practising. In light of Butler's (2005) perspective, it is taking the risk that makes him human.

Power beyond death

As mentioned in the section above, there are several possible meanings attached to the Holy Prophet Muhammad's action to decline a funeral prayer for an individual who ends his own life. The Senior Religion Officer could choose to accept, resist or change the example of the Holy Prophet Muhammad. This suggested a kind of political agency in managing a dead body itself. I explore this situation through Foucault's and Agamben's concept of power.

Foucault argues that power had been exercised on and by the bodies of individuals, and bodies are the products of the specific disciplines such as psychology, medical, criminology and sociology (Foucault, 1978). Therefore, the body, for Foucault, is not merely a biological product, but is a product of knowledge and power. However, power in Foucault's (1978) terms can only exercise its influence over life, therefore, he views "death is power's limit" (138). Foucault's (2003) further claims that death is no longer a visible exhibition of power, "it is the end of life, the term, the limit, or the end of power too. Death is outside the power relationship" (p. 247). In contrast to Foucault's conceptualisation of power, Agamben suggests that "death is not power's limit but the terrain on which it operates" (Noys, 2005, p. 35). In this example of the body of a deceased Muslim man who had died by suicide, the interference of human culture or religious practice enables power to extend beyond death. The Senior Religion Officer and the washers both exercised power to make decisions about the value and dignity of a human body after death. The body of a deceased thus becomes the new paradigm of power that Agamben (1998) calls thanatopolitics, or a politics of death.

My concluding thoughts

In this chapter, I discussed Mazuki's encounter with the body of a deceased person who had died by suicide. Although the event itself had not happened in a counselling context, the learning from this profound experience played out when Mazuki became a counsellor. He spoke of how this experience had opened him to new learning:

> Sometimes when people committed suicide, what I believe is that there's something inside him that we fail to explore. And in that matter, we should respect the dead no matter how the person dies.

The way in which the Senior Religion Officer resolved the dilemma of the washers taught Mazuki to investigate available value positions within the Islamic context that he could use to support clients presenting with suicidal ideation. While one's body belongs to Allah, every Muslim individual has the responsibility to care for one's own body (Hamdy, 2012). Through the practice of the Senior Religion Officer, Mazuki learned to respect the person and his or her body without passing judgment of his or her behaviours. Mazuki constructing this experience as educative and locating this knowledge within a history of change practice that influenced his professional practice as a counsellor. There are implications here for all counsellors undertaking professional learning to prepare us for working with clients experiencing suicidal ideation, and with their families.

CHAPTER ELEVEN
GROWING PRACTICE WISDOM FOR RESPONDING TO SUICIDAL IDEATION

Paving the way: Chekhov's play to 'ink in my pen'

I began Chapter One by saying that there is no absolute truth to Ivanov's suicide, and that taken-for-granted ideas about suicide could and should be questioned. While Chekhov's play focuses on a singular character, Ivanov, and the statements of other characters surrounding Ivanov's life as witnesses to his struggles, the text of this thesis has focused on the practice of a number of Malaysian counsellors and their accounts of professional practice in the context of suicidal ideation. In a series of scenes from client practice, I have illuminated my research questions through accounts of the ways in which counselling practice in relation to suicidal ideation has played out in the lived experience and professional practice of counselling practitioners. While holding this thought about my research investigation, I now tell the story of Chinese calligraphy and the 'ink in my pen'. The journey of this study has provided me with 'ink in my pen' as a researcher and counsellor. The phrase 'ink in my pen' reaches back in time and comes forward to the present, just as Chekhov's account of Ivanov's suicide does.

Chinese calligraphic handwriting (书法, [Shūfǎ]), a traditional art of writing using a soft-tipped brush, has a five-thousand year of history (Tseng, 1993). In ancient China, calligraphy is a means for communication and information recording (Kao, 2006; Yen, 2005). In an age of ballpoint pens and electronic devices, practising calligraphy is preserved by many Chinese people around the world. For example, calligraphy of Chinese characters is a compulsory subject for students studying in the Chinese-medium primary schools and selected secondary schools in Malaysia.

Practising calligraphy requires calligraphers to exercise a great level of attentiveness, concentration and motor control skill, to coordinate the body and orient the movement of the brush to produce a character (Kao, 2006; Yen, 2005). I learned Chinese calligraphy for six years in my primary education. The learning of calligraphic handwriting began with adopting an appropriate sitting posture and body positioning: keeping my head upright and upper body straight, relaxing my

shoulders and chest, sitting on the front half of a chair, not touching the desk with my front upper body, and positioned with both my feet planted on the floor with my knee bent to a 90-degree angle. Next, I was taught the way to hold the brush. The writing materials for calligraphy included: black ink (chemically produced), brush (the brush is made from animal hair and the body of the brush is commonly made from bamboo), paper or calligraphy exercise book to practise writing, and a copybook serves as a model for students (楷书技法字帖, [Kǎishū jìfǎ zìtiě]).

I began the writing process by holding the brush and dipping it into the ink several times. I then gently wiped the brush under the inner edge of the bottle top or 'mouth' to get rid of any excess ink and carefully re-shape the brush into a writing point. The challenge of this practice was not to have too much ink on the brush but enough to complete a single stoke before I dipped the brush for new ink for the next strokes. The quantity of ink I left on the brush would influence the 'spirit' I gave to the shaping of a character. While holding the brush ready to write, I relaxed my shoulders and chest, concentrated and breathed. In the writing process, I moved my eyes looking between the copybook and my exercise book while I used the brush to write each stroke of each character on the calligraphy exercise book. I focused on the movement of my hand to position the brush with every brush stroke. As Chinese characters are pictorial in origin (Tseng, 1993), I 'brushed' down a character on my exercise book repeatedly to produce characters that gave me a sense of balance and harmony. I became aware in the moment-by-moment of my body movement and breathing with every brush stroke. After numerous practices, my body and the brush established a close collaboration in the creation of a dance position that produced a writing I was satisfied with.

I did not practise Chinese calligraphic writing after my primary education. However, I had the opportunity to practise it during Qingming Festival. I discussed this festival in Chapter One. This festival takes place once a year, and many Chinese people around the world would "*balik kampung*" (Gannon & Pillai, 2015, p. 247) or travel back to their homeland or village to pay respect to their ancestors. At the grave sites, my family and I would clean the grave surrounding, sweep and tidy the tombs and the gravestones of my ancestors and loved ones. While the others were placing the offerings on the ground in front to the gravestones, I was preparing to

replace the faded writing on the gravestones with new fresh ink. I followed what I had been taught at school years ago to carefully re-shape the brush with ink and copy the writing, stroke by stroke on the gravestones. With every brush stroke I made on their names, dates of birth and death, and the name of the province in China where they came from; I experienced a sense of re-connection with my ancestors/loved ones in this journey of remembrance. Practising calligraphy taught me to take a step at a time, to be patient, determined and disciplined. It was this thought of my learning and experience from practising calligraphy that I embodied as I embarked on the journey of knowledge to New Zealand to begin this doctoral study.

It is common for Chinese people to use the phrase 'drinking ink from overseas' (Chinese: **喝洋墨水**, [Hē yáng mò shuǐ]) to describe individuals who study abroad to learn different knowledge and skills. The character, **洋** ([Yang], overseas) can refer to Western people or a country which is different from one's own; while the metaphor of ink (Chinese: **墨水**, [Mò shuǐ]), commonly refers to knowledge or skills. The use of this phrase has a history associated with the study-abroad movement of Chinese students in the late Qing Dynasty (1644-1911) (Zhang, 2011; Zhou, 2017). The government of the Qing Dynasty began sponsoring students to study overseas to learn knowledge in sciences and technologies as part of their Westernisation Movement (1860s-1890s) to reform the country after the Opium Wars (1839-1860) (Geng, 2015; Zhang, 2011). In contemporary society, students who return to their homeland after completing their studies are often referred to as "overseas returnees" (Chinese: **海归**, **[**Hǎiguī]), (Liu, 2016, p. 48). I was hoping to return to Malaysia as a **海归** (Hǎiguī), with *ink* from New Zealand for my brush to produce the writing with brush strokes of different meanings and values to respond to the practice problems I had experienced in my country.

The practice problems

I came to this doctoral study as a practitioner, counsellor educator and supervisor. In all of these roles, I had encountered uncertain ethical issues in counselling clients experiencing suicidal ideation. I had learned, and taught student counsellors and

other practitioners, manualised approaches to risk assessment and management such as crisis intervention models (Flannery & Everly, 2000; Granello, 2010; Roberts, 2000; Rojas & Rogers, 2013) to assess and respond to clients with potential suicidal risk.

Manualised protocols had limitations, I found. When I employed the protocols with the intention to keep clients safe, the intervention process did not necessarily fall into place as the manual predicted. While I have a duty, legally and ethically as a counsellor, to do what is possible to intervene to maximise client safety, this duty often resulted in practising an approach of 'forcing' clients to accept the intervention plan I developed to keep clients safe. In the process, my focus to understand the pain clients were experiencing became secondary as I had limited time to achieve the objectives set by the manual. My approach often led clients to refuse and resist participating in the suicide risk assessment or safety plan that I developed as part of standard care. While I did not experience a client taking their own life, I on many occasions experienced myself not knowing what to do next when it was impossible for me to anticipate ahead of time what uncertainties and ambiguities would emerge in the consultation.

Similarly, student counsellors or practitioners I supervised followed the protocols, and then came to supervision asking what to do when the protocols positioned them to police clients' lives. They too experienced tensions between managing risk and respecting clients' right to autonomy. We were having this unsatisfactory experience because we were using our professional expertise to respond to clients but we kept encountering client resistance to assessment we wanted to engage in or the safety plan we were trying to put in place. In Derrida's (1992) words, I entered into the "experience of aporia" by which he means:

> …an experience is a traversal, something that *traverses* and travels toward a destination for which it finds the appropriate passage. The experience finds its way, its passage, it is possible. And in this sense it is impossible to have a full experience of aporia, that is, of something that does not allow passage. An aporia is a non-road. (p. 16, original emphasis)

In the aporia, I experienced the impossibility of traversal where the path leading forward was impassable. I questioned the impossibility by exploring more possibilities to create a passage for traversal of the non-road. I questioned my own

counselling and supervision practice. I sought consultation from peer counsellors and supervisors, attended numerous training and practices in Malaysia, and attempted to learn more knowledge and skills of supporting clients. I began this study with the hope to discover new ways or techniques that I can practise in Malaysia. However, I learned to view my own practice from different perspectives from the philosophical thinking I introduced in Chapter Two as the thinking that provided me with ideas and words to make sense of the client resistance and the aporia I experienced in my practice.

I invite Foucault's (1972) ideas of discourse and power/knowledge, and Davies and Harré's (1990) positioning theory to inspect my practice in a wider context. I connected my practice problem to the playing out of discourses, such as the legal, medical, religious, cultural, institutional and educational discourse; and how these discourses position me and limit my practice. For example, I often encountered clients resistant to my suggestion to seek psychiatric services for further assessment. If I invite myself to consider how the discourse of medicalised suicide may shape a clients' view about mental health problems, perhaps I can interpret their resistance as feelings of shame or fear about being viewed as a person with mental health problems when others see them seeking psychiatric services. The philosophical ideas offered me broader yet flexible means to conceptualise the complexities and nuances of client resistance. This different way of conceptualising client resistance may have provided me with therapeutic options to co-construct with clients a more preferred way of seeking psychiatric services.

The operation of Foucault's (1977) power/knowledge also invited me to be more aware of the privileged or expert position I, as a counsellor, hold in the counselling relationship with clients, and their family members. When I take up this expert role and in a power relation with clients who consult me, I frequently position myself (and am positioned by the wider society) as the sole caregiver who has the ability and responsibility to prevent client suicide. As I converse as an expert, I may adopt concepts or language salient of that position (Davies & Harré, 1990), which potentially limit the space for clients to speak up in our interactions. This expert position may also shape the responses of clients and their family members in the counselling relationships. For example, clients and their family members who

accept counsellors' expert position may speak in ways that solicit the professional knowledge of counsellors.

The understanding of the shaping effects of discourses opened up a space for me to stand and reposition myself, to see, listen to and interpret my own practice and client responses to my therapeutic plans. In this new positioning, I experienced a shifted perspective from focusing on my practice competence and the idea that I was the only person (counsellor) responsible for client safety, to paying greater attention to the constitutive role of discourse (Foucault, 1972, 1978), and to the facilitation of a co-construction between clients and counsellors.

Through a Foucauldian lens, I now understand that the resistance by clients can be understood to be a refusal of the disciplinary power (Foucault, 1977) that I exercised. When clients express suicidal ideation, counsellors are required by the suicide legislation, professional code of ethics, and institutional protocol to take responsibility to offer a standard of care that protects client safety. In taking up this responsibility, counsellors exercise disciplinary power (Foucault, 1977) to conduct the conduct of clients. 'Suicide' brings clients into the regime of truth (Foucault, 1980) that pronounces counsellors as having the professional responsibility to conduct the conduct of the other. From this perspective, clients become the objects (see Foucault, 1977) of professional intervention and clients' rights to autonomy to accept or refuse therapeutic intervention may be forfeited to some degree. To resist the disciplinary power I exercised upon them, some clients took an oppositional stance towards the suicide discourse and discursive practice that I developed with an intention to keep them safe. Client resistance in this context might be seen as a way to keep themselves safe from experiencing the potential gaze of judgemental disciplinary power and being stigmatised in the public perception. Clients refused to be transformed into "'docile bodies' and conscript[ed] them into activities that support the proliferation of 'global' and 'unitary' knowledges" (White & Epston 1990, p. 20).

When clients refused to participate in the therapeutic plans I developed, I frequently had to make painful decision to forgo clients' rights to autonomy in order to submit to the goal of the suicide legislation, the professional code of ethics and the institutional protocols where I practised, to maximise client safety. While I had the

responsibility of intervening to keep clients safe, I also desired to respect client autonomy by not coercing clients into intervention plans that might intensify their distress and unbearable pain. In this particular moment, I did not know what to do or what questions to ask clients in order to move therapy forward. The issue of ambiguity gave rise to the question of how could I (or the student counsellors and practitioners I supervised), in Bauman's (1998) words, "take *responsibility for one's own responsibility*" (p.17, original emphasis) in the presence of client resistance which made the path forwards unclear and uncertain. This regularly occurring and significant question led me to investigate the practices counsellors called on to navigate the uncertain and complex contexts when counselling clients who express an intention to end their own lives. The counsellors in this study offered rich descriptive accounts of practice wisdom of their counselling with clients to co-construct responsibility towards safety.

Practising wisdom to the co-construction of a relational dialogic-responsive approach

The analysis I offered suggested that the counsellors, too, had experiences of manualised approaches not always answering the practice question. The tensions between managing risk and respecting clients' right to autonomy that they experienced in the counselling process at times played out in various forms of client resistance to participate in form of risk assessment and safety plan that counsellors established as therapeutic intervention, such as refusing to use *suicide* language in their conversation with their counsellors. The clients were also unwilling or hesitant for counsellors to inform their families about the risk, and declined counsellors' suggestion for a psychiatric referral.

In the counsellors' narratives, I identified client resistance, and I found that they responded to these resistances by developing a whole range of practice wisdom from their professional knowledge, that went beyond manualised protocols, about what was important in times of suicidal ideation. More importantly, my analysis showed that in their practice, the counsellors worked closely with clients as collaborative participants in producing a preferred therapeutic plan through a co-constructed engagement of clients and counsellors.

The idea of wisdom has its origins in Aristotle's concept of phronesis or practical wisdom (Lacewing, 2017). Aristotle argues that practical wisdom involves the ability using particular knowledge to make choices and to act on these choices. The kind of wisdom I describe here involves forms of knowledge, skills or practices which individuals engage with to produce "good actions [or thoughts], whose goodness is intrinsic to the actions [or thoughts] themselves" (Hughes, 2001, p. 94). In a study to investigate practice wisdom in therapy, Levitt and Piazza-Bonin (2016) interviewed seventeen psychologists who were nominated as wise practitioners by their peers. They maintain that therapeutic wisdom embraces practitioners' professional knowledge for practice and skillful use of manualised intervention. They suggest that one of the ways practitioners practised wisdom is to give up their preconceived notions about their clients, and to adopt a not-knowing position to guide them in exploring clients' concerns with respectful interest and curiosity. In the following sections, I present how the counsellors practised wisdom and worked to co-construct with their clients in navigating challenging situations when counselling clients with suicidal ideation.

My analyses demonstrated that counsellors called on creative and wise situation-specific crafted ways of responding to the particularity of a particular client. These approaches reflected the counsellors' capability to be sensitive and responsive to a particular client in a specific situation. In my work of unpacking or deconstructing (Derrida, 1998) discourses that shaped their practices, I learned that the counsellors drew on specific counselling skills, cultural and personal knowledge to guide them what the appropriate response was in a specific context with a particular client.

Siva demonstrated a highly refined skill in putting a counselling theory into practice. When a client left the counselling office having handed over a suicide note, Siva determined that building a therapeutic alliance with the client was crucial. He approached the client by asking – "What's up?" Siva perhaps was not aware how the use of everyday language shaped the client's response. However, I interpret that he chose this form of language as a way of (re)inviting the client to a counselling relationship and taking up a position to welcome what the client had to say. This language use is also resonated with what Oyama (2012) identifies as "the usual conversational forms of a sociocultural background" (p. 16). To strengthen the alliance, I suggest that Siva called upon a shared cultural perspective of

hospitality – *Atithi Devo Bhava* – into counselling. To stand alongside the "What's up?" form of welcoming, Siva decided that the counselling theory he subscribed to was not appropriate to be applied at that point of time. I read Siva's decision as resistant to being positioned by a counselling theory to guide his therapeutic approach. Instead, he repositioned himself by calling on the less-told account of the theory to focus on establishing a therapeutic alliance with the client. Siva was also faced with client silence in therapy. I see the client silence as a response to the hospitality the client expected to receive but did not. This silence can also be seen as a form of resistance to bureaucratic systems. In such a situation, Siva employed the refined skills of observation and discernment to guide his responses to move ahead the 'conversation' with the client. I unpacked Siva's practices to demonstrate how the process of co-construction took place when Siva and the client communicated through powerpoint presentation, papers and pens.

Similarly, Bahar and Peng-Yu invited themselves to be careful and cautious about what was the appropriate language to use when assessing risk when clients had attempted to take their lives. They talked about their practice of waiting for the clients to use the word *suicide* in their conversations. I became aware of a Māori cultural practice: when guests who want to come into the marae (cultural meeting place) they have to wait at the gate to be invited (Swann et al., 2013). This Māori cultural practice prompted me to locate a relevant cultural practice of hospitality available for Malaysian people as I interpreted Bahar's and Peng-Yu's practice. I associated Māori cultural practice of waiting-at-the-gate to the approaches of *budi* and *ménkǎn* as a way of visitors showing respect for their host before entering the host's house. The cultural discourse positioned Bahar and Peng-Yu as *visitors* who took care about how they entered the relationship. The position as visitors enacted a different interaction with the clients and thus shaped the therapeutic relationship in particular ways.

Social constructionist ideas argue that it is not possible for individuals in social interaction to avoid being situated within a specific cultural and historical context as knowledge is considered historically embedded in cultural values and practices (Burr, 2003; Gergen, 1994). Winslade (2003) further argues that one is "never speaking in a vacuum but always from some place, some time, some social context" (p. 88). Drawing from a social constructionist lens, engaging clients through the

cultural practices of hospitality such as *budi* and *ménkǎn*, as well as *Atithi Devo Bhava*, to form a meaningful connection with clients may be considered a culturally appropriate practice. These examples of practices invited me to rethink the validity and richness of cultural practices involved in counselling.

In another situation, Umadevi and Cheng-Mei respected the clients' decision to terminate the counselling relationship when family beliefs and values influenced their parents to decline mental health services for their daughters. The professional status and knowledge which counsellors hold confers on Umadevi and Cheng-Mei authority and influence to maintain the well-being of clients and keep clients safe. Indeed, I offered the suggestion that Umadevi and Cheng-Mei exercised their authority to support the clients' decision to act on the terms of filial responsibility, as daughters to their parents by inviting the clients to co-construct more flexible forms of support that were culturally appropriate for the clients and their families.

Li-Na's accounts offered a different perspective concerning institutional protocols, and how the protocols positioned her and at the same time limited her practice when clients expressed suicidal ideation. When family beliefs and values intersected with the counselling intervention plan that Li-Na established according to the requirements of the protocols, my analysis suggested that Li-Na took responsibility to interact with the client to co-construct responsibility towards safety. In the co-construction process, I became aware of how Li-Na used her creativity and flexibility skills to negotiate with the client an action plan that supported helpful outcomes.

The "experience-near" (Bondi & Fewell, 2016b, p. 30) accounts of Anuja and Mazuki offered my study detailed examples of how professional practice could be shaped by the value of counsellors' personal lived experience. I learned from both of them that personal lived experience can provide a source of clinical knowledge. This idea helped to challenge the notion that counselling knowledge can be developed through evidence-based research, and education and training. Personal knowledge is made visible in these examples, knowledge which can be considered valuable and reliable knowledge for counselling practice.

In the context of medicine, Sackett, Rosenberg, Muir Gray, Haynes, and Richardson (1996) argued:

> Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. (p. 72)

The detailed examples in my study show effective use of clinical expertise, thus extending the range of the knowledge available to counselling professionals in Malaysia.

It might be understood that the counsellors in my study practised with potential consideration for the professional power relation, resisting whenever possible using force to conduct the conduct of others. Their practices were informed by two particular relational qualities: relational responsiveness, and a sense of the importance of dialogue between counsellors and clients. I introduce this approach as relational dialogic-responsive practice (see Shotter, 2008). This practice reflects a focus on a way of being *with* (Shotter, 2008) clients at time of desperation and despair. This way of being *with* involves counsellors taking a dialogic and responsive stance to engage with: themselves and their own professions; the discourses that are in circulation; the clients and their families; and the wider communities. This stance suggests a withness process of counsellors' positioning and repositioning themselves in the moment-by-moment interaction with clients, led by responsibility to clients, while practising a crisis intervention protocol. Shotter (2010b) suggests that a withness relationship is an embodied experience of dialogical thinking counsellors have with their clients:

> It is a meeting of outsides, of surfaces, of 'skins' or of two kinds of 'flesh' (Merleau-Ponty 1968), such that they come into 'touch' with each other. They both touch and are touched, and in the relations between their outgoing touching and resultant incoming, responsive touches of the other, the sense of a 'touching' or 'moving' difference emerges…In short, we are spontaneously 'moved' toward specific possibilities for action in such thinking. (p. 269)

Shotter's argument proposes a dialogical thinking where counsellors are responsive to clients' utterances and bodily expressions in their interactions. Counsellors are being in the moment of the conversations, by which they move within, back and

forth, and along with the flow of clients' narratives and are prepared to respond in the here-and-now. The way the counsellors engage their clients in a withness relationship provides a relational context of therapy that emphasises the establishment of particular kinds of relationships and conversations to fit to the uniqueness of each client's situation and context, and the particular risks to safety in that moment.

In this thesis, I propose that the counsellors I met with offered clients hospitality to invite them to feel their presence or withness by taking a position of a "fellow traveller" (Weingarten, 1998, p. 4) in listening and responding respectfully. As a fellow traveller, the counsellors positioned themselves side-by-side in "a shared world of meaning co-created" (Seikkula & Trimble, 2005, p. 473) with their clients to bring forth the clients' voices, even when in the context of suicidal ideation they were complicated, hesitant or difficult to understand. In the process everything matters, particularly what is occurring in the space between counsellor and client, as I develop in the next section.

The ethical relation of Levinas and Derrida

I now follow the ethical philosophy of Levinas and Derrida, which I presented in Chapter Two, to enrich this account of the counsellors' responses to clients presenting in their practice with suicidal ideation. Through these ethical accounts, I pay attention to the work of counsellors with two questions; When meeting clients who consider choosing suicide as a way of coping with the unbearable pain they experience, what does it mean to counsellors to be responsible? And how do counsellors practise hospitality?

Approaches to ethics are primarily informed by the professional code of ethics and the five ethical principles: respect for autonomy, non-maleficence, beneficence, justice and fidelity (Lembaga Kaunselor, 2011). Counsellors often refer to the code of ethics for guidance when meeting with ethically problematic situations. However, a code cannot anticipate every situation that may take place and offer a clear approach to every complex ethical dilemma (see Crocket, 2011). In particular, when ethical principles and values are competing make the path forward may be unclear. Working in such a situation of complexity and ambiguity, a question arises

as to how practitioners can take up responsibility for clients while holding the tension of competing ethical principles and values. When counselling a client who speaks suicidal ideation, the code of ethics positions counsellors with the responsibility to protect client safety (Lembaga Kaunselor, 2011, B.2.a). At times, this responsibility has the potential to cause harm to clients. For example, disclosing the confidential information that a client may be contemplating to take his or her own life to his or her family members may run the risk of a client being perceived as insane (Raja Mohan & Sorooshian, 2012) or a client feels that he or she has brought shame, embarrassment, or social exclusion to his or her family (Baptiste, 2005; Conrad & Pacquiao, 2005). I suggest here that Levinas and Derrida each offer an approach to ethics that makes room for counsellors to practice ethically while taking accountability for their professional conduct and practice.

Levinas's account of ethics recognises the other as different; in other words, the otherness of the other is not knowable (Levinas, 1969). It is this recognition that enacts a relationship with the other that *recognises* the Other as a subject, not reducing the other to the same. My use of the term recognition draws from Butler's (2005) account of ethical practice. Butler (2005) edges close to Levinasian ethics when she argues that to make recognition of the other possible, one begins by recognising the limits of self-knowledge that "there is an other before us whom we do not know and cannot fully apprehend" (p. 31). The skill to *recognise* can be learned through "[a]n ability to affirm what is contingent and incoherent in oneself may allow one to affirm others who may or may not ''mirror'' one's own constitution" (p. 41). In other words, to disrupt one's self-knowledge and to become open to receive the other on their own terms "requires [one] to risk [oneself] precisely at moments of unknowingness" (Butler, 2005, p. 136).

Levinas considers reducing the other into sameness – to being knowable – to be a form of violence (Levinas, 1985). In a face-to-face encounter with the other, one is brought into a position of unknowingness:

> The first word of the face is the "Thou shalt not kill." It is an order. There is a commandment in the appearance of the face, as if a master spoke to me. (Levinas, 1985, p. 89)

This is a radical move to consider that a counsellor cannot fully know, and can potentially do violence to another through claiming to know, for example through the claim to 'know' that a person is a danger to themselves and should be hospitalised. In a counselling context, assimilating the experience of the other person into a defined category has the potential of doing violence – *killing* – the other through language which reduces possibilities and limits client's agency (Larner, 2004). Levinas emphasises the relational in which "the face speaks to me and thereby invites me to a relation incommensurate with a power exercised, be it enjoyment or knowledge" (Levinas, 1969, p. 198). The assimilation of clients' experience perhaps has the potential of moving counsellors "outside the [therapeutic] relationship and [ceasing] to participate in a conversation" with clients (Larner, 2004, p. 16). So what is to be done if counsellors are to both take responsibility for safety and to avoid a violent use of professional power? A compelling example was demonstrated by Siva when he was confronted with a client whose potential action posed an imminent suicide risk. In such a tense moment, Siva discernibly applied counselling theory that stood side-by-side *with* the client and was within an ethical relationship where the client was put first. Siva fostered a relational-dialogical space by being responsive to client's needs in attuned, flexible and creative ways.

As the other is not the same as me, to Levinas (1969), it is impossible for one to claim to fully comprehend of the other. The result of such a claim invites counsellors to approach clients from a position of curiosity as part of their response to the other's otherness. A curious stance likely promotes relationship, as counsellors take up a position of learning about the particulars of a client's life. In this position, counsellors relinquish their expertise to be open to what clients want to convey and responsive to clients at the dynamic moments of encountering clients. In the process, counsellors use their discernment and judgement to "[know] *when* to know and when to let the client do the knowing" (Larner, 2004, p. 26, original emphasis). Larner (2004) further argues that the interplay between counsellors' various ways of knowing opens up space for agency and voice of the clients in therapeutic conversation.

In the physical presence of the other, language becomes an important means to acknowledge the otherness of the other. Language is viewed by Levinas as ways of

relating to the other's otherness with ethical responsibility (Larner, 2004). Levinas (1981) approaches the structure of language as *said* and *saying*. The *said* takes the form of mastering the otherness through "the objective content of what we say, the ideas, meanings and observations we want to communicate. This form of discourse is totalising and violent when it forces meaning on a person ignoring what is uniquely different about [this person]" (Larner, 2004, p. 16).

In a way, the *said* functions to conceptualise the other based on one own understanding, and not the "uniquely different" of the other. By contrast, Levinas's *saying* attends to the otherness of the other through a here and now dialogic aspect of language (Larner, 2004). The *saying* has no content as it is the outcome of the speaking that takes place *with* the other person. The content fluctuates depending on the response process of conversational exchange within an interaction. Counsellors in this study reported using non-pathologising, language to engage with their clients in dialogue to facilitate the process of understanding them and their concerns. Counsellors became mindful about not using language to totalise (Levinas, 1969) clients' experience, avoiding language that treats others as an object and closes down the possibility for dialogue.

The language of *saying* disrupts the *said* with a gesture of welcoming the other. This welcoming gesture *recognises* the person as other and promotes the possibility of opening up new spaces to welcome what the other has to say. Ethics in this sense becomes a welcoming of the other. Following Levinas, Derrida refers to welcoming of the other as an ethic of hospitality, which means "to invite and welcome the "stranger"" by a "host" who "receives strangers" (Caputo, 1997, p. 110). In the space of relationality, the face of the "stranger" calls for a welcome. Within this hospitality, a host (counsellor) takes up the responsibility to engage with the stranger (client). For example, Siva chose to greet a client with "What's up?" question as a form of welcome he accorded to the client to invite a shared language of *saying* from the client about his concerns and personal story. In this context, this kind of language had the potential to promote a dialogic space where the client was invited by Siva to enter together into an exploration of different ideas and understandings. From his welcome to the client, Siva was welcomed *by the client*. Language in this regard comes before the other and it functions as the starting point in the presence of the other.

In the context of Levinas's and Derrida's ethical framework, counsellors put clients first and withhold expert language. Counsellors *recognise* clients as Other while the manualised protocols are used as "a part, rather than focus of [client] care" as Mulder (2011, p. 606) argued. I have shown in this study that the ethical use of language by the counsellors is closely associated with how and when to employ professional and technical knowledge to welcome clients. In the face of clients' desire to take their own lives, the counsellors offered accounts of where they were called to host their clients as a person with their presence of withness. The counsellors did not send their clients away to face the psychiatrist on their own or to the care of the security personnel. They joined their clients in the process of notifying their family members about the suicidal risk. They drew upon cultural knowledge to host their clients and to invite them into safe space when they felt the clients' hesitation to talk openly about suicide. Through the philosophy of Levinas and Derrida on ethics, in this study I offer counsellors a platform to stand so that ethical relationship practice can be approached through a relational dialogic-responsive manner in each encounter with a client experiencing suicidal ideation.

Different value of 'ink for my pen'

Suicide issues have been a consistent concern in Malaysia (Aishvarya, Maniam, Hatta, & Oei, 2014; Aishvarya, Maniam, Oei, & Subramaniam, 2014; Kok, Gan, & Goh, 2011) and everyone within the society has a moral obligation to intervene to prevent suicide. Counsellors are one of the many professional groups charged with responsibility to provide help to individuals struggling with suicidal ideation. Counsellors in Malaysia work within a culture where suicide prevention is seen as being of paramount importance, with government regulation (Laws of Malaysia, 2006a) and suicide prevention efforts (Masiran et al., 2017) developed and implemented to prevent suicide. Furthermore, suicidal behaviour has been pathologised as a mental health problem in Malaysia (Foo et al., 2012; Loo et al., 2012; Raja Mohan & Sorooshian, 2012). Though the counsellors did not express this medical pronouncement on suicide explicitly, the theme was woven within their stories and practices.

In addition to counselling within a context of suicide being dominated by suicide prevention and medical discourse, support for clients required counsellors to work

alongside the professional regulatory, and ethical standards and practice. At the same time, counsellors are to take into account the often-invisible influences of stigma, cultural and family values. The practice of counselling clients in the context of suicidal ideation is a complex and challenging therapeutic process with professional, personal, social, legal, medical, ethical issues, and with shades of uncertainties inherent to the suicidal threat shaping the counsellor-client relationship.

The contribution of this study is into the very tension between ethical choice of respecting clients' right to autonomy and protecting client safety. This tension locks counsellors in a place where they struggle to know what to do, and yet there is a responsibility to intervene with clients who are thinking of taking their own lives. In the space of this tension, relying on a singular manualised approach that features crisis management and risk assessment driven intervention is not sufficient for counsellors to care for clients and keep them safe.

As part of the crisis management plans, it is a requirement of the manualised protocols for counsellors to predict the likelihood of suicide using a suicide risk assessment tool (see Reeves, 2010; Mulder, 2010). However, Mulder (2010) argues that despite the presence of certain risk factors, the ability of practitioners to accurately predict the likelihood of suicide is limited. Providing care solely based on suicide risk scores may result in a client struggling with suicidal ideation not receiving necessary support, and vice versa. Mulder goes on to maintain that risk assessment process involves more than identifying the presence of risk. He urges practitioners to value ongoing therapeutic conversations as the focus of client care intervention. Rojas and Rogers (2013) also caution counsellors who emphasise on identifying the level of suicide risk may progress counselling too soon to problem-solving and spend insufficient time to explore clients' experience and the meaning of suicide in a wider context. The focus of client-centred approach has led to another contribution of this research: the importance of establishing a therapeutic alliance with clients (see Michel & Jobes, 2011) particularly during the risk assessment process.

Michel (2011) identifies the therapeutic alliance in the context of suicidal ideation as a "major, although largely unspecific, therapeutic element that keeps

the…person alive in the short term as well as in the long term" (p. 24). I have shown through the examples of practices that the counsellors paid great attention to co-construct a therapeutic alliance using carefully-sensitively crafted language, and weave together counselling knowledge and relevant cultural practice of hospitality. These practices attended to clients' particularity by *recognising* each client as Other, and played out through "the small and the ordinary" (Weingarten, 1998, p. 3) practices that open up a safe space for a dialogical conversation, that welcome what clients say in counselling, and that are respectful, non judgemental and doing hope.

In focusing on ethics in practice, this thesis concludes that ethics is part of counsellors' everyday practice whether or not a crisis is present (Crocket, 2011). Ethics is more than rule adherence and decision-making in response to ethical dilemmas. Rather it is about the small and the ordinary actions and thoughts that are embedded and embodied in the minutiate of everyday practice. The development of everyday ethics practice relies on practitioners weaving together the manualised protocols, counselling knowledge and skills, personal and cultural knowledge, respectful face-to-face encounter with the other; responsiveness to the particularity of a particular client and a specific situation and the relationships with these particularities. This study can be considered as a demonstration of a "power of examples" (Bondi & Fewell, 2016b, p. 41) research approach that engages with "the interpretive, reflexive, situated, and context-dependent character" (p. 30) of counselling experience.

As I am writing this thesis, it is like witnessing the moment-by-moment counselling process experienced by the counsellors in sessions with their clients. I am grateful for being entrusted with counsellors' stories of the experiences at a point in their counselling journey when they were walking a line of life and death experience with their clients. Their knowledges and skills gifted me with a different lens to view my own knowledges, skills, values, and challenged the ways I understand my counselling and teaching practice. The learning I acquired from this study enables me as a practitioner, counsellor educator and supervisor to contribute a space to welcome wisdom and a co-constructive way of having conversations in my practice. This learning offers me a different value of *ink* for me to speak and 'write' myself into existence:

> …aware of the discourses through which we are spoken and speak ourselves into existence. We must find the lines of fault in and fracture those discourses. And then, in those spaces of fracture, speak new discourses, new subject positions, into existence. (Davies, 2005, p. 1)

I am making and will continue to make small shifts daily in my everyday thoughts and writing, an ongoing process. I now notice and recognise the playing out of available discourses and how they work to shape and position me, other counsellors, and the wider community when the aspect of suicidal ideation enters into the space of therapeutic relationship. Discourses are so invisible to us that, according to Davies (1993), we "…disattend the pane of glass to look at the view out the window, so we generally disattend discourse. It is not until the glass fractures or breaks, for example, that we focus differently" (p. 153). My own learning from this study opened space for me and offered me a form of freedom to read counselling practices in a different perspective. I will be committed to listen, not only to the readily available stories, but I will also look for the untold and unfamiliar, as l listen to clients in therapy and to students in supervision. I carry the hope to make contributions that will help open the door in Malaysia for a different way of doing research and practising counselling.

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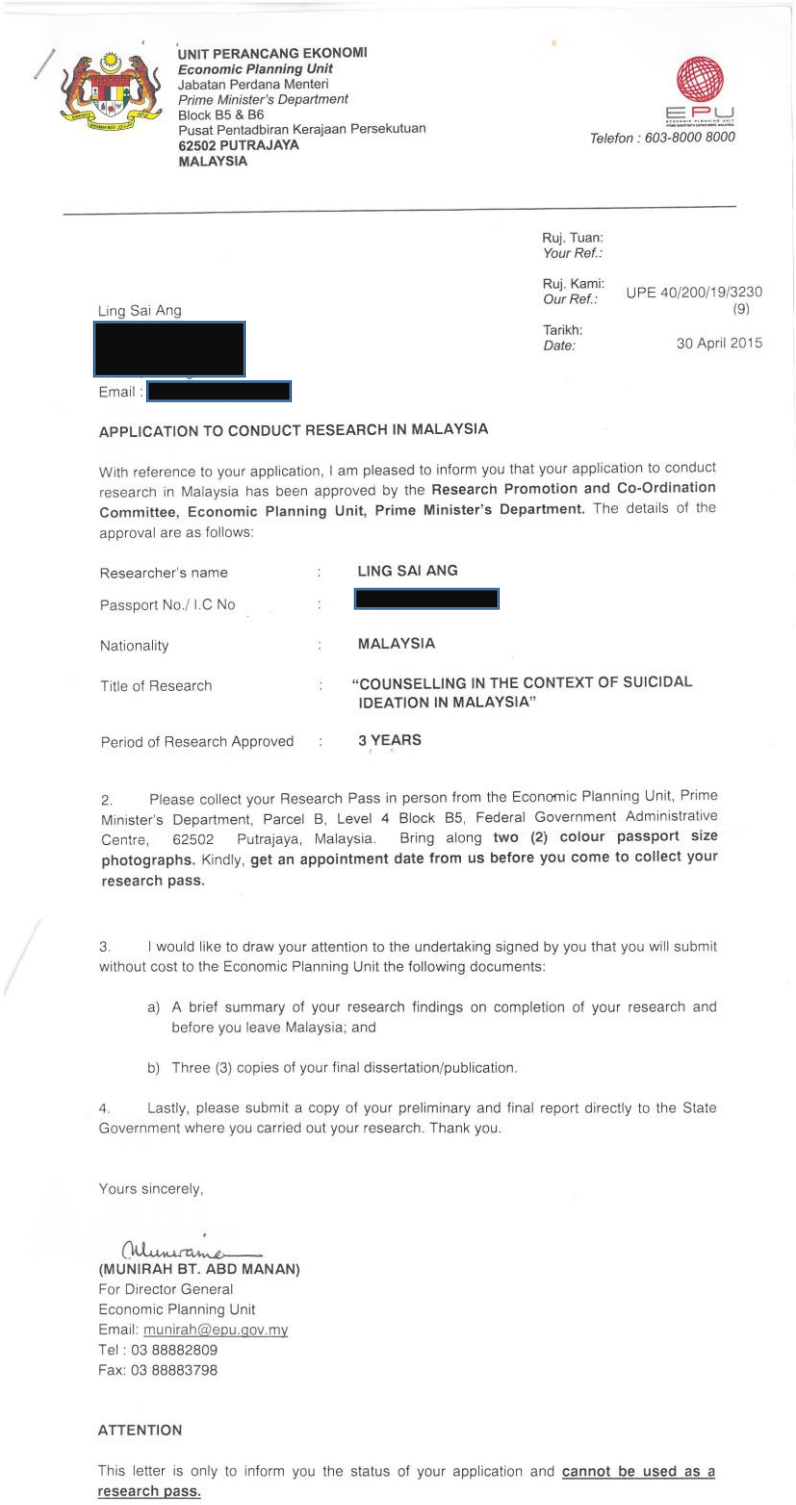
APPENDICES

Appendix A: Approval letter from the Economic Planning Unit (EPU)



UNIT PERANCANG EKONOMI
Economic Planning Unit
Jabatan Perdana Menteri
Prime Minister's Department
Block B5 & B6
Pusat Pentadbiran Kerajaan Persekutuan
62502 PUTRAJAYA
MALAYSIA

Telefon : 603-8000 8000

Ruj. Tuan:
Your Ref.:

Ruj. Kami:
Our Ref.: UPE 40/200/19/3230 (9)

Tarikh:
Date: 30 April 2015

Ling Sai Ang
[redacted]
Email : [redacted]

APPLICATION TO CONDUCT RESEARCH IN MALAYSIA

With reference to your application, I am pleased to inform you that your application to conduct research in Malaysia has been approved by the **Research Promotion and Co-Ordination Committee, Economic Planning Unit, Prime Minister's Department.** The details of the approval are as follows:

Researcher's name	:	**LING SAI ANG**
Passport No./ I.C No	:	[redacted]
Nationality	:	**MALAYSIA**
Title of Research	:	**"COUNSELLING IN THE CONTEXT OF SUICIDAL IDEATION IN MALAYSIA"**
Period of Research Approved	:	**3 YEARS**

2. Please collect your Research Pass in person from the Economic Planning Unit, Prime Minister's Department, Parcel B, Level 4 Block B5, Federal Government Administrative Centre, 62502 Putrajaya, Malaysia. Bring along **two (2) colour passport size photographs.** Kindly, **get an appointment date from us before you come to collect your research pass.**

3. I would like to draw your attention to the undertaking signed by you that you will submit without cost to the Economic Planning Unit the following documents:

a) A brief summary of your research findings on completion of your research and before you leave Malaysia; and

b) Three (3) copies of your final dissertation/publication.

4. Lastly, please submit a copy of your preliminary and final report directly to the State Government where you carried out your research. Thank you.

Yours sincerely,

(MUNIRAH BT. ABD MANAN)
For Director General
Economic Planning Unit
Email: munirah@epu.gov.my
Tel : 03 88882809
Fax: 03 88883798

ATTENTION

This letter is only to inform you the status of your application and **cannot be used as a research pass.**

Appendix B: Application to recruit particpants – Malaysian Board of Counsellors

Ling Sai Ang
No XX, Jalan XXXX
Selangor D. E.
Malaysia

Date:

Urus Setia Lembaga Kaunselor,
Kementerian Pembangunan Wanita, Keluarga dan Masyarakat,
Tingkat 19, No.55, Persiaran Persint 4,
62100 Putrajaya
Attn: The President, Puan Hajah Nor Amni Yusoff

Dear Puan Hajah Nor,

Permission to invite registered counsellors to participate in Doctor of Philosophy research project: "Counselling in the context of suicidal ideation in Malaysia"

My name is Ling Sai Ang, NRIC: XXXXXX-XX-XXXX and my counsellor registration no. is XXXXXXX. I am a Doctoral candidate at The University of Waikato, Hamilton, New Zealand undertaking a PhD research project investigating counsellors' experiences when counselling clients with suicidal ideation in Malaysia. My research questions are:

1. how do counsellors work collaboratively with their clients?
2. what approaches do counsellors use to develop a good working relationship with the families?
3. how do counsellors assist the families to become effective partners in suicide prevention?
4. how does the legislation shape counselling practice and family responses?
5. how does the religious context shape counselling practice and family responses?

I am writing to ask you to forward an invitation letter and information sheet of my research via email to registered counsellors. I aim to recruit eight to ten counsellors and they:

- Malaysian national and a registered counsellor with the Malaysian Board of Counsellors;
- Experience counselling clients who are struggling with suicidal ideation and where there has been a need to inform the clients' families about the suicidal ideation
- Counselled and assisted families to become effective partners in suicide prevention
- Religious beliefs: two participants from each religion that represent the most prominent religions in Malaysia, i.e. Muslim, Buddhist, Hindu and Christian.
- Indigenous groups: two participants from the largest indigenous groups such as Negrito, Senoi and Proto-Malay from the Peninsular Malaysia; Kadazan-Dusun, Bajau and Murut from Sabah; and Dayaks from Sarawak.
- Those I have no professional contact with, either as a counsellor, counsellor educator or supervisor.

Interest in the topic
I am a counselling practitioner with experience in counselling clients of all ages with suicidal ideation. During initial and on-going counselling sessions, I frequently met with clients who expressed suicide. I have been in the position of collaborating with a client

experiencing suicidal ideation to bring family members into counselling and calling on family members' support in order to take care of the safety and well-being of the client. I experienced this as a time of delicate negotiation as I attempted to promote active participation by my client in counselling, find support for my client, as well as supporting a family to manage the shame or fear they may experience, in the context of the stigma that surrounds those with suicidal ideation. This study arises out of my interest in counselling practice at this time of negotiations.

Data generation
The project will generate data through semi-structured individual interviews. I will audio-record and transcribe the individual interviews. I will seal the transcripts in an envelope, and deliver it to the participants (via the participants' preferred delivery mode) to read, review, amend or remove any material in the transcript.

Anonymity and confidentiality
Anonymity of participants will be protected by using a pseudonym of their choice. Although all measures will be taken to safeguard the identity of participants, anonymity cannot be guaranteed. In the event that a participant mentions the name of their workplace or learning institution, current/former supervisors/supervisees, clients with suicidal ideation, and clients' families during the interview sessions, it is my responsibility to ensure the privacy of other people who are at the centre of the counselling offered to them but not present during the interviews. I will consult with participants if I have any doubt. The results of the study will be published as part of my PhD thesis, may be utilized for future publications and/or presented at professional meetings, but the identity of the research participants, any individual clients, clients' families or agencies, will not be revealed. The research materials and data stored on my personal computer or phone will be password protected. The anonymised materials will be retained for a minimum of five years to allow for academic examination or peer review. After that, I will take responsibility to destroy them safely.

The data-gathering phase of this research is scheduled to begin in Kuala Lumpur and Selangor in July 2015 and to be completed by the January 2016.

This project is being undertaken through the University of Waikato and has been approved by the Faculty of Education Research Ethics Committee. Attached please find a copy of the ethical approval received from Faculty of Education Research Ethics Committee for your information. If you have any queries regarding this study, you can contact me directly at XXXXXXXXX or my mobile at XXX XXXXXXX or my Doctoral Supervisors Dr Elmarie Kotze, at elmariek@waikato.ac.nz and Associate Professor Kathie Crocket at kcrocket@waikato.ac.nz. I look forward to hearing from you soon. Thank you

Yours sincerely,
Ling Sai Ang

Appendix C: Application to recruit particpants – International Counselling Association Malaysia

Ling Sai Ang
No XX, Jalan XXXX
Selangor D. E.
Malaysia

Date:

Persatuan Kaunseling Antarabangsa Malaysia
Pejabat PERKAMA, Lot 3-1B, Jalan Hentian 1C, Pusat Hentian Kajang,
43000 Kajang, Selangor Malaysia
Attn: *Vice President, Prof. Madya Dr. Rusnani Abdul*

Dear Dr Rusnani Abdul,

Permission to invite registered counsellors to participate in Doctor of Philosophy research project: "Counselling in the context of suicidal ideation in Malaysia"

My name is Ling Sai Ang, NRIC: XXXXXX-XX-XXXX and my counsellor registration no. is XXXXXXX. I am a Doctoral candidate at The University of Waikato, Hamilton, New Zealand undertaking a PhD research project investigating counsellors' experiences when counselling clients with suicidal ideation in Malaysia. My research questions are:

1. how do counsellors work collaboratively with their clients?
2. what approaches do counsellors use to develop a good working relationship with the families?
3. how do counsellors assist the families to become effective partners in suicide prevention?
4. how does the legislation shape counselling practice and family responses?
5. how does the religious context shape counselling practice and family responses?

I am writing to ask you to forward an invitation letter and information sheet of my research via email to registered counsellors who are members of the Association. I aim to recruit eight to ten counsellors and the selection criteria are:

- Malaysian national and a registered counsellor with the Malaysian Board of Counsellors;
- Experience counselling clients who are struggling with suicidal ideation and where there has been a need to inform the clients' families about the suicidal ideation
- Counselled and assisted families to become effective partners in suicide prevention
- Religious beliefs: two participants from each religion that represent the most prominent religions in Malaysia, i.e. Muslim, Buddhist, Hindu and Christian.
- Indigenous groups: two participants from the largest indigenous groups such as Negrito, Senoi and Proto-Malay from the Peninsular Malaysia; Kadazan-Dusun, Bajau and Murut from Sabah; and Dayaks from Sarawak.

- Those I have no professional contact with, either as a counsellor, counsellor educator or supervisor.

I am a counselling practitioner with experience in counselling clients of all ages with suicidal ideation. I have been in the position of collaborating with a client experiencing suicidal ideation to bring family members into counselling and calling on family members' support in order to take care of the safety and well-being of the client. I experienced this as a time of delicate negotiation as I attempted to promote active participation by my client in counselling, find support for my client, as well as supporting a family to manage the shame or fear they may experience, in the context of the stigma that surrounds those with suicidal ideation. This study arises out of my interest in counselling practice at this time of negotiations.

The project will generate data through semi-structured individual interviews. I will audio-record, transcribe the interviews and return the transcripts to participants to read, review, amend or remove any material in the transcript. Anonymity of participants will be protected by using a pseudonym of their choice. Although all measures will be taken to safeguard the identity of participants, anonymity cannot be guaranteed. I will consult with participants if I have any doubt.

The data-gathering phase of this research is scheduled to begin in Kuala Lumpur and Selangor in July 2015 and expected to be completed by the January 2016.

This project is being undertaken through the University of Waikato and has been approved by the Faculty of Education Research Ethics Committee. Attached please find a copy of the ethical approval received from Faculty of Education Research Ethics Committee for your information. If you have any queries regarding this study, you can contact me directly at XXXXXXXXX or my mobile at XXX XXXXXXX or my Doctoral Supervisors Dr Elmarie Kotze, at elmariek@waikato.ac.nz and Associate Professor Kathie Crocket at kcrocket@waikato.ac.nz. I look forward to hearing from you soon. Thank you

Yours sincerely,
Ling Sai Ang

Appendix D: Invitation to participate in Doctor of Philosophy research project

Participant's name
Address

Date

Dear counsellors,

Invitation to participate in the Doctoral of Philosophy research project: "Counselling in the context of suicidal ideation in Malaysia"

I invite you to participate in a research study to investigate counsellors' experiences when counselling clients with suicidal ideation in Malaysia. You are selected as a potential participant because you are a registered counsellor with the Malaysian Board of Counsellors (Lembaga Kaunselor Malaysia).

This study is being conducted by me, Ling Sai Ang, a doctoral candidate, supervised by Dr Elmarie Kotze and Associate Professor Kathie Crocket, Department of Human Development and Counselling at The University of Waikato, Hamilton, New Zealand. I invite you to join this research project if:

- You have had experience counselling clients who are struggling with suicidal ideation and where there has been a need to inform the clients' families about the suicidal ideation
- You have counselled and assisted families to become effective partners in suicide prevention
- Your religious belief is Muslim, Buddhist, Hindu or Christian. I hope to recruit two participants from each religion
- You are from one of the indigenous groups: Negrito, Senoi and Proto-Malay from the Peninsular Malaysia; Kadazan-Dusun, Bajau and Murut from Sabah; and Dayaks from Sarawak. I hope to recruit two participants from these groups.
- You have had no professional contact with me, either as a client, student or supervisee.

My research questions are:

- how do counsellors work collaboratively with their clients?
- what approaches do counsellors use to develop a good working relationship with the families?
- how do counsellors assist the families to become effective partners in suicide prevention?
- how does the legislation shape counselling practice and family responses?
- how does the religious context shape counselling practice and family responses?

Together with this letter, I enclose an information sheet that introduces the project and what will be involved if you decide to take part as research participant. I will contact you when/if I receive the Participant Reply Form from you. I appreciate you taking time to consider this. If you would prefer not to take part, please ignore this letter and no further contact will be made. I will leave the information sheet and consent form with you for your consideration. If you are interested to contribute in my research, and would like to find out more, please contact me at XXXXXXXX or my mobile at XXXXXXXX. Thank you.

All the very best,
Ling Sai Ang

Appendix E: Research information for participants

INFORMATION FOR POTENTIAL PARTICIPANTS

Researcher:
Ling Sai Ang

Project Title:
Counselling in the context of suicidal ideation in Malaysia

Thank you for your interest in my study "Counselling in the context of suicidal ideation in Malaysia". Included here is further information about the research.

Purpose of the research
The study investigates counsellors' experiences counselling clients with suicidal ideation. My research focuses on the interplay between the client's well-being and counsellor's duty to protect at the intersection of family involvement in suicide prevention. My research questions are:

- how do counsellors work collaboratively with their clients?
- what approaches do counsellors use to develop a good working relationship with the families?
- how do counsellors assist the families to become effective partners in suicide prevention?
- how does the legislation shape counselling practice and family responses?
- how does the religious context shape counselling practice and family responses?

Your contributions
There are no direct benefits for participating in this study, but your contributions will open up various possibilities in counselling practice. In particular, you will contribute to knowledge and practice in the area of effective treatment and risk management in the presence of suicidal ideation in Malaysia.

Your rights as researcher participant
You will have the right to withdraw completely from the study or withdraw part of your contribution, up to three weeks after receiving the final transcripts of the second interview. You do not need to give me any reason for your withdrawal, and your part or whole contribution during the individual interview will no longer be part of the research materials. You are free to decline to answer any questions. I will turn off the recording when you wish not to record a particular part of the conversation. In some other scenario where it is specifically requested by you to exclude a particular section of the conversation that I already recorded from using as data in the project, I will honour your request without asking for any reason. When the transcripts are ready I will negotiate with you about your preferred mode to receive and return the transcripts, for example, by hand-delivery, email or post. I will invite you to view and amend transcripts of interviews and you are free to remove any material in the transcript.

Individual Interview
You will be involved in two interview sessions carried out by me. The first interview session will last from 45 minutes to 90 minutes, while the second interview session will be 45 to 60 minutes. During the interview, I will ask about your experiences, as a counsellor, with clients who express suicidal ideation. The interview is semi-structured in format and I have a schedule to guide me. I will send a copy of the questions to you one week prior to each interview. I will audio-record the sessions and transcribe the interviews.

Anonymity and confidentiality

Your anonymity will be protected by using a pseudonym of your choice. Although all measures will be taken to safeguard your identity, your anonymity cannot be guaranteed. In the event that you mention the name of your workplace or learning institution, current/former supervisors/supervisees, clients with suicidal ideation, and clients' families during the interview sessions, it is my responsibility to ensure the privacy of other people who are at the centre of the counselling offered to them but not present during the interviews. I will consult with you if I have any doubt.

The results of the study will be published as part of my PhD thesis, may be utilized for future publications and/or presented at professional meetings, but the identity of the research participants, any individual clients, clients' families or agencies, will not be revealed. The research materials and data stored on my personal computer or phone will be password protected. The anonymised materials will be retained for a minimum of five years to allow for academic examination or peer review. After that, I will take responsibility to destroy them safely.

It may be possible that during interviews, you will disclose information where a health or life-threatening situation arises that could potentially harm you, specific third parties or your clients. Should this happen, based on the PERKAMA Code of Ethics (clause A.11 and B.3), such information will be excluded from confidentiality and anonymity. In this situation, we will discuss the matter and I would encourage you to report the specific incident to your workplace supervisor and/or seek counselling supervision.

Concerns

A potential risk of participating in this study will be a possibility that you may find yourself experiencing discomfort elicited by discussing your experiences in providing counselling to clients who express suicidal ideation. If you feel concerned about your responses due to this, we can pause the interview to discuss how you prefer to manage it, for example the means to access professional help and/or seek supervision. Please contact me for any questions. My contact details are:

Contact information in Malaysia:	Contact information in New Zealand:
Mobile phone no: XXXXXXXXXX	Mobile phone no: XXXXXXXXXX
Email: XXXXXXXXXX	Email: XXXXXXXXXX

If you have any concerns regarding this study and would like to talk to someone other than me, you may contact my University supervisors at The University of Waikato, Department of Human Development and Counselling, Private Bag 3105, Hamilton, New Zealand

Dr Elmarie Kotze	Office phone no: 07 838 4466 Email: elmariek@waikato.ac.nz
Associate Professor Kathie Crocket	Office phone no: 07 838 4466 Email: kcrocket@waikato.ac.nz

Appendix F: Participant Reply Form

PARTICIPANT REPLY FORM

Researcher:
Ling Sai Ang

Project Title:
Counselling in the context of suicidal ideation in Malaysia

If you are willing for me, the researcher to contact you, please complete this form, save it and email to me at XXXXXXXXXXX

Participant:

I have read and understand the research information sheet for the above study and I am interested to take part as a research participant.

I am a registered counsellor with the Malaysian Board of Counsellors

I have had past experience of counselling a client who is struggling with suicidal ideation and where there has been a need for me to inform the client's families about the suicidal ideation.

My ethnic background:

☐ Malay ☐ Chinese ☐ Indian
☐ Other (please specify:_____)

My religious belief:

☐ Muslim ☐ Buddhist ☐ Hindu ☐ Christian ☐ Confucianism
☐ Taoism ☐ Other (please specify:_____)

I agree for Ling Sai Ang to contact me on the below telephone number and/or email address to arrange an initial meeting at a time and location that suit me to clarify my queries related to the research.

Signature: _____

Name: _____

Date: _____

My Contact no: _____

My email address: _____

Appendix G: Letter of appreciation to responsent who are not included in the research

Dear <respondent>,

Thank you for your interest in participating in my research project: "Counselling in the context of suicidal ideation in Malaysia". I have been greatly enthused by the responses to my project and at this time I have more participants than required. It is with regret that I inform you at this time your involvement is not required. I am very grateful for your willingness to take part and thank you for your time in responding.

Kind Regards,

Ling Sai Ang

Appendix H: Consent Form for Individual Interview

Consent Form for Individual Interview

Doctoral Research Project: "Counselling in the context of suicidal ideation in Malaysia"

Name of Researcher:	Ling Sai Ang
Contact details:	Email: XXXXXXXXXX
	Mobile number: XXXXXXXXXX
Supervisors:	Dr Elmarie Kotze and Associate Professor Kathie Crocket
Affiliation:	The University of Waikato Department of Human Development and Counselling

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I received the information sheet regarding the research project, I have read the information and have discussed this consent form with the researcher, Ling Sai Ang. I have had the opportunity to ask questions which have been answered to my satisfaction. I understand that I may withdraw completely, or withdraw part of my contribution, up to three weeks after receiving the final transcripts of the second interview without giving any reason. If I have any concern, I can contact the researcher directly or through the University Supervisors.

[Please tick the boxes to confirm your participation.]

- ☐ I agree to participate in the individual interviews for this Doctoral Research Project.
- ☐ I understand that my participation is voluntary and I have the right to withdraw completely from the study at any time without giving any reason.
- ☐ I agree for the interviews to be audio-recorded and transcribed.
- ☐ I understand that the transcripts will be fully anonymised with all identifying information removed. Although all measures will be taken to safeguard my identity, my anonymity cannot be guaranteed.
- ☐ I am aware that I am free to review, amend and remove any material in the transcript.
- ☐ I would like to receive notification from the researcher when the thesis is completed to provide me the link to access the thesis in an electronic form, and it is my responsibility to update the researcher of my up-to-date email address

<u>Your background and experiences</u>

Please respond to the following questions:

1. What is your gender? ☐ Male ☐ Female
2. What is the highest degree you have earned in a helping-related field?

   _____

   _____

3. At what type of agency do you work?

☐ Public Hospital ☐ University Counselling Centre

☐ Private Hospital ☐ School

☐ Independent Practice ☐ Other (Please specify:_____)

4. Does your agency have a written protocol for intervening with a client who is struggling with suicidal ideation? ☐ Yes ☐ No ☐ Not sure
5. How long have you been practising as a counsellor? _____
6. Have you received any formal training related to suicide intervention skills?

☐ Yes ☐ No ☐ Not sure

7. If yes, what type(s) of formal training you received in related to suicide intervention skills?

_____

_____

_____

_____

_____

8. In your current position, how often do you encounter clients who express suicidal ideation?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ daily

9. In your career, how many clients you have counselled who struggled with suicidal ideation? _____.

Signature: _____

Name: _____

Date: _____

Appendix I: Research interview guiding questions

Research interview guiding questions

The following are tentative questions to guide the conversation in my interviews with participants:

First Interview

a) Contextual Questions:

1. On the demographic questionnaire you completed, you mentioned you received formal training in suicide intervention skills, please tell me a little bit more about these trainings. (skip this question if participants responded "No", "Not Sure")
2. To what extent do you feel your training prepared you to counsel clients who speak suicide ideation?
3. Tell me about the agency where you work as a counsellor. What is your role within the agency?
4. You also indicated on the questionnaire that your agency has written protocols for intervening with a client who is struggling with suicidal ideation. What do these protocols involve? (skip this question if participants responded "No", "Not Sure")
5. Can you speak in general terms:
    a. When counselling clients with suicidal ideation in the past or present, do you have access to supervision or opportunity for consultation? If yes, please tell me about this. What difference does it make to your practice to have this support of supervision?
    b. What do you consider the biggest challenges you face when counselling with clients who speak suicide ideation? How do you navigate these challenges?

b) Questions about specific piece of practice:

1. On the demographic questionnaire you completed, you indicated that in your career, you have provided counselling to approximately _____ individuals. In this interview, I would like to focus on one particular experience where the counselling has ended. How long ago was this experience?
2. Please describe what happened.
3. What makes this situation particularly stand out to you?
4. How was this counselling experience different from your usual counselling practice? Did you have to adjust your practice? If so, in what ways?
5. Can you tell me about your responses when your client informed you that s/he is struggling with suicidal ideation?
6. You talked about your responses, may I ask how did you then take care of your *self*?

c) Informing the client that you are going to make the client's families aware about the suicidal ideation:

1. What are possible ways to tell the client of your responsibility to reach out to his/her families about the suicidal ideation?
2. What has it been like for you to tell the client about involving his/her families?
3. How did the client respond to you?
4. What do you believe contribute to a successful collaboration with client to involve his/her families?
5. Whether or not your client support your decision to notify the families; what do you believe is the best practice for this particular situation?
6. What other possible practices are there?

d) Reaching out to the client's families to make them aware of the suicidal ideation:

1. In this particular situation, I am curious to know how did you contact the client's families to alert them about the suicidal ideation? Did you contact them via phone, meet them personally or both?
2. How did the client's families respond?
3. What was it like for you to alert the client's families about the suicidal ideation?
4. After informing the client's families about the suicidal ideation, how did you invite them to join you in a collaborative effort in suicide prevention?
5. In this particular situation, did the families decline or agree to join you?
   Questions to ask if families declined to join:
   - What do you believe contribute to families refused become active partners in suicide prevention?
   - What options did you offer the families?
   - How did you convey this message to your client?
   - What was your next action?
6. Questions to ask if the families agreed to join:
   - What do you believe contribute to the kind of relationship with the families that would invite them to work with you and actively take part in the counselling process?
   - How did you support them?
   - Did you conduct family therapy?
   - When did you conduct family therapy? What inform you the best time to hold a family therapy?

e) Legal Situation:

1. How do you interpret the anti-suicide legislation?
2. When a client indicates that suicidal ideation is present, what role or services do you provide?

3. What sort of concerns do you have in relation to your role or the services you provided for clients and families?
4. In relation to the concerns you mentioned just now, where would you go first for help or advice?
5. What else would be the likely effects of the anti-suicide legislation on your counselling practice in the context of suicidal ideation?

Second Interview

1. Having read the transcript of our first interview - is there anything that stands out as something you would like to discuss?
2. How did you make meaning of this particular event that we talked about in the transcript?
3. What reflections do you have now that you have read it? Would you consider any changes? If so, what will these be?
4. How would you describe the effects of this counselling experience with a client who speaks suicide on you personally? On your work as a counsellor?
5. In what ways do you think this particular experience in counselling a client with suicidal ideation would affect your counselling practice with subsequent client?
6. In retrospect, what would you do differently, if you could hold the session again with your client and his/her families?
7. What advice would you give to other counsellors when counselling a client who expresses suicidal ideation?
8. Do you have any suggestions or requests for counselling supervisors and/or educators that may help inform this study?
9. One last question, is there anything that we have not discussed regarding your experience that you would like to add?

Appendix J: Research Pass