The experiences of C&V self-harm/suicide counsellors, in the Western Health Trust, of the prevalence of alcohol abuse among their clients and their confidence and competence in dealing with these clients.

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Abstract

Background: Research has shown that there is a prevalence of excessive drinking among people who experience self-harm ideation and behaviour, the severity which also increases with the alcohol consumption. The abuse of alcohol by a client has also been shown to create difficulties both for the counsellor and the counselling process. Recent findings in the north-west region of N. Ireland indicated that this geographical area had the highest levels of alcohol use in episodes of self-harm recorded in Accident & Emergency departments of the local hospitals. The aim of this study was to investigate if there was a prevalence of excessive drinking among clients who were referred to community and voluntary sector counsellors and if this had any impact on the self-harm ideation/behaviour and the counselling process itself, including the counsellor's confidence and competence.

Method: A qualitative study was carried out using semi-structured interviews with seven experienced self-harm counsellors from the Western Health and Social Care Trust area. Five of these were generically-trained counsellors and two were cognitive behaviour therapists. The data from the interviews was analysed using a seven step method and relevant information was gathered at baseline then analysed around the questions of, prevalence of drinking, effect of this on self-harm ideation and behaviour, effect on process, effect on counsellors' confidence and competence and whether the counsellors identified any needs in this area of work

Results: All of the counsellors experienced a high and in most cases very high prevalence of alcohol abuse where some clients seemed to be oblivious of the problematic nature of the drinking. All of the counsellors experienced that it lead to increased self-harm ideation and behaviour and, in turn, a greater increase in risk to the clients' wellbeing. The counsellors

experienced an ‘unpredictability’ with clients who abused alcohol compared with those who did not. The counselling process did suffer because of this with the counsellors reporting occasional anxiety and frustration and many experienced negative effects on their confidence and competence. They unanimously agreed that training in this area of work should be part of the core counselling training programmes. Most of the counsellors agreed that professionals need to review the assessment and referral procedures they use as many alcohol abusing clients are inappropriately referred. The CBT therapists seldom engaged alcohol abusing clients as these are screened out at assessment stage and referred on.

Conclusion: There is a high prevalence of alcohol abuse among self-harming clients that leads to increased risk through unintentional episodes of self-harm ideation and behaviour. Self-harm counsellors require more extensive training in working with the problem of alcohol abuse because of this prevalence and in order to minimise the dynamics of low confidence and feelings of being un-skilled in working with this client group. The statutory services would need to review the extent of this problem and focus on assessment and referral protocols as well as ensuring substantial resources are allocated to working with this increasing rise in alcohol abuse especially with this client group. They might also want to reflect on CBT as the preferred model for many who self-harm if, despite the percentage who abuse alcohol, these clients are not engaged because of their drinking.

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Chapter 1. Introduction

By way of outlining the rationale for this specific study the researcher can identify two underpinning motives that have culminated in the choice of this area of investigation.

Firstly from a personal perspective, the researcher developed alcohol dependency over a period of years in the 1980's and early 1990's. In the latter stage of this experience, the use of alcohol led to severe depressive episodes during which the researcher experienced self-harm and suicidal ideation and behaviours. It was obvious at that time that it was only with excessive alcohol use that these behaviours surfaced and that during frequent sober times neither self-harm nor suicidal ideation and behaviours existed. The life problems that alcohol dependency created were numerous and distressing but the use of alcohol to self-medicate these difficulties created a vicious cycle of 'catastrophising' circumstances to the point where life seemed too difficult to face. Of course, when acute alcohol use became the coping mechanism then all other coping skills seemed unachievable. On hindsight the researcher could say that at no time did the sober man want to seriously hurt himself or even to die but in the throes of alcohol abuse these thoughts became frighteningly real. In reality the researcher had to deal firstly with the problem of alcohol dependence before addressing the self-concept issues that created the need for the 'medicine' in the first place.

Secondly, from a professional perspective, the researcher was employed as an addiction counsellor from 2001 to 2004 with Northlands, a Derry-based alcohol problem treatment centre. The researcher was seconded to the Homefirst Trust, Community Addiction Service in the Northern Health & Social Services Board area. All of the referrals the researcher received were from the statutory services i.e. GPs, Social Services, Probation Service, Community Mental

Health teams and the Ross Thompson Unit of the Causeway Hospital in Coleraine. The referrals were all diagnosed as having alcohol and drug problems and referred accordingly for therapy. Through assessments, record-keeping and case-notes the researcher soon noticed a high prevalence of self-harming, even suicidal behaviour, in those referred with alcohol–related problems. At one point, the end of year 2002, the researcher collated the statistics and discovered that 82% of those referred (N=250) had carried out an act of self-harm and 48% of these had acknowledged an act of attempted suicide before being referred to the Addiction Service. Only 20% of these had also been referred into statutory psychological services.

At the same time the researcher worked, in a voluntary capacity, 4 hours per week, as a self-harm/suicide counsellor with Zest: healing the hurt Ltd., a WHSSB-based community counselling service for self-harming and suicidal service-users. Referrals, again, were mainly from the statutory services, as above, but self-referrals were also accepted. Statistically, it soon became evident that those referred as self-harming or suicidal were presenting with high levels of alcohol abuse/dependency, 72%, but only 28% of these had also been referred for or sought alcohol counselling. Although these statistics are based on clinical findings they are very much supported by the recent findings of the Self-harm Registry Project being carried out by the Western Health and Social Services Board since 2007 as well as the longitudinal studies of Haw et al, (2005)

The implementation of the Northern Ireland Suicide Prevention Strategy (2006) resulted in the setting up of specific referral pathways to the Community and Voluntary (C&V) sector for self-harm and suicide counselling throughout the Province, through specific pilot services as well as through the provincial self-harm and suicide telephone helpline ‘Lifeline’.

The researcher is currently a full-time counsellor with the Zest organisation working with exclusively self-harming and suicidal service-users as part of the Northern Ireland Suicide Strategy and still finds that only a small percentage of those who are referred to Zest, and are also abusing alcohol, have also been referred for separate alcohol-related counselling to the Community Addiction Service or relevant community alcohol counselling service.

As will be seen later, much research evidence exists that correlate the co-existence of self-harm/suicide and alcohol abuse, (Berglund & Ojenhagen,1998; Clark & Bukstein, 1998; Tucker 1999; Di Clemente et al., 2001; Baker & Rooney, 2003; Modesto-Lowe et al. 2006; Pirkola et al. 2004; Rossow et al. 2007; Hawton et al. 1997 etc.) however little research has been carried out into the confidence and competence of community and voluntary self-harm/suicide counsellors in dealing with the alcohol abuse issue and how this is impacting on the counselling process.

Knowing that the researcher's own personal and professional experiences as a drug and alcohol counsellor is invaluable as a self-harm/suicide counsellor, the researcher would like to investigate how other community and voluntary self-harm/suicide counsellors in the WHSSB area, find what implications their service-users' alcohol abuse have on their work with those service-users and how they deal with these implications. The researcher has chosen, for this study, the WHSSB area as this has the highest levels, in N. Ireland, of those presenting at A&E after an episode of self-harm/attempted suicide (DHSS&PS 2006; WHSSB 2008.). The study will seek to inform and target current service provision within the WHSSB in particular and the Northern Ireland Suicide Strategy Implementation in general.

Chapter 2. Review of literature

2.1 A definition of Self-harm:

The act of deliberate self-harm is a perplexing behaviour that has been investigated and discussed in the scientific community for many years without definitive results. The term 'deliberate self-harm' superseded the term 'parasuicide' and is defined as:

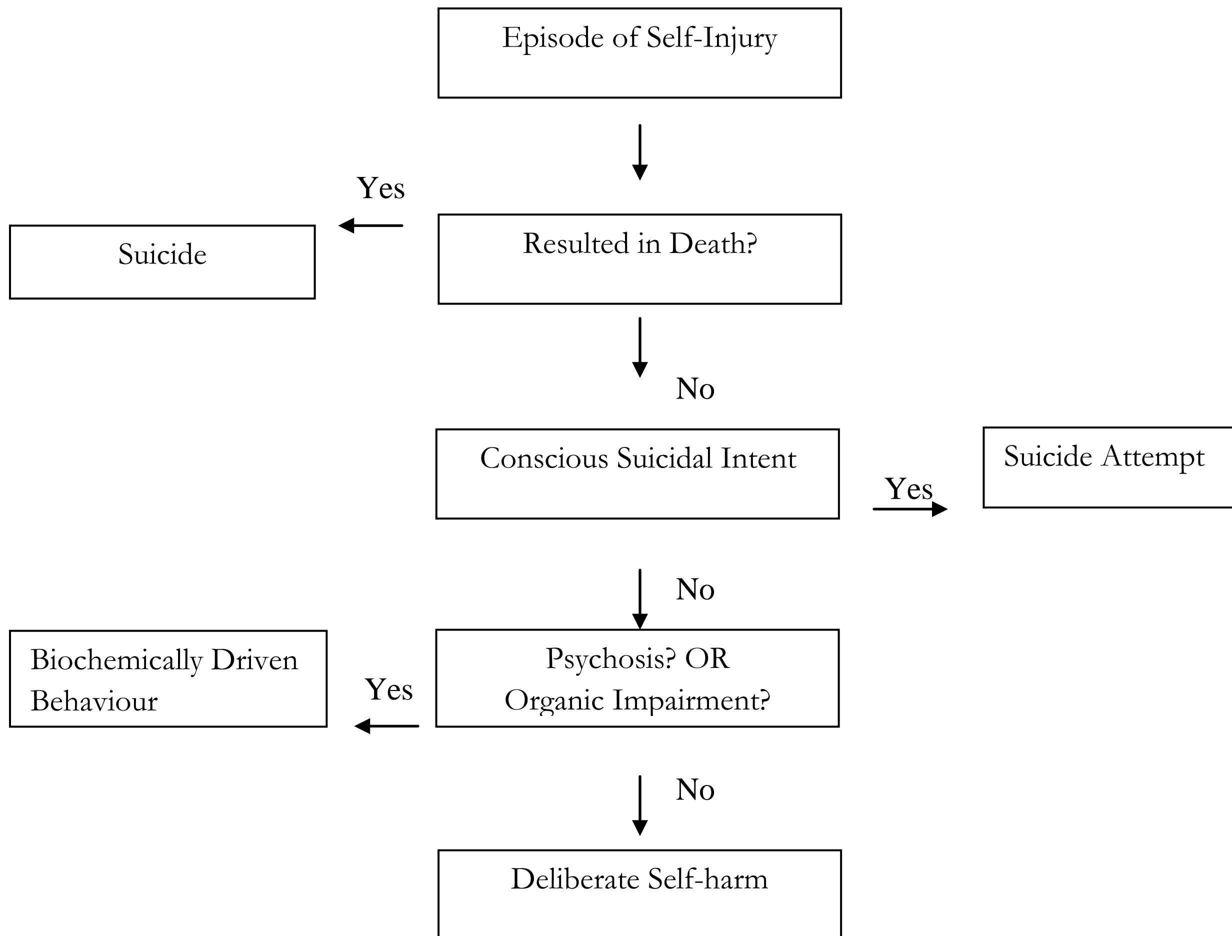
> "An act with non-fatal outcome in which and individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a sub stance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences"
> (WHO/Euro Multicentre Study Working Group, 2001 p.14)

Mangnall & Yurkovich (2008) carried out a review of literature on deliberate self-harm (DSH), from 2000 to 2006 using Health Source, Psychology Proquest and Academic Search Premier Database searches. They found that a variety of names have been attributed to the concept of DSH e.g. episodic and repetitive self-injury (Favazza, 1998), self-harm (Beasley, 2000), repeated self-injury (Crowe & Bunclarck, 2000), self-wounding (Huband & Tantam, 2000), self-injurious behaviour (Alper & Peterson, 2001: Bockian, 2002), para suicide (Conaghan & Davidson, 2002) self-mutilation (Ross & Heath, 2002) and auto-destructive behaviour (Kocalevent et al., 2005). They also found that recent literature defines the phenomenon of DSH in different ways as well. For example, some define DSH as existing only when the intention is clearly **not** to kill oneself (Conaghan & Davidson, 2002), whereas Klonsky et al., (2003) and Ross & Heath, (2002) define DSH as existing when there **is** a clear intent to kill oneself. Others define DSH as self-harm

regardless of the intent (Saxe, Chawla, & van der Kolk, 2002). From the review of the literature Mangnall & Yurkovich (2008) derived a definition of this concept that is schematically depicted in Figure 1 and is defined as:

> "…a direct behaviour that causes minor to moderate physical injury, that is undertaken without conscious suicidal intent, and that occurs in the absence of psychoses and/or organic intellectual impairment."

Figure 1. Differential Algorithm of Deliberate Self-harm: (Mangnall & Yurkovich, 2008, p.177)



The client group that attends for counselling in this study, are usually referred after an episode of self-injury/self-poisoning and so can fall within the definitions of 'attempted suicide' or 'deliberate self-harm' and a small number have been known to go on to complete the act of suicide after referral for counselling. Although official figures are not available or collated in this respect, one organisation involved in this study reported the suicide of two clients who had been referred out of a total of 117 referrals..

2.2 The Co-existence of Alcohol Abuse and Self-harming Behaviour

In their review of literature on acute alcohol abuse and suicidal behaviour Cherpitel et al (2004) found that the majority of studies in MEDLINE, The Institute for Scientific Databases, EMBASE and Cochrane Library, showed a wide-range of alcohol positive cases were found for both completed suicide and suicide attempts. The countries represented in the review included, USA, Australia, Finland, Canada, Scotland, Sweden, England, Northern Ireland, Germany, Norway and South Africa. Cherpitel et al. (2004) reviewed 37 studies that included data on acute alcohol use and completed suicide and found an average acute alcohol use of 37%, the median was 36% and the range was 10 to 69%. Table 1 shows the range of alcohol positives by method of suicide.

Table 1: Range of Alcohol Positives by Method of Suicide

(Cherpitel et al. 2004 p.20S)

Method	% alcohol positive
Asphyxiation, hanging, strangulation, suffocation (5 studies)	10-38%
Burn, self-mutilation, electrocution (2 studies)	43-67%
Drowning (4 studies)	06-26%
Gunshot wound (8 studies)	20-62%
Jumping from a height (4 studies)	06-26%
Self-poisoning (8 studies)	07-51%
Stabbing, cutting, piercing (3 studies)	07-16%
Railway, motor vehicle intentional accidents (6 studies)	03-65%

For the 16 studies reviewed that included data on acute alcohol use and suicide attempts, the mean percentage of alcohol use was 40%, the median was 41% and the range was 10 to 73%, These findings were based on self report, blood alcohol content (BAC), toxicology, breath analysis and medical notes review. Of the 16 studies, 4 did not specify the methods used in the suicide attempts. For the 12 studies that did report specific methods used, 6 studies focussed exclusively on those who had attempted self-poisoning whereas the remaining 6 studies focussed on a variety of methods attempted and self-poisoning attempts ranged from 63 to 96% of the samples. The range for acute alcohol use among victims of self-poisoning was 10-63% (mean43%: median 49%). The next most common methods reported listed in order of frequency were self-laceration, hanging and jumping from a height. The literature review also indicated a significantly higher risk of suicide before during or shortly after the use of alcohol compared with alcohol-free periods. Cherpitel et al. (2004) also concluded that all individuals with alcoholism should receive a suicide risk assessment based on known risk factors.

There has been a long tradition of sociological and epidemiological studies on suicidal behaviour dating as far back as Emile Durkheim in the late 1800's. (Silverman 2006) Although Durkheim (1951) considered alcohol abuse was only an individual and psychopathological factor in suicide it is now generally accepted that alcohol consumption is a sociological phenomenon that has a strong impact on self-harming and suicidal behaviours. (Berglund & Ojenhagen,1998; Clark & Bukstein, 1998; Tucker 1999; Di Clemente et al., 2001; Baker & Rooney, 2003; Modesto-Lowe et al. 2006; Pirkola et al. 2004; Rossow et al. 2007; Hawton et al. 1997; Academy of Medical Sciences 2004; Sher 2006; Preuss et al. 2003 & 2006; Toumbourou et al., 2002; Skinner et al 2004; Gorwood 2001; Schneider et al. 2006; Cherpitel et al., 2004; Hufford 2001).

These studies indicate that the role of alcohol in suicide behaviour has several aspects. The lifetime risk for suicide in people with alcohol abuse or dependence is almost six times the expected risk. (Baker & Rooney, 2003) It is assumed that long term acute use of alcohol induces depressed mood, thus increasing vulnerability for suicidal behaviour (Clark & Bukstein, 1998). It is also likely that associations between the use of alcohol and suicidal behaviour are to some extent confounded by various shared risk factors, (Di Clemente et al., 2001), mental health and impulsivity (Preuss et al., 2003), or that both behaviours initially serve the same purpose, such as temporary relief from distress. Acute intoxication may even trigger the suicidal act in vulnerable individuals through increasing impulsiveness, enhancing depressive thoughts and suicidal ideation, limiting cognitive functions and ability to see alternative coping strategies and reducing barriers for deliberate self-harm. (Hufford, 2001; Academy of Medical Sciences, 2004).

2.3 The Increase of Alcohol Abuse in Self-harming Episodes

Haw et al. (2005) carried out a longitudinal study spanning 14 years in the Oxford area and concluded that there had been a significant increase in excessive drinking shortly before or at the time of self-harming behaviours by patients aged 15 years and over. During the 14-year study period, 1989 – 2002, a total of 10,414 DSH patients presented to the general hospital in Oxford, England. Of these, 8.6% were diagnosed as suffering from alcohol dependence at the first assessed episode during the study period (see Table 2). Alcohol dependence was more common in males than females. Excessive drinking was present in a total of 23.4% of the DSH patients and was also significantly more common in males than females.

Table 2. Alcohol dependence and excessive drinking in DSH patients at first assessed episode during the study, 1989-2002. (Haw et al. 2005, p. 965)

	Both genders (N=7,916)		Males (N=3,251)		Females (N=4,665)	
	N	%	N	%	N	%
Alcohol dependence	682	8.6	447	13.7	235	5.0
Excessive drinking	1,854	23.4	953	29.3	901	19.3
No alcohol misuse	5,380	68.0	1,851	56.9	3,529	75.6

The annual overall number of male DSH patients rose progressively over the period of the study, 1989-2002, while there was no significant change in the number of males with a diagnosis of alcohol dependence. The annual number of females also rose progressively during the study and again there was no significant increase in those diagnosed with alcohol dependence. (See

Appendix 2). However, the proportion of DSH patients diagnosed with excessive drinking behaviours rose significantly during the period of the study from 23.1% to 31.1%. (See Appendix 3)

Other significant findings in this study showed that 46.1% of DSH patients consumed alcohol within 6 hours of the DSH episode.

> "Patients with a diagnosis of alcohol dependence or excessive drinking were more likely to have consumed alcohol as part of the act of DSH than those without these diagnoses, (alcohol dependence (59.9%) vs. excessive drinking (40.2%) vs. no alcohol misuse (17%)" (Haw et al. 2005, p. 969).

NHS Quality Improvement Scotland (2007) carried out a study on harmful drinking in relation to presentations at emergency departments in Scotland as a result of self-harm. A total of 3,454 patients were seen in the emergency departments as a result of self-harm. 62% of males and 50% of females reported consuming alcohol before the episode of self-harm. 27% of males and 19% of females cited alcohol as the reason for self-harming. Clinical staff reported that 32% of males and 20% of females had alcohol-related conditions in their past medical history. (NHS Quality Improvement Scotland, 2007, p. 9)

O Connell & Lawlor (2005) found that alcohol use and suicidal behaviours are among the most prevalent and damaging of all psychiatric phenomena in Ireland and highlighted the importance of identifying and tackling acute alcohol intake and binge drinking as a risk for suicidal behaviour.

2.4 The WHSSB Experience: A Comparative Study

The Northern Ireland Suicide Prevention Strategy, 'Protect Life – A shared Vision' (DHSS&PS 2006) set out to tackle the issue of suicide and self-harm with actions targeting both the general population and those individuals and communities most at risk. Part of the strategy included a parallel implementation with the Republic of Ireland's Suicide Prevention Strategy 'Reaching Out' (HSE 2005) particularly in the work of the Irish National Registry of Deliberate Self-harm which is operated by the National Suicide Research Foundation (NSRF) in Cork which has been collecting data from a number of general hospitals since 2002. In 2007 The Department of Health, Social Service and Public Safety, Northern Ireland (DHSS&PSNI) commissioned a Pilot Study to implement the work of the NSRF in the Western Health and Social Services Board area (WHSSB). For this pilot project information was collated on the incidence of hospital attendance due to self-harm behaviour at Accident & Emergency Departments in Altnagelvin Hospital, Derry, Tyrone County Hospital, Omagh and Erne Hospital, Enniskillen.. The aim was to identify trends and patterns of self-harm which in turn will inform and target resource effectively.

The WHSSB (2008) The Interim Report for 2007 found a self-harm incidence rate of 471 per 100.000 in the Western Board compared to 236 per 100,000 in the Republic of Ireland. (See Table 3).

Table 3. The Incidence rates per 100,000 in the WHSSB and Republic of The Ireland.

(WHSSB 2008, p.20)

	Males	Females	Total
WHSSB	437	505	471
Rep. of Ireland	205	267	236

A further comparison with three centres in England and main cities in the Republic of Ireland shows that Derry City Council area has an incidence rate of 621 per 100,000 compared with Manchester 527, Leeds 333, Oxford 314 (Hawton, 2007) and Limerick 556, Dublin 354, Galway 351, Waterford 332 and Cork 322 (Corcoran & Perry 2007). (See Table 4)

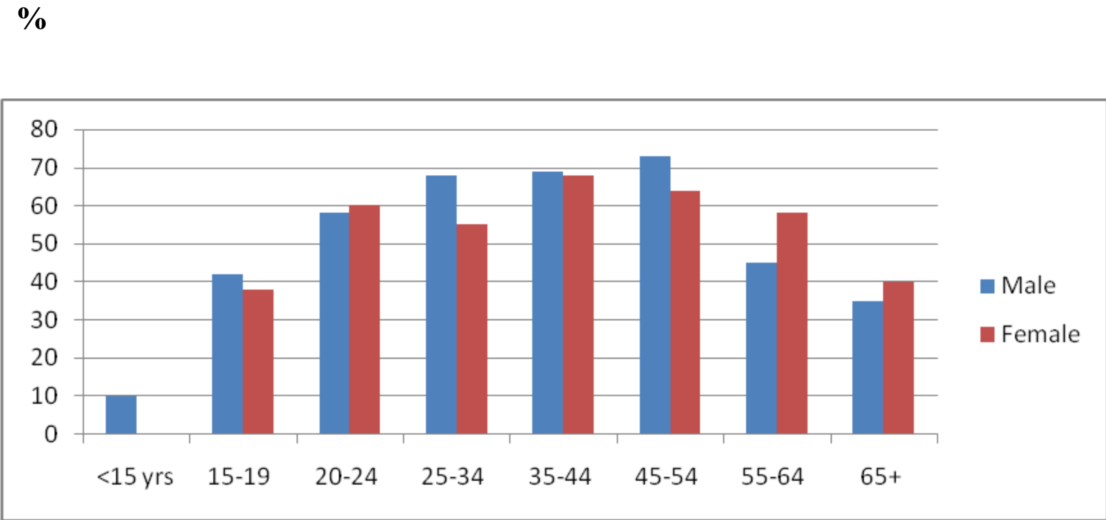
Table 4. Incidence rates per 100,000 in WHSSB compared to Republic of Ireland and UK cities. (WHSSB, 2008, p. 20)

	Males	Females	Total
Derry City	616	626	621
Limerick	573	543	556
Manchester	460	587	527
Dublin	313	396	354
Galway	369	333	351
Leeds	291	374	333
Waterford	338	323	332

Cork	330	313	322
Oxford	285	342	314

The study's findings did not highlight alcohol as a main method of self-harm but alcohol was involved in 59% of all cases (See Table 5). Alcohol was involved significantly more often in male self-harm episodes (64%) than in female (55%). This was higher than the Republic of Ireland where alcohol was involved in 44% of male episodes and 38% of females. (See Table 6)

Table 5. Percentage of episodes with alcohol involved by age-group. (WHSSB, 2007, p. 26)

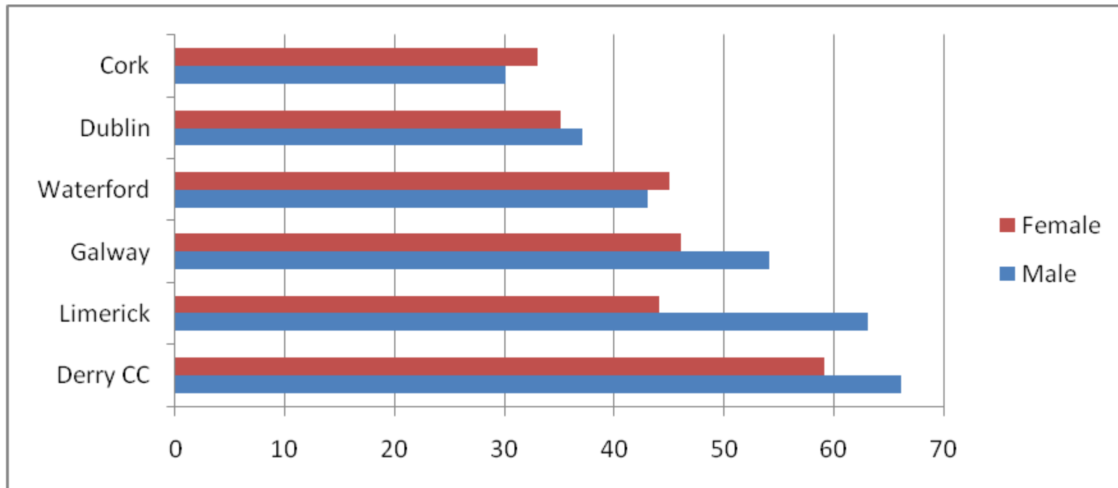


There was a clear pattern in the use of alcohol with ages for both genders. Its frequency increased with age for both genders, peaking for males at 73% in the 45-54 year olds and for females at 67% in the 35-44 year olds. Derry City Council area had the highest overall percentage of episodes of self-harm involving alcohol at 63%.

Table 6. Percentage of self-harm episodes involving alcohol by gender in cities (all-island).

(WHSSB, 2007 p. 29)

Cities



Percentage of Episodes Involving Alcohol

All of the above studies highlight the potential implications for self-harm/suicide counsellors in the WHSSB area whose clients are abusing/dependent on alcohol, but little literature exists as to what these implications are.

2.5 The Counsellor and Alcohol-abusing Clients:

Shaw et al (1978) found a role insecurity and low therapeutic commitment in a survey of professionals such as social workers and probation officers working with clients with drinking problems. Shaw et al. (1978) found that there were four main characteristics of professionals who felt a high degree of therapeutic commitment:

- They were experienced in working with drinkers
- Role support was available
- They had received counsellor training
- They had clinical knowledge about alcohol and alcohol related problems

> "Agents with few or no anxieties about their role adequacy knew, for instance, how to recognise acute withdrawal symptoms, to describe patterns of behaviour of the highly tolerant drinker, and the likely physical, social and psychological consequences of excessive drinkers" (Shaw et al. 1978, pp.165-166)

Although this study did not focus specifically on counselling professionals it still highlighted some of the effects of clients' misuse of alcohol on the therapeutic relationship.

Wheeler & Turner (1997) in examining counsellors' attitudes towards working with people with alcohol problems and perceptions of problem drinking highlighted a lack of previous research and what there was referred to counsellors working specifically in alcohol-related settings. Leavy (1991) investigated the characteristics of 223 alcohol-related counsellors and their perceptions of what constitutes a drink problem. Kurtz (1984) surveyed Alcoholics Anonymous members and professional alcohol-treatment centre directors to look for ideological differences between them. Mc Govern & Armstrong (1987) examined the attitudes of recovering alcoholic counsellors and

non-alcoholic counsellors and found no significant differences. Roche et al. (1995) surveyed trainee psychiatrists in Australia and New Zealand to learn how much the trainees knew about substance abuse and the treatment of problem drinkers. The research concluded that there was a need for specific strategies to enhance the training and performance of psychiatrists working with problem drinkers.

Wheeler & Turner (1997) carried out a study of generic counsellors' attitudes and experiences in working with people with drinking problems. This was after Alcohol Concern (1987) had estimated that up to one million individuals in England and Wales had alcohol related problems with 25% of males and 10% of women running the risk of developing an alcohol problem at some time in their lives. More recent statistics (Drink Aware 2009) show that 10 million people in England drink above the recommended guidelines while 33,000 deaths occur each year as a direct result of alcohol abuse. In N. Ireland a survey of 1753 respondents carried out in 2008 found that 32% of those surveyed admitted to binge drinking while 10% admitted to having an alcohol problem. (N. I. Statistics & Research Agency, 2008)

Wheeler & Turner (1997) designed a questionnaire to ask generic counsellors about their attitudes, experience and understanding of working with people with alcohol problems and about their knowledge and understanding of Alcoholics Anonymous. The counsellors were also asked what sort of problem they thought alcoholism was (see Table 10). The category chosen most frequently was 'a mental health problem'.

Table 7. Which of the following is the closest to how you view alcoholism? (Wheeler & Turner 1997, p322)

A moral problem	01
A mental health problem	43
A socio-economic problem	14
A spiritual/existential problem	23
A disease	23
Other	06

(N=94: some respondents thought it was a combination of two or more of these categories)

While 68% of the counsellors questioned claimed to have experience of counselling problem drinking clients, 25% of these 94 counsellors said they would not be willing to engage such clients in the future. Their reasons are outlined in Table 8

.

Table 8: Reasons for refusing further clients with alcohol-related problems (Wheeler & Turner 1997, p322)

Reason	Count
Therapeutic alliance difficult to establish	7
They are difficult to work with	5
Alcoholic clients do not attend regularly	3
Counsellors have their own issues around drink	2
Counsellors feel de-skilled	2
Experience of clients coming to sessions drunk	2
Other unstated reasons	2
Total	23

When asked if their clients attended with alcohol abuse as their presenting problem, 34% of the counsellors replied in the affirmative and 48% replied that this usually came to light at a later point in the therapy. Given their experience the counsellors were asked how they would respond now to clients presenting with alcohol-related problems and 54% indicated that they would consider the clients for therapy, while 14% said they would take the clients themselves and 27% said they would refer them to an alcohol counselling agency.

On the issue of skills and training (see Table 9) counsellors were asked how skilled they felt in dealing with alcohol-related issues and found that the more experienced counsellors felt more skilled. They found that generic counsellors tended not to feel competent working with such clients. Feelings of competence increased with greater experience of this client-group and, to a lesser extent, with more hours of specialist training.

Table 9: How skilled do counsellors think they are in dealing with alcohol problems?

(Wheeler & Turner 1997, p323)

	N	%
Feel highly skilled	3	(5)
Feel competent	35	(54)
Feel de-skilled	20	(31)
Feel useless	3	(5)
Feel alternately de-skilled and competent	3	(5)
Total	64	

Other studies that investigate the areas of competence and confidence of professionals include Shaw et al. 1978; Roche et al. 1995; Lindstrom 1992; Clark 1987; Biegel et al. 1977) As previously indicated these studies are not specifically related to generic counsellors' experiences of alcohol abuse in clients. It seems to me that while the majority of studies clearly define the correlation between alcohol abuse and self-harm/suicide the same studies are weak in examining or defining the causal effect of alcohol abuse on these behaviours. This point is also highlighted in Cheryl (2004) and Rossow et al. (2007).

In conclusion the research cited has defined the nature of self-harming in order to explain the nature of the client group that the chosen participants work with, through the findings of Mangnall & Yurkovich (2008), It also highlights the evidence that exists that shows a significant correlation between the co-existence of alcohol abuse in self-harming episodes as presented by

Cherpitel et al. (2004), Hawton et al. (1997), Schneider et al. (2006), Preuss et al. (2006), Rossow et al. (2007) etc.. Haw et al. (2005) found that there had been a significant increase in excessive drinking before or at the time of self-harming behaviours in a total of 23.4% of patients over a 14 year period in the Oxford. However the WHSSB (2008) in a comparative study of 9 cities in the UK and Ireland showed not only was alcohol abuse involved self-harming increasing but that the WHSSB, in general, and Derry, in particular, had the highest statistics for alcohol abuse and self-harming patients who presented at the Accident and Emergency department of Altnagelvin Hospital with an average of 59%.

Shaw et al. (1978) and Wheeler & Turner (!997) found that there were issues of confidence and competence for those who worked with alcohol abusing clients. However, the researcher was unable to find any recent studies that examined the impact, if any, that alcohol abuse had on the counselling process, in particular with clients who were self-harming. Considering that the WHSSB (2007) Self-harm Registry statistics showed the highest rates of this phenomenon in the Western Area of N. Ireland then it seemed a natural focus point for this study and is well supported by existing findings.

Chapter 3. Research methodology

1. Rationale

In considering the research methodology for this study there were several factors that determined the choice of approach. It was initially evident that due to the small number of community and voluntary self-harm/suicide counsellors in the WHSSB area that a quantitative approach might not lend itself to reliable or valid findings. As the research question is open-ended and exploratory and not precise and hypothesis-testing then a qualitative approach seemed the more appropriate option (McLeod 2007). The question also focused on helping to develop a sensitive understanding of the nuances of the therapeutic process in relation to the implications of alcohol abuse on the self-harm counselling process. This indicated that a qualitative process study as being more appropriate (Creswell, 2007).

By using this qualitative approach the researcher was able to address questions that were not amenable to quantification, to study more complex aspects of experience, to allow for a more flexible approach as the data was not constrained by a pre-existing hypothesis and this allowed the participants more freedom of expression. (Silverman, 2008)

As Barker et al (1999) point out a qualitative approach is built on phenomenology i.e.

> "that which appears real to the senses regardless of whether their underlying experience is proved real or their nature understood" (p 74)

The phenomenological approach distinguishes 4 central assumptions, namely, perceived meaning, understanding of the person's experience in the form of descriptive narrative, lists of themes or defining features, each person's perspective has its own validity and what we perceive

is based on many assumptions about ourselves, others and the world. (Cresswell, 2007, pp. 59-61)

The phenomenological method is made up of two key features, bracketing and describing. (Barker et al 1999; Cresswell, 2007: Husserl (1931) describes bracketing as the attempt to put to one side one's own assumptions, biases and expectations as far as reasonably possible until the end of the study. Spinelli (1989) highlighted that description should involve a focus on the immediate, specific impressions as opposed to the abstract or general and trying to avoid explaining but rather discover meaning. Moustakas' (1994) 'transcendental' or 'psychological phenomenology' is less focussed on how the researcher interprets the issues and more on the description of the participants' experiences. Moustakas (1994) defines 'transcendental' as "everything is perceived freshly as if for the first time" (p.34).

The researcher's intention was to describe his own experiences with the phenomenon and bracket out these views before proceeding with the experiences of the participants. However it was evident during some of the interviews that the researchers own views became apparent in some of the interjections and comments. This would concur with Moustakas' (1994) own admission that this state is seldom perfectly achieved.

The method of interviewing was chosen by the researcher in order to collect the participants' experiences of self-harming clients who also abuse alcohol, in therapy sessions. Rubin & Rubin (2005) point out:

> "If what you need to find out cannot be answered simply or briefly, if you anticipate that you need to ask people to explain their answers or give examples or describe their experiences, then you rely on in-depth interviews. Through qualitative

interviews you can understand experiences and reconstruct events in which you did not participate." (pp.2-3)

Semi-structured interviews allowed the participants to articulate their personal experience of the phenomenon through the open-ended questions and at the same time this method allowed the researcher to discuss some issues in more detail with the participant and both were also able to raise new issues of relevance. (Denzin and Lincoln 2008) The researcher was also able to explore issues that arose with the participant in order to elaborate on their original response or to follow up a further line of enquiry that became significant.(Rubin and Rubin 2005).

Face to face interviews were chosen as the researcher believed that the participants would not be hesitant to speak and share experiences and ideas. The relaxed informal settings for these interviews were also available. Telephone interviews were considered to accommodate maybe the less articulate and shy participant but participants showed a preference for one-to one meetings. This allowed the researcher to pick up on any informal communication that telephone interviewing would miss. (Creswell, 2007) The focus group interview was ruled out as it would have been impossible to get the group together at the same time considering their geographical spread and their workloads.

2. Participants and means of recruitment used

The researcher's original intention was to carry out the study by interviewing eight suitable participants, however, due to the comparatively narrow focus of the study, as well as professional and personal circumstances among the consenting participants that led to

postponements and cancellations of pre-arranged meetings, the researcher carried out seven interviews. This was agreed with the study supervisor.

This study was carried out with 5 female and 2 male C&V self-harm/suicide counsellors who work in the WHSSB area. The participants came from different areas of the WHSCT area and represented the geographical spread of Limavady, Derry, Strabane, Omagh and Enniskillen. The researcher used those organizations that are contracted to Lifeline, the DHSS&PS-funded provincial counselling helpline, to provide counselling services for those who are in distress and self-harming/suicidal. These organizations have been audited by Contact Youth (Lifeline) through a contracting process, as to their suitability to carry out this work with self-harming and suicidal clients. By choosing these counsellors the researcher had established a consistent and appropriate standard of practice that has been impartially verified to a recognised level. (See Appendix 2 for Lifeline criteria for Counsellors)

Contact was made with the managers of those organisations to explain the study and the researcher asked them to discuss this with the counselling staff and to provide contact details to any counsellor willing to discuss the study. Interested parties were sent a letter with a reply slip and stamped addressed envelope to confirm their willingness to participate in the study. This allowed them a short time to consider their participation. The researcher then provided interested parties with a comprehensive information sheet. The participants had the main question areas in advance so that they could prepare for their interviews and feel more in control of the interaction (McLeod, 2007). (See appendix 3). After the interviews had taken place, each participant signed a consent form for the use of the material and an acknowledgement that they understood the terms and conditions of the use of the material (See Appendix 3). Letters of thanks were sent out to each participant at the end of the study. (See Appendix 7)

Four of the participating counsellors were generic in their practice, i.e. integrative in their approach to counselling practice, two were Cognitive Behavioural Therapists who offered this model of therapy to their clients and the other counsellor was also generic in the approach although the counsellor also had 25 years experience as an addiction counsellor with the Sperrin Lakeland Trust.

3. Procedure

The researcher met with each participant in a venue that was suitable to him/her. All the interviews were carried out in the participants' own places of work. The settings were comfortable and relaxed and privacy was maintained. The researcher spent time in advance reviewing the nature and process of the study and the interviews in particular. Although the researcher carried out this preparation on tape for the first two participants it was decided to do this in advance of taping for the remaining participants. This allowed for a final informed consent before the interviews began. All interviews were tape-recorded and subsequently transcribed verbatim by the researcher who found that this helped get a greater feel for the content.

The key questions and exploratory prompts that the researcher used were:

1. How prevalent do you find the co-existence of alcohol abuse with your service-users?
    - What action is the service user taking to deal with their alcohol abuse?
2. How do you think that their alcohol abuse affects their self-harming and/or suicidal behaviour
3. What effect do you think their alcohol abuse has on the counselling process

4. How confident do you feel dealing with alcohol abuse with your service-users?
    - What do you find particularly difficult, if anything?
5. How competent do you feel dealing with alcohol abuse in your service-users?
    - What specific training have you undertaken, if any?
    - How effective has this training been in equipping you to deal with this issue?
6. What steps, if any, do you think need to be taken to address the issue of alcohol abuse within self-harm and suicide counselling?

As McLeod (1999) recommends the researcher began the study by interviewing

> "…..one or two informants whom you know to be tame, friendly, co-operative and robust…..Tape-record the interview. Transcribe it. Look closely at the process of the interview and review it with your supervisor. Where did you try to go too deep? Where could you have gone deeper?" (p. 124)

This allowed for a more focussed process for the remaining interviews. The interviews ranged in length from 1850 words, 20 minutes in length, for the shortest interview to 8500 words, 55 minutes in length, for the longest interview. The average word count for the 7 interviews was 3800 words.

4. Method of data analysis

The researcher used the Jenkins (1994) seven point guide to data analysis. This was very similar to the Miles and Huberman's (1994) data reduction strategy. It was decided to use this method of analysis as it was seen as being best fit for the qualitative approach being used. The researcher

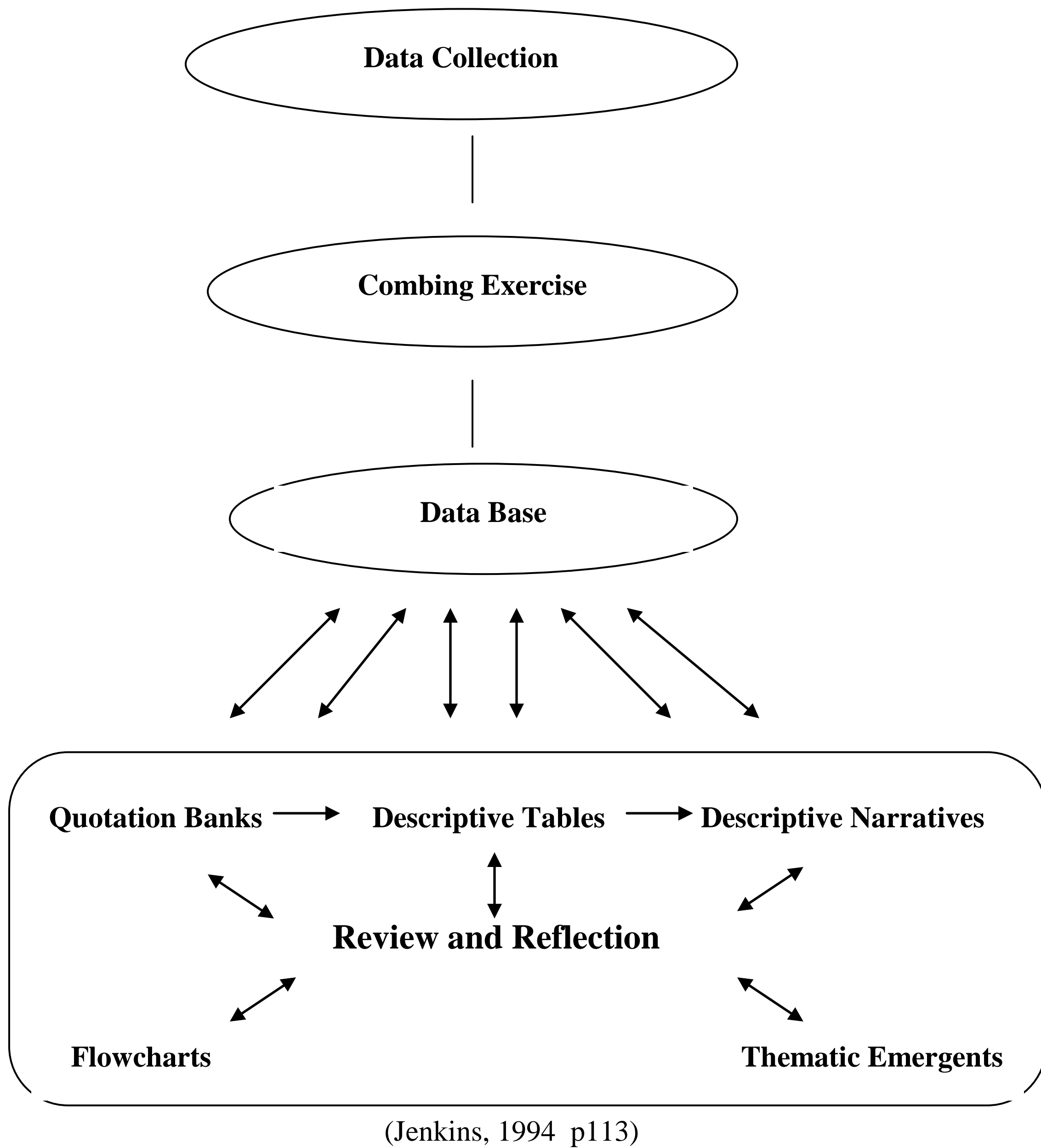
wanted to get as in-depth an analysis of interview content as possible and saw this as being an excellent method of achieving this.

After the initial data collection and verbatim transcription of interviews the analysis involved:

1. **Combing exercise:** reducing data to a manageable level by getting rid of superfluous material which in turn provided me with a **data base** i.e. baseline material about how individuals are experiencing the topic from which to identify participant statements that seek explanation,
2. **Quotation Bank:** comprising of the above statements that produced either a thematic or group based storyline
3. **Descriptive tables:** by examining each question across the different participants the researcher was able to reduce and display the data findings in table form
4. **Descriptive narratives:** these are accounts relating to each table that ensure a complete representation of the findings that provide qualifying content on a group basis. At this point anomalies were highlighted which would need further analysis.
5. **Review and reflection** of the quotation banks, descriptive tables and descriptive narratives in order to highlight emerging data
6. **Thematic emergents:** this involved a re-examination of data in order to verify or nullify the thematic findings
7. **Flow charts** were then created to summarise the study findings

The data analysis method process can be summarised in the following flow chart (Figure 2)

Figure 2: Data Analysis Method



(Jenkins, 1994 p113)

When considering the validity of the findings in the study the researcher followed Polkinghorne's (1989) notion that the idea is well grounded and well supported. He asks:

"Does the general structural description provide an accurate portrait of the common features and structural connections that are manifest in the examples collected." (p. 57)

He goes on to suggest some points that researchers should keep in mind and which the researcher tried to keep focussed on throughout the data collection and analysis:

1. Did the researcher influence the contents of the participants' descriptions in such a way that the descriptions do not reflect the participants' actual experiences?
2. Is the transcription accurate and does it convey the meaning of the oral presentations in the interviews?
3. In the analysis of the transcriptions were there conclusions other than those offered by the researcher that could have been derived?
4. As mentioned above, is it possible to go from the general structural description and to account for the specific contents and connections in the original participants' experiences?
5. Is the structural description situation specific or does it hold in general for the experience in other situations? (Polkinghorne, 1989, pp. 57-59)

Throughout, the researcher sought to convey the overall essence of the experience of the participants and tried to remain reflexive throughout. (Creswell, 2007, p 159)

5. Ethical considerations

Due to the nature of these interviews the researcher did not perceive a great likelihood that participants would find the interviews distressing. However, alcohol abuse affects many individuals and families, so the researcher fully informed the participants of the nature of the study prior to taking part and, as previously mentioned, the researcher asked each one to sign a consent form, pointing out their ability to leave the study at any point in time. (Silverman 2008)

Another possible ethical scenario might have been where a participant has experienced the suicide of a client as a result of alcohol abuse and this might have caused the participant emotional distress. If, at any point during the interviews, the participant had become distressed by the issues the researcher would have terminated the interview immediately and offered the participant contact information where he/she could have accessed support.

By way of client confidentiality all participants were instructed not to reveal the identity or specific details about particular clients. Participants were encouraged to talk in more general client terms and to focus primarily on their own experiences. The confidentiality of the participants' contributions were also be emphasised. (McLeod 2007) The researcher also endeavoured not to disclose the identity of the participants during the interviews. Where this did happen on a few occasions, the researcher deleted the name from the tape and ensured that it was not included in the transcription.

A personal ethical consideration that the researcher needed to keep in mind at this time is the fact that the researcher experienced alcohol dependency for several years during which time the researcher also experienced suicidal ideation and behaviour. Any issues of counter transference have been addressed over the years in clinical supervision. If, however, the researcher had been

affected or distressed by any part of this study he would have immediately notified his supervisor and sought personal support, before deciding with his supervisor whether to continue with the study. Part of the challenge of this study for the researcher was to maintain a personal objectivity for the issues being studied while at the same time acknowledging the life experience.

Throughout the study the researcher closely adhered to the principles of the BACP Ethical Framework, namely: autonomy, fidelity, justice, beneficence, non-maleficence and self-care and acted with integrity and honesty at all times. (Silverman, 2008)

An application was made for ethical approval to carry out the study from the University of Ulster Ethics Committee and this was granted after due consideration. (See Appendix1)

Chapter 4. Data Analysis

The analysis of the data involved seven steps (Jenkins 1994)

1. The data was reduced to a manageable level through a combing exercise in which superfluous data was eliminated from the transcriptions. This provided a baseline of material about how the participants experienced the phenomenon and which allowed
2. Quotation banks for each participant to be created.
3. As a way of categorising data from the interviews a detailed examination of each question across the quotation banks was carried out to create descriptive tables.
4. Then, to ensure a full representation of the findings descriptive narratives were created in relation to each table
5. All of the above were then reviewed and
6. Thematic findings were discussed
7. These were then summarised in flow charts.

4.1 Descriptive Tables and Descriptive Narratives

Table 10: Descriptive Table Question 1

Q.1 Prevalence of alcohol abuse among self-harming and suicidal clients	**#1 Generic**	**#2 Generic**	**#3 Generic**	**#4 CBT**	**#5 CBT**	**#6 Generic**	**#7 Generic (former addiction)**
Low prevalence					X		
High prevalence	X	X	X	X		X	X
Unexpected prevalence	X	X				X	X
Clients aware of the problem		X					X
Clients unaware	X		X	X	X	X	
Client denying and minimising problem	X	X	X	X	X	X	X
Client believes drinking is 'normal'	X	X	X	X	X	X	X
Drinks to cope	X	X	X	X	X	X	X

Descriptive Narrative 1: Question 1

The response to question one about the prevalence of alcohol abuse with self-harming clients drew a unanimous response from the seven participants. It was interesting to note that all the participants answered this question without any hesitation whatsoever and were quite spontaneous and emphatic in their tones. Some of the responses included, "certainly would be

playing quite a big part", "definitely", "definitely a high percentage", "most definitely", "most definitely" and " a high level of alcohol abuse or misuse". In terms of estimated numbers three participants suggested statistics of "about seven in every ten", "probably about 70%", and "around seven or eight in every ten" and one answered "I wouldn't have percentages but I found it to be quite high". These experiences of the counsellors would indicate a slightly higher prevalence than the recent available statistics from WHSSB (2008).

One of the participants, a Cognitive Behavioural Therapist found it to be "a high percentage" but only had "three or four clients who abused alcohol over the last few years" however on following this anomaly up the researcher was informed by the participant that when a client is assessed to be abusing alcohol "I would refer them on" at the assessment stage so that she doesn't actually engage them if the problem is identified in advance of therapy. This experience was echoed by the other Cognitive Behaviour Therapist "I'm not supposed to see them now as a CBT therapist" however she did go on to talk about her experiences with alcohol abusing clients as a generic counsellor before specialising in CBT. One issue that arises here is, given the prevalence of alcohol abuse among self-harming clients and the tendency shown by statutory services for CBT as the preferred model of treatment then there may be a need to investigate what happens to alcohol abusing clients if they are not engaged by CBT therapists and whether alcohol treatment resources are sufficient to deal with this client group.

Two of the participants expressed surprise at the number abusing alcohol "a higher percentage than I would have expected", and "probably a higher percentage rate than I would have expected" whereas the others expressed their findings as 'matter of fact'.

To the follow-up on question one about the clients' awareness of alcohol abuse being a problem there were several issues raised. Firstly, two participants felt that "out of the seventy percent about half see the drinking as part of the problem" and "I would say that about half of them would be aware that it is problematic" whereas the others felt that only a few would be aware of the problematic aspect of their drinking, "They're not really aware of it", "not seeing the impact that it was having", "they're in denial", "don't have the insight" and "see it as a way of coping". This aspect of 'coping' came up several times in terms of "using it to deal with their feelings", "the alcohol just made it a bit easier", "uses alcohol as a coping mechanism to deal with their problems" and "they don't even see it as making them worse".

The elements of 'denial' and 'minimising' of the problem by the clients came up in all responses "in denial about it being abusive without doubt", " denial is central", "they see it as a 'wee drink'", and "people drink far more than me". One participant saw their clients denial in terms of "the old saying in A. A. "its the only disease that tells you 'you haven't got it'".

All the participants spoke of some of their clients as viewing their drinking as 'normal', "had normalised their drinking and not seeing the impact that it was having", "Its just part of their overall behaviour, they wouldn't have seen it as bad", "drinking ten pints, socially acceptable amounts", "eight to ten pints in one evening would be looked upon as normal", "didn't think there was anything wrong with it", " 'normal' would be the word they use as they wouldn't see anything wrong with what they do", "they see it as a positive thing" and "its almost like the drunker you are the more accepted you are".

Table 11: Descriptive Table Question 2

Q.2 Effects of clients' alcohol, abuse on self-harming or suicidal behaviour	#1 Generic	#2 Generic	#3 Generic	#4 CBT	#5 CBT	#6 Generic	#7 Generic (former addiction)
Increased ideation	X	X	X	X	X	X	X
Increased behaviour	X	X	X	X	X	X	X
Unintentional	X	X		X		X	X
Possible fatality	X				X		
High risk	X	X	X	X	X	X	X

Descriptive Narrative 2: Question 2

In response to the question as to whether the counsellors experienced the alcohol abuse as affecting the self-harming behaviours of their clients, again the answers were unanimous. All of the counsellors believed that increased ideation and behaviours in both frequency and severity occurred with alcohol abuse "when their alcohol had become more intense then their self-harming became more intense", "during their episodes of drinking they're more likely to self-harm", the drinking would take away their inhibitions to the point where they would actually carry out suicidal behaviour", "leads to a very low mood when their self-harming or suicidal tendencies become more noticeably pronounced", "the client who is using alcohol presents with self-harming behaviours that are not as evident with those who don't use", "I think the self-harm happens almost always whenever they have been either drinking, or in the middle of having a

drink" and "the depression is increased and the person often makes unsound, ill-judged, bad decisions"

Two participants give examples of how the increased self-harming behaviour could have proven fatal "some may have cut an artery so therefore it's a lot more serious but it could have been fatal", and "they might be in a state where they might try and kill themselves"

Another experience of the participants was the notion of 'intentionality'. Five counsellors reported that some of clients who had abused alcohol had self-harming episodes without intending to do so prior to drinking, " young girl says she drunk bottle of cider, was running out in front of cars. Did she want to kill herself? No, she didn't understand what the alcohol did to her and how it impaired her", "she was like two different people when she drank", "during their episodes of drinking they didn't know it was going that way, 'when the drinks in the wit's out'", "during the episodes of drinking they are more likely to self-harm or become suicidal that afterwards they say they didn't mean it", "they don't seem to get it, that their drinking is so dangerous, so dangerous in relation to the number of suicides", "I would go up to the Erne Hospital and meet the person afterwards, and they would say "Well I didn't really mean to do it…it was the drinking…I got drunk" probably quite vulnerable at the time and that's what happens"

The unambiguous experiences of all the counsellors on this issue is that there is a higher level of risk for alcohol abusing clients compared with those who don't abuse alcohol "I think there is a higher risk level", "I do feel it increases the risk", "often you will find the depression is increased because alcohol is a depressant and creates a sense of hopelessness", "their drinking leads to very

low moods when their self-harming or suicidal tendencies become more noticeably pronounced",

"drinking would take away their inhibitions"

Table 12: Descriptive Table Question 3

Q.3 Effect of clients' alcohol abuse on counselling process	#1 Generic	#2 Generic	#3 Generic	#4 CBT	#5 CBT	#6 Generic	#7 Generic (former addiction)
Drinking affects the counselling process	X	X	X	X	X	X	X
Need for detoxification	X						
Physical inability to engage	X	X	X	X	X	X	X
Emotional inability to engage	X	X	X	X	X	X	X
Lack of focus	X	X	X	X	X	X	X
Therapist confusion	X	X	X	X	X	X	
Alcohol abusing clients not engaged				X	X		

Descriptive Narrative 3: Question 3

The participants were unanimous in their experiences of alcohol abuse affecting the counselling process "It will affect the counselling, its gone to place where you cant be effective", "there tends to be a barrier with the person that's misusing it", "the process can go around in circles", "the process feels stuck", "It means you have to keep going back to the beginning, they can't really get into the flow of the session, like you're not moving forward", "There is an effect, sometimes they don't want to even be there", " Its detrimental to the process, it really is a waste of time for them" and "DNA's are a big element in the process sometimes you have to arrange an

appointment for later in the week", "there's more DNA'ing, they attended, didn't attend, attended, didn't attend.."

This effect is experienced both physically and emotionally," because of their alcohol there is an inability to attend sessions", " they may be slightly hung-over they don't seem to be there", "They can be hung-over, anxious and distant", "they miss the early week dates because they were drinking all weekend", "without a doubt, psychologically they are not as aware of what is going on", "they are more reluctant to talk about their feelings", "there's a lot of ambivalence going on, there's part of them don't want it and there's part of them wants it", "things being blocked because of their drinking", "emotionally they can't engage", "they're not accepting", "the impact of the alcohol has on their ability to cognitively and emotionally engage has most certainly decreased".

One counsellor connected the emotional difficulties leading to further abuse of alcohol, "the person who is abusing alcohol tends to be detached from the counselling sessions, not understanding it fully and when the emotions are arising, when the difficulties are arising, they're using more alcohol to suppress the difficulties and not ever actually dealing with it".

Several counsellors highlighted the ethical implications of engaging alcohol abusing clients in the process, "its alright to see them as long as they're not drinking, say, the day before or the night before, and certainly not the day they're coming in, because its detrimental to the process", "I rely on my ethics, my organisational policies and procedures, if we open up their history while they're actively drinking then it increases the risk they run the risk of maybe accidental suicide", "we see people from the hospital who are in withdrawal and in need of detoxification, my

protocol is to get them to their GP for detox before counselling can begin” and “I’ve had the experience of people needing detox and having to get them to their GP”.

The two CBT therapists were very adamant about their approach to alcohol abusing clients, “I am very firm about the boundaries around alcohol and my clients I find that they just cant do the homework, they would need to get treatment for alcohol before coming to me for CBT”, “if you don’t stop drinking then I cant treat you, it would be unethical for me to treat them, it would do more harm than good”, “As a CBT therapist I am expected to refer on anyone that is abusing alcohol..at the point of assessment, that’s because of their inability to concentrate, to do the homework, its too difficult for the person”. One CBT therapist offered some evidence for the increased depressive state of drinking clients “I would use measures if they have been drinking, you know the Depression Inventory, the measures are always higher when they’ve had a few drinks in the last couple of days”.

Table 13: Descriptive Table Question 4

Q.4 Confidence of therapist working with clients who abuse alcohol	#1 Generic	#2 Generic	#3 Generic	#4 CBT	#5 CBT	#6 Generic	#7 Generic (former addiction)
Confident with all clients	X	X					X
Confident with clients who abuse alcohol							X
Positive attitude to clients who drink	X	X					X
Negative attitude to clients who drink			X		X	X	
Anxious	X	X	X	X		X	
Afraid			X			X	
Judgemental			X	X		X	
Frustrated	X	X	X	X	X	X	
Advantage of personal experience of alcohol abuse: family or self	X	X	X		X	X	

Descriptive Narrative 4: Question 4

Question Four dealt with the confidence of counsellors in dealing with the issue of alcohol abuse among their clients. The former addiction counsellor, as expected, showed a very positive approach to his clients in this regards, “It’s second nature to talk about it, to feel comfortable”. This counsellor, although confident, felt the need to treat each client with alcohol abuse as an

individual and highlighted "how tentativeness is important, you could be very confident about what you are talking about but the person might not want to hear it, its not the place they want to be at that moment" and "I've no problem raising the topic of drinking but it's the timing that can be very important."

The other counsellors reflected a mixture of positive and negative experiences. Several initially expressed a confidence in working with people, in general, but then qualified their experiences of confidence when it came to alcohol abusing clients, "I feel confident in being with people but to speak confidently in my full understanding of addiction, I don't, because these people need something more, you will always feel a we bit not confident", "I suppose I am very confident around people, around my clients, no matter what the issues are. It probably depends on the individual this issue does make me nervous" and "I think as you work with people you build a trust in yourself". One counsellor mentioned the support of her supervisor in helping with her confidence, "I get great help from him (supervisor) in relation to addiction"

The other counsellors did not hesitate in expressing a lack of confidence with this client group and introduced other feelings of confusion, frustration, anxiety, fear, being ill-informed "I have to be completely honest I don't feel completely comfortable for a lot of the time", "the issue does make me nervous maybe that's around the unpredictability, denial and minimising"., "maybe a bit slightly frightened about where it's going and can I manage?", "Knowing what harm I might do to the client because of my lack of knowledge", "It's difficult to be really focussed, I'm not as knowledgeable as I would like to be" Its was noticeable at this time that the tone and non-verbal communication of the answers reflected anxiety and frustration much more than the answers themselves.

The issue of fear seemed to be related to the level of risk that the clients might reach because of their drinking "when the person leaves the room and they go home to a place by themselves and they start drinking where there's no controlled environment, then you'll always feel a wee bit you know not confident", "you do know the risks and you're afraid for that risk", "you know the risk has to be ascertained, I would find the difficulty in getting to the risk part", "I would have to admit to a nervousness, maybe that's around the risk the person is in", "I've been scared because its such a big thing, its really frightening, you know because of the high risks and the high number of suicides"

Two of the counsellors acknowledged personal experiences of alcohol abuse by family members and saw this as an advantage in helping their confidence in dealing with clients who abuse alcohol "I have a recovering alcoholic in my family and I am aware of the difficulties around it", "I know it from a personal level, that personal experiential level of living with it in the family, I think the personal experience informs my professional practice".

However one of these counsellors also expressed very negative and judgemental attitudes towards those who abuse alcohol stemming from the personal experience "I've struggled for years with my assumptions, when someone mentions alcohol and says "I don't think I'm an alcoholic" my assumption always is "Ay you are.." because alcoholics are so manipulative they can win you over easily, so I'm always on my guard, but that can be very wrong. I find that a big problem and I don't know if there's an easy way to resolve that for me".

The counsellor who experienced alcohol abuse in his own life felt that it added to his confidence now in dealing with others "Without a doubt based on my own life experience, I would be very comfortable around the issue of alcohol abuse" however he would still feel anxious around the

issue of risk “I feel comfortable and confident…then marry that with the whole unpredictability that’s where I would probably feel there’s a bit of lack of confidence”

The CBT counsellors felt that their confidence with alcohol abusing clients was not such an issue as in general they would refer these clients on if alcohol abuse was the priority issue “I’m not an addiction trained person so I would refer them on to someone who is, first, if they cant stay off it” and “Its not an issue I am supposed to deal with in therapy I am trained to deal with their thinking not their drinking”. One of the counsellors was able to put a time limit on this “I would definitely be saying to them “I wont be able to work with you til you’ve been off the alcohol, the guidelines says six months, you have to be off it six months”

Table 14: Descriptive Table Question 5

Q.5 Competence of therapist working with clients who abuse alcohol	#1 Generic	#2 Generic	#3 Generic	#4 CBT	#5 CBT	#6 Generic	#7 Generic (former addiction)
Advantage of personal experience of alcohol abuse: self or family	X	X	X		X	X	
Need for training	X	X	X	X	X	X	
Counsellors who have basic information training	X	X	X		X		
Counsellors who have a recognised alcohol training course						X	X
Feel un-skilled at times	X	X	X	X	X	X	
Competence not an issue as alcohol-abusing clients not engaged				X	X		

Descriptive Narrative 5: Question 5

The question of the counsellors' sense of competence again was straightforward for the CBT therapists as they do not engage alcohol abusing clients "I just wouldn't be qualified to do that and again I wouldn't", and "as a CBT therapist I am expected to refer on", however this counsellor went to explain "but when I did work as a generic counsellor I would have felt a bit

incompetent in my knowledge about alcohol, I would love to have had a better more insightful approach"

From a competence perspective four of the counsellors had completed basic one-day information training on alcohol issues while another had completed the Certificate in Addiction Studies. The former addiction therapist had spent 25 years working in the Community Addiction Service.

Six of the participants however admitted to feeling un-skilled when working with these clients "No I don't feel skilled enough", "I feel as if I would need more training so that I can feel more competent", "I feel there's always the need for training, I have asked for more training", "I did do a bit of training but would have need more specific training", "I'm doing a course now in September, I can't wait because I'm thinking this will give more tools to work with" and "I feel as if I would need more training, I did a bit of training and it was hugely effective and it was just a background knowledge"

On the issue of competence the former addiction counsellor highlighted the complicated nature of working with alcohol abusers "There's such a gambit, there's so many different facets to it, some many different angles to it, its maybe tapping into the emotional end and the feelings and the resentment and the hurt and the pain and that is sometimes emotionally draining and very powerful stuff and you must be competent in doing that". He also stated that his competence would be called upon by his colleagues to support them in their work "I would normally be called on by colleagues to do an assessment or maybe through an informal supervision session, to do sort of a clinical assessment of the client's drinking and give them feedback". This would indicate a feeling of lacking competence by his colleagues who also carry out this work.

As with question four the counsellors who had personal experience with alcohol abuse felt that it helped them from a competence perspective in dealing with their own clients “the difference for me when it was personal was that you made a decision to support that person and went through the bad times with them, then the therapeutic work is much easier to work with”.

Table 15: Descriptive Table Question 6

Q.6 What steps need to be taken to address the issue of alcohol abuse within self-harm and suicide counselling	#1 Generic	#2 Generic	#3 Generic	#4 CBT	#5 CBT	#6 Generic	#7 Generic (former addiction)
More training	X	X	X	X	X	X	X
Core training	X	X	X	X	X	X	X
Skills training	X	X	X				X
Improved assessment skills	X	X		X		X	
Improved referral protocols	X	X		X		X	
Improved attitudes of professionals towards alcohol abusers	X	X	X			X	X
Increased access to alcohol treatment programmes	X	X		X		X	
Joined-up/seamless services		X		X			

Descriptive Narrative 6: Question 6

The final question then sought to identify any action that the counsellors felt need to be taken to improve the service they offered to alcohol abusing clients who were self-harming or suicidal

and this produced several significant suggestions. This was broken down into training, improved assessment and referral, a review of attitudes towards alcohol abuse and improved services for alcohol abusers.

Following on from question five the initial response from all the counsellors was the need for more training on alcohol issues and that this training should be a core element of counsellor training, “There should be more courses, I’d love to do a course on drugs and alcohol but it was quite difficult to get them”, It should be part of a counsellor’s training, in working with suicide and self-harm and training in alcohol counselling”, There should be compulsory training in relation to the tell-tale signs and what to look for, the actual behaviour and how that impacts”, “The Drug and Alcohol Training Programme has helped a lot it looks at the global aspect but it doesn’t look at the specific help that the person need, what would be important is that it be a central module” and “it should be part of the core training, presenting issues around suicide self-harm and alcohol misuse, are those big factors that contribute to accidental suicide, misadventure, it should be part of core training”.

The need for improved assessment and referral was also highlighted by the counsellors’ experiences “clients come through to us from the hospital, certainly alcohol dependent, knowing that they need to be referred into addiction services but they have just been put back out into the community”, “I had one client recently who was referred and had to go back to their GP for detoxing”, “Well I think in the assessment that would need to be found out and then obviously be advising those people” and “referrals are made that are inappropriate, because there is nowhere else to send them, the problem isn’t assessed properly before they are referred and when they come we have to disappoint the client by sending them somewhere else”

One counsellor felt that the alcohol abuse by clients was overlooked when being assessed for mental health issues "I think that the statutory services is, whether it's the resources, this isn't a criticism, just find that their assessments aren't properly….it's like there's almost so many people coming through at the moment with mental health difficulties, if they are depressed, they sort of ask questions in relation to the depression but the alcohol consumption might not be top of the priority so I don't think their assessments are carried out properly, properly is not the right word, they need to be more focussed". One counsellor felt the need for "assessment training for us all".

The issue of the attitudes of professional towards alcohol abusers was also evident in the counsellors experiences "how do I put this without being too critical, I find that there are some attitudes around people that drink heavily, like, it's their own fault and that they should pull themselves together and just stop. It's seen as somehow as self-inflicted", "the risk for suicide and self-harm is definitely missed at times because of the bad attitude", "I think self-harm and suicide and alcohol dependency are all treated in the same vein and the attitude towards them is not very caring" and "Its really dismissive, its judgemental, its like they're (drinkers) a waste of time and space". One counsellor felt that "the GPs just offloaded them".

Finally the need for improved services was highlighted in the counsellors experiences "The services are very disjointed, what part is the community doing and what part is the statutory doing, how do we do that for the best of the person?", "people that's misusing alcohol go and get alcohol treatment and people that's self-harming come for self-harm and suicide counselling. I believe something where we could treat both problems in a parallel process", "I would love to see a seamless service, we are all over the place nowadays"

Review and Reflection: Emerging Themes

Review and reflection was a natural course of action to analyse the collected evidence and identify the emergent themes of the next stage (Miles & Hubermann, 1994). Having reviewed the quotation banks, the descriptive tables and the descriptive narratives the researcher was able to highlight emerging significant themes that were encapsulated in the counsellors' experiences: Re-examination of the data helped establish the relevance and consistency of these emerging themes:

1. **High Prevalence:** Prevalence of alcohol abuse among the self-harming clients.

   The experiences of the counsellors would appear to indicate that a high percentage, in some cases as many as 70-80%, of those referred for self-harm counselling present with a co-existing problem of alcohol abuse. Although the numbers estimated by the counsellors are higher than the Haw et al (2005, p. 967) findings, they are reflected more accurately in the WHSSB (2008, p. 20) findings where certain age-groups showed percentages of 67-73% for 2007 self-harm admissions to hospital. Although the current report of the WHSSB is not yet published for 2008/09 current indications are suggesting a 10% increase in alcohol taken since 2007. If this is true then the findings of this study and the statistics collated by the WHSSB Self-harm Registry are very similar.

2. **'Normality':** The majority of self-harming clients perceive their alcohol abuse as 'non-problematic' and in some cases as 'normal' drinking.

   Although two of the counsellors estimated that up to fifty percent of the clients were aware of their problem drinking, the majority of the counsellors experienced their clients as, initially, not seeing their drinking as a problem at all. In fact clients would regard it as

a positive way of coping with difficult or strong emotions/feeling. One very significant theme to come out of this was the clients' belief that the amount of alcohol taken was within normal drinking limits. In some cases clients believed that drinking 16-20 units of alcohol (8-10 pints) per night was normal alcohol use. The counsellors themselves believed that the social acceptance and current practice of high levels of alcohol intake contribute to this mindset.

3. **High Risk:** Where alcohol abuse and self-harming behaviours co-exist there is an increased level of risk around the severity and frequency of the self-harm episodes.

   The counsellors unanimously experienced the alcohol abusing clients to be at higher risk than non-alcohol abusing clients. This, they believed manifested itself in increased self-harm ideation and behaviours which some of the counsellors reported as unintentional on the part of the client but was due solely to the fact that they had drink taken at the time of the episode. Two of the counsellors expressed concerns that the element of drinking when leading to a self-harm episode might even prove fatal. This raises the question of whether some completed suicides are unintentional insofar as they are a possible consequence of the amount of alcohol consumed and not of 'wanting to die' per se.

4. **Unpredictability:** The impact of alcohol abuse on the client leads to a lack of consistency within the counselling process.

   The counsellors' experiences reflected an unpredictability with clients who abuse alcohol compared with those who do not. This manifested itself in:

   - non-attendance, inconsistency in attendance

- attendance but physically not well, “hung-over”
- inability of clients to focus and concentrate because of alcohol consumption
- inability to engage emotionally
- difficulty in remembering previous sessions
- defensiveness of clients in discussing alcohol use including minimising and denying the problematic nature of their intake
- increase in the self-harm ideation and behaviours when drinking

5. **Impact on Counsellors Confidence:** Clients’ abuse of alcohol has a negative effect on counsellor confidence in dealing with problem.

   Apart from the counsellor who was an experienced addiction therapist for 25 years, all the other counsellors reported personal experiences of anxiety, confusion, frustration and, in two cases, fear, when dealing with the alcohol abusing clients. These feeling are attributed by the counsellors to the previously discussed aspects of client unpredictability and the increase in self-harming ideation and behaviour. Four of the counsellors believed that having experienced the problem within their own families helped in coming to terms with the negative impact of their clients’ drinking. One counsellor however believed that the experience of alcohol abuse within her own family lead to a very judgemental attitude towards the clients who abused alcohol and saw everyone who abuses alcohol as being ‘an alcoholic’.

6. **Needs identified by Counsellors**: The counsellors identified a range of needs that should be addressed when dealing with self-harming clients who also abuse alcohol:

   - **Training:** The counsellors believed that training in working with alcohol abuse should be a core element of counsellor training because of the high prevalence of this among clients. Those who had undergone alcohol related training, even a one-day course, felt that it was very beneficial in their work. Although they recognised the value of existing courses some felt that greater practical/skills experience in training was needed as opposed to the existing underpinning theoretical approach.

   - **Assessment:** The skill of assessment was highlighted by the counsellors as lacking in many examples of clients who were inappropriately assessed regarding their alcohol abuse. These assessments were carried out in both voluntary and statutory settings. This was attributed by some of the counsellors to the clients' denial or minimising their alcohol abuse at the assessment stage. Others attributed this to those carrying out the assessments as not linking the importance and seriousness of the alcohol abuse to the self-harming ideation and behaviours, focussing more on the depressive side of the symptoms presented, even though alcohol itself is a known depressant.

   - **Referrals:** Following on from the issue of assessment several of the counsellors felt that the practice of referral was also in need of being addressed as many of the referrals received were inappropriate. In some cases the counsellors felt the referrals were made because there was nowhere else to send the clients. Some of the counsellors experienced clients being sent for counselling because they were

self-harming while the aspect of their alcohol abuse was ignored. This issue brought up for some counsellors the lack of existing resources for those who abuse alcohol. A need was expressed for a more comprehensive range of services for those who abuse alcohol and are self-harming. It was felt that the current range of alcohol treatment services were inadequate to deal with the extent of the problem.

- **Attitudes:** Several of the counsellors felt that judgemental attitudes towards alcohol abusing clients existed at statutory level. This, they believed, resulted in the clients being seen as 'hopeless' cases whose alcohol abuse was seen as a choice rather than a possible medical condition in need of separate treatment. This raises the possible question of professionals in the statutory sector experiencing the same frustration, confusion and anxieties as expressed by the counsellors in working with this client group and whether this impacts on the assessment and referral processes.

Flow Charts:

In summarising the findings throughout the analysis the researcher could distinguish two separate sets of themes that arose from the participants' experiences.

The first set summarised the counsellors' experiences of the clients' alcohol abuse in respect to the clients themselves, i.e. issues that affected the clients. These are seen in terms of how much they drank and how they perceived their drinking. They also highlighted how the clients drinking, in most cases, increased their level of risk with regard to their self-harming ideation and behaviours as well as identifying the experiences that clients neither foresaw nor intended these increases before they started to drink.

The second set of themes highlighted those issues that affected the counsellors in working with this client group. Firstly, how the alcohol abuse of their clients had a negative effect on the counsellors' confidence causing occasional anxiety, frustration and at times fear for the clients. The personal experiences of the counsellors of alcohol abuse in their own families and in one case, personally, had a mainly positive effect on the counsellors in terms of confidence but in one case caused a negative attitude to all drinkers. The theme of the competence of the counsellors highlighted their experiences of feeling at some point un-skilled in working with the clients although they felt even basic training was beneficial. All of the participants felt that core training in alcohol issues was important and should be part of generic counsellor training. The therapeutic process itself was a theme that emerged for counsellors that involved the client dynamics of unpredictability, physical and emotional difficulties as well as the effect that the increased higher risk of these clients had on the process. Finally the participants identified the themes of

assessment, referral and the attitudes of professionals towards those who abuse alcohol as needing addressed.

These themes are summarised in the two sets of flow charts Figure 3 and Figure 4

Figure 3 : Client themes: Flow Charts

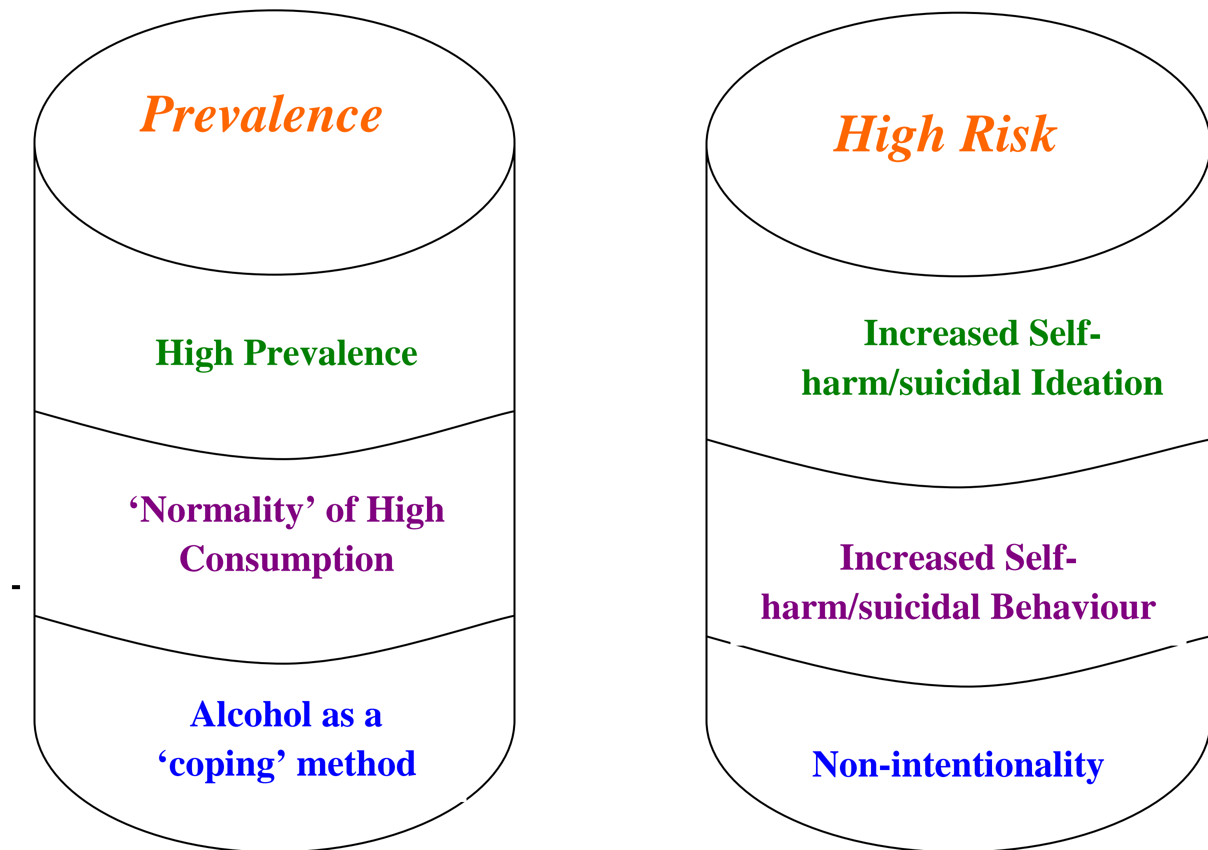
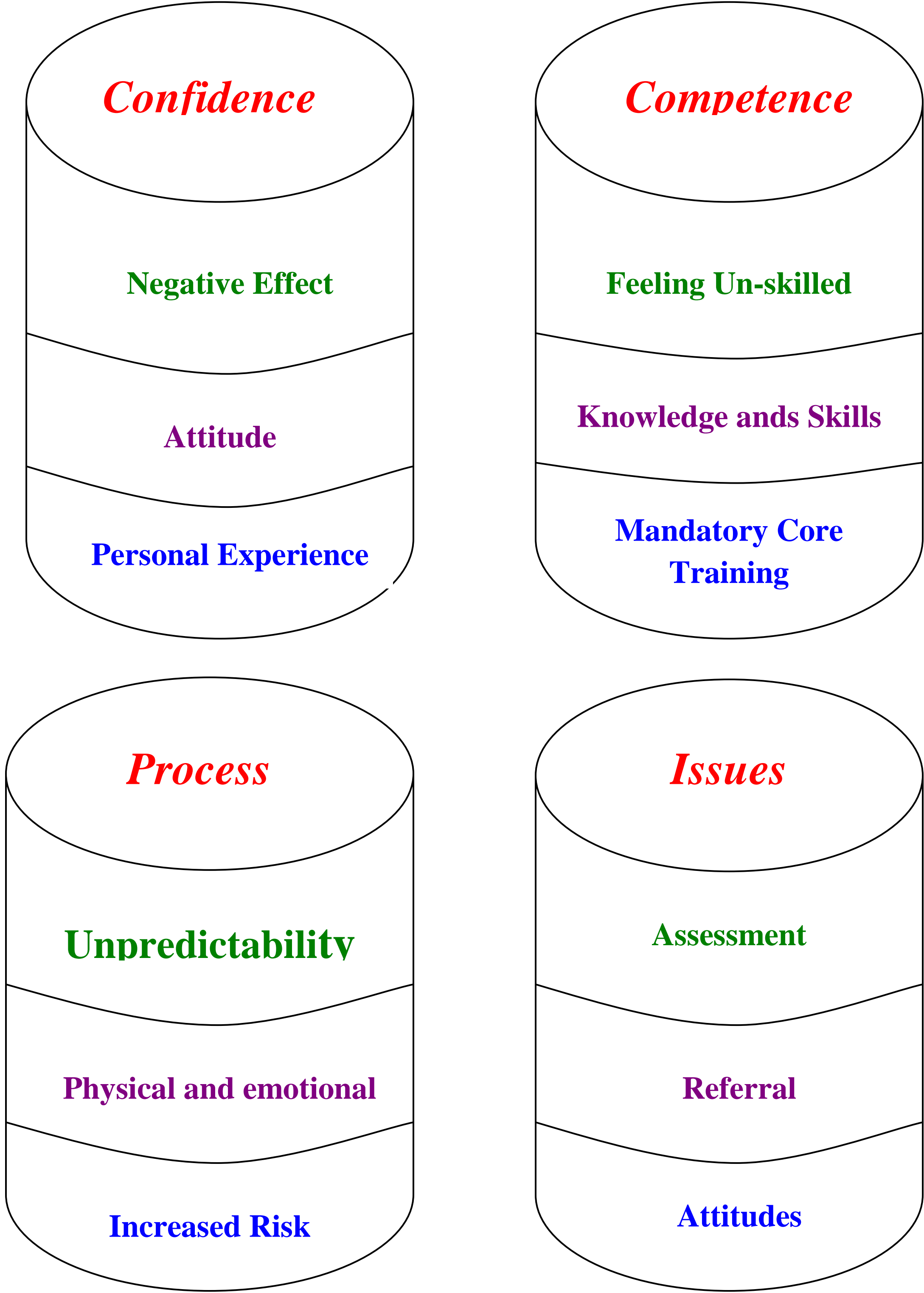


Figure 4 : Counsellor Themes: Flow Charts



Chapter 5. Conclusions:

In conclusion, the study identified that the self-harm/suicide counsellors experienced a prevalence, and in most cases, a high prevalence, of alcohol abuse among their self-harming clients. This would be in keeping with the studies carried out by Berglund & Ojenhagen,1998; Clark & Bukstein, 1998; Tucker 1999; Di Clemente et al., 2001; Baker & Rooney, 2003; Modesto-Lowe et al. 2006; Pirkola et al. 2004; Rossow et al. 2007; Hawton et al. 1997; Academy of Medical Sciences 2004; Sher 2006; Preuss et al. 2003 & 2006; Toumbourou et al., 2002; Skinner et al 2004; Gorwood 2001; Schneider et al. 2006; Cherpitel et al., 2004; Hufford 2001). The findings specifically reflect the figures presented in the WHSSB (2008) study but this study's findings would indicate a slightly higher level of prevalence.

Most were concerned that the clients were oblivious of their excessive drinking as being problematic and in some instances the clients viewed their alcohol intake as normal. Like Haw et al. (2005) all of the counsellors reported increases in self-harming ideation and behaviour with this client group with some expressing concern that in many instances this was unintended by the client prior to drinking.

The participants reported that they had regularly experienced an inconsistency in the counselling process where the client was abusing alcohol and they highlighted instances of physical and emotional unpredictability. This, according to the participants, was one of the factors along with the clients' denial and minimisation of the alcohol problem that contributed to professional issues of confidence and competence for them when working with this client-group. The natural follow on from these experiences was for the participants to recommend a more thorough training in alcohol issues for all counsellors, with many suggesting that it should be part of core

counselling training. For some participants, the personal experience of excessive drinking in the family, and in one instance, self, provided them with a greater understanding of these clients, except for one participant who felt that it made her judgemental towards the excessive drinker. Again these findings reflect the results presented by Wheeler & Turner (1997) in which the counsellors highlighted very similar problems that arose during the counselling process for both the client and the counsellor.

On a wider level it was the experience of the majority of the participants that the assessment and referral of many of their clients by statutory and voluntary agencies were inappropriate. In some cases the participants reported that the drinking behaviour of the clients was overlooked by the referrer and others felt that it had been ignored. Several participants followed this up by reporting that they had experienced judgemental, negative attitudes on the part of professionals towards clients who abused alcohol. Finally many of the participants reported the need for improved services and resources for this particular client-group. It might be useful for statutory services to reflect on their assessment and referral protocols around the whole issue of self-harm and co-existing alcohol problem with specific reference to the increased levels of risk that were reported by the participants. This suggestion is very well supported by the WHSSB (2008) findings and it brings into question the resources and services available for those who drink excessively.

The findings of this study may be useful to practitioners insofar as they highlight the need to determine the alcohol intake and use of the client from the outset to ensure the appropriateness of engaging the client both from a personal and professional perspective. This would help address the issues of assessment and referral that emerged. Another useful outcome might be that the University of Ulster and other educational establishments review their core counselling training programmes with a view to consider incorporating a compulsory module on alcohol and drug

issues including the element of skills practice. This would also address the first issue of assessment and referral as well as giving trainee counsellors the opportunity to reflect on their own family or personal experiences in the Personal Learning Record element of the module. This would address the confidence, competence and attitude issues that are reported, here and in Wheeler and Turner (1997), Shaw et al. (1978) and Roche et al. (1995)

One very important finding that emerged from this study was the report by the CBT therapists that they normally do not engage clients with alcohol abuse problems. If CBT therapy is the model of choice at statutory level for self-harming clients and the majority of these are shown to have alcohol abuse problems then the possibility of a gap in provision may exist especially in light of the increased levels of self-harming ideation and behaviours that were reported. It might also be appropriate for a study of CBT therapists to be undertaken to determine if there is a professional practice of not engaging alcohol abusing clients who are referred for other mental health issues and conditions.

This study was focussed on only one small geographical area and although it was the area with the highest reported statistics for this problem, it might be useful if the other Health and Social Care Trusts were studied in relation to this issue in order to determine a province wide picture for future service and training development by individual Trusts, the Public Health Agency and the DHSS&PS.

(word count 14561)

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Appendix 1:

Ethical Approval Received from the University of Ulster

Appendix 2:

Numbers (%) of assessed DSH patients with a diagnosis of alcohol dependence each year, 1989-2002 (figures based on patients first assessed episode in each year). (Haw et al. 2005, p. 966)

Year	Both genders			Males			Females		
	Total no. Of Patients	(Alcohol-Dependent) N	%	Total no. Of Patients	(Alcohol-Dependent) N	%	Total no. of Patients	(Alcohol-Dependent) N	%
1989	571	57	10.0	220	42	19.1	351	15	4.3
1990	631	62	9.8	266	46	17.3	365	16	4.4
1991	604	70	11.6	256	48	18.9	348	22	6.3
1992	656	70	10.7	258	39	15.1	398	31	7.8
1993	653	68	10.7	272	47	17.3	365	21	5.8
1994	655	70	10.7	274	42	15.3	381	28	7.3
1995	677	70	10.3	296	49	16.6	381	21	5.5
1996	710	79	11.1	295	48	16.3	415	31	7.5
1997	745	87	11.7	310	50	16.1	435	37	8.5
1008	747	92	12.3	291	54	18.6	456	38	8.3
1999	740	78	10.5	308	50	16.2	432	28	6.5
2000	790	84	10.6	294	45	15.3	496	39	7.9
2001	785	82	10.4	358	54	15.1	427	28	6.6
2002	811	75	9.2	316	47	14.9	495	28	5.7

Appendix 3:

Numbers (%) of assessed DSH patients with a diagnosis of excessive drinking (excluding alcohol dependence), 1989-2002 (figures based on patients first assessed episode in each year). (Haw et al. 2005, p. 967)

Year	Both genders			Males			Females		
	Total no. of Patients	(Excessive-Drinking) N	%	Total no. of Patients	(Excessive-Drinking) N	%	Total no. of Patients	(Excessive-Drinking) N	%
1989	571	132	23.1	220	65	29.5	351	67	19.1
1990	631	155	24.6	266	87	32.7	365	68	18.6
1991	604	127	21.0	256	71	27.7	348	56	16.1
1992	656	133	20.3	258	69	26.7	398	64	16.1
1993	653	135	21.2	272	72	26.5	365	63	17.3
1994	655	125	19.1	274	73	26.6	381	52	13.6
1995	677	127	18.8	296	73	24.7	381	54	14.2
1996	710	170	23.9	295	81	27.5	415	89	21.4
1997	745	204	27.4	310	103	33.2	435	101	23.2
1008	747	188	25.2	291	89	30.6	456	99	21.7
1999	740	198	26.8	308	89	28.9	432	109	25.2
2000	790	198	25.1	294	81	27.6	496	117	23.6
2001	785	233	29.7	358	111	31.0	427	122	28.6
2002	811	252	31.1	316	113	35.8	495	139	28.1

Appendix 4:

Lifeline Criteria for Counsellors

SECTION 7

HUMAN RESOURCE MANAGEMENT

Core Induction

All Service Providers must complete the Contracted Organisations Core Induction.

The Key Contact will provide Contact Youth with content of the Core Induction.

The Core Induction must incorporate all policies and procedures referenced in the Lifeline Contract and Staff Handbook.

Staff should be provided with a copy of the Contact Youth Contracted Services Handbook.

Evidence of completion of the Core Induction by Service Providers will be sought during monitoring visits.

Recruitment and Selection Policy

Contracted Organisations have provided, at the tender stage, CV's for all the staff they intend to allocate Lifeline work to. If an organisation would like to add additional staff or amendments to staffing, these should be submitted to Contact Youth prior to staff commencing Lifeline work.

It is the Contracted Organisations responsibility to ensure that staff meet all necessary criteria outlined below and in the tender document. The Key Contact will undertake to check that all memberships of regulatory bodies are valid.

Please refer to the Contract sections 5 for legal obligations.

Essential Criteria for Counsellors

Counsellors
Diploma in Counselling
Membership of BACP or equivalent
150 hours post qualified, supervised experience

Also refer to section 4.7 of the Contract

Access NI Checks

Contracted Organisations must hold the **Enhanced** Access NI number for all staff working with Lifeline clients. Organisations will follow the guidelines outlined by Access NI regarding the updating of these checks. Organisations must meet all criteria and requirements under the new Vetting and Barring scheme coming into effect in September 2009.

Supervision for Counsellors

Counsellors must receive supervision in line with BACP recommended standards each month. The supervisor should be recognised and registered with the appropriate BACP or equivalent regulatory body. Staff members’ supervisor should not be their line manager.

Line Management

All staff working with Lifeline clients should receive at least 1 hour Line Management each month. Line Management should be an opportunity for staff to raise any concerns about their Lifeline work and to gain support for working with difficult cases.

Any adverse incidents raised or concerns should be forwarded to Contact Youth immediately.

Child Protection and Vulnerable Adult Training

Contracted Organisations will ensure that all staff have completed Child Protection and Vulnerable Adult Training and hold a current certificate. Training should be updated annually.

Reproduced from the Lifeline Handbook May'09

Appendix 5:

Participant Information Sheet

Title of proposed study for:

MSc in Counselling and Therapeutic Communication

"The experiences of C&V self-harm/suicide counsellors, in the Western Health Trust, of the prevalence of alcohol abuse among their clients and their confidence and competence in dealing with these clients."

Research Aims and Objectives

My aim in this research is to investigate any possible implications of clients' alcohol abuse on their self-harm or suicidal behaviour counselling and how the counsellors perceive this dynamic including how competent and confident they feel in dealing with it. A list of sample questions is included under **'Procedures'**

Research Rationale

Much research evidence exist to correlate the co-existence of self-harm/suicide and alcohol abuse, however little research has been carried out into the confidence and competence of community and voluntary self-harm/suicide counsellors in dealing with the alcohol abuse issue and how this is impacting on the counselling process.

Knowing that my own experience as a drug and alcohol counsellor is invaluable as a self-harm/suicide counsellor, I would like to investigate how other community and voluntary self-harm/suicide counsellors in the WHSSB area, find what implications their service-users' alcohol abuse have on their work with those service-users and how they deal with these implications. I have chosen, for this

study, the WHSSB area as this has the highest levels, in N. Ireland, of those presenting at A&E after an episode of self-harm/attempted suicide (DHSS&PS 2006; WHSSB 2008). The study will seek to inform and target current service provision within the WHSSB in particular and the Northern Ireland Suicide Strategy Implementation in general.

Procedures

I will use qualitative, in-depth, semi-structured interviews. The questions will be open-ended but based on the topic under investigation. I will be able to discuss some topics in more detail with you and you will also be able to raise new issues of relevance. I will also be able to explore with you in order to elaborate on their original response or to follow up a further line of enquiry that may become significant. Some of the key questions and exploratory prompts that I will use will be:

1. How prevalent do you find the co-existence of alcohol abuse with your service-users? …..
   (What action is the service user taking to deal with their alcohol abuse?)

2. How do you think that their alcohol abuse affects their self-harming and/or suicidal behaviour
3. What effect do you think their alcohol abuse has on the counselling process
4. How confident do you feel dealing with alcohol abuse with your service-users? ………..
   (What do you find particularly difficult, if anything?)
5. How competent do you feel dealing with alcohol abuse in your service-users?....
   .(What specific training have you undertaken, if any? How effective has this training been in equipping you to deal with this issue?)
6. What steps, if any, do you think need to be taken to address the issue of alcohol abuse within self-harm and suicide counselling?

Location and Timing

If suitable I will arrange a time to call to your workplace during work hours to carry out the audio taped interview. The interview should last no longer than one hour approximately. If your workplace is unsuitable or inappropriate then we can agree a suitable venue in your area.

Confidentiality

If you agree to participate your identity will remain anonymous throughout the study. Although our interview will be audio-taped and transcribed these pieces of work will be protected and will not carry any identifiable information. All tapes will be wiped at the end of the research study.

Appendix 6: Letter to Interested Participants

Date:

Re Participation in Academic Research

Dear

First of all, I would like to thank you for showing an interest in participating in the proposed study. Enclosed is a comprehensive summary of information for your consideration in order to help you decide whether to participate or not. Your participation is completely voluntary and should you agree to participate you are still free to withdraw at any time and have your data returned to you. If you are dissatisfied with any of the process you can contact the study supervisor at the contact number on the consent form.

If you would like to participate I would ask you to sign the enclosed consent form and to send it to me in the pre-paid stamped addressed envelope as soon as is reasonably possible. If you have any queries about the research please feel free to contact me on +447810791917. I have also enclosed a copy of the Principles of Ethical Research for your information. If you do not intend to participate I would appreciate it if you would let me know by way of the same stamped addressed envelope or at the above mobile number.

I look forward to hearing from you in the near future

Yours sincerely

Conor McCafferty

Appendix 7: Letter of Thanks Sent to each Participant

Date:

Dear

I would like to take this opportunity to express my sincere thanks for your recent generous contribution to my dissertation for the MSc Award with the University of Ulster. I would like to acknowledge the experiences and opinions that you shared with me during the interview. I would also like to acknowledge the welcome and hospitality extended to me by your organisation.

If successful in this academic achievement I would like to offer you a copy of the completed dissertation as a token of my appreciation for your contribution.

I wish you every success in your work for the future.

Yours sincerely

Conor Mc Cafferty

Appendix 8:

University of Ulster, School of Communication

Consent to Participate in Academic Research

I…………………………………………………………………………………….

Of (address)…………………………………………………..………………….

……………………………………………………………………………………..

Post Code:………………………   Telephone:………………………………

(This information is only needed to obtain consent to the research and will not be used in any results or publications resulting from this research)

have read and understood the attached Principles of Ethical Research and agree to participate in the under noted research:

Title: ***The experiences of self-harm/suicide counsellors of the prevalence and counselling implications of their clients' alcohol abuse, in the WHSSB community and voluntary sector and their confidence and competence in dealing with these clients.***

in which the researcher named:

…………………………………..Conor McCafferty………………………………

is supervised by:

…………………………………Dr Pauline Irving…………………………………

Supervisor's telephone:……… 02890 368847………..

I understand that I have the right to refuse to continue to support the research at any stage, to require the return and no subsequent use of any data provided and that special issues of confidentiality or the like listed below will be subject to agreement between myself and the department before any research begins.

Signed:…………………………………………………….

Date:………………………………………………………….

If you require further information about the research please contact the supervisor in the first instance.

If there are any unresolved problems please call the School and ask for the Chair of the School Ethics and Risk Panel. School of Communication, Tel. 02890 368847/366453.

Appendix 9:

PRINCIPLES OF ETHICAL RESEARCH

1. All members of staff and all student at all levels are required to read and agree to comply with these statements and to operate them in the full spirit in which they are written. Failure to comply with these statements will be regarded as a disciplinary offence.
2. In all forms of research conducted in the School, we will operate with as full a consideration as possible of the consequences of our work for society at large and the groups within it.
3. We will handle all confidential information with appropriate levels of discretion and compliance with the law and due diligence to the security of that data.
4. Any material being prepared for publication will be produced in such a way as to reduce the possibility of breaches of confidentiality and/or identification.
5. We will try to avoid overburdening subjects, causing them inconvenience and intruding into their private or personal domains.
6. Subjects will be informed as to the purpose and nature of any inquiry in which they are being asked to participate.
7. We will avoid misleading subjects or withholding material facts about the research of which they should be aware.
8. Where the research methodology allows for it, a research subject will be expected to be provided with a consent form which will also indicate a subject's right of referral and appeal to a higher authority in the School through the University Ethics Committee.

9. Where the research methodology suggests that a different kind of consent is the only one possible, this will be made clear in the ethical approval form but the subjects will be made aware of the Principles of Ethical research.
10. All staff, researchers and their supervisors are required, before a dissertation begins, to submit an ethical and risk approval form to the School Ethics and Risk Panel. Only on formal approval, will the project be permitted to begin.
11. All research involving children, patients or staff in the Health Service or Education, will not be permitted at Undergraduate level and in this case, the research design and methodologies will need to be reviewed.
12. Research will not be permitted where there might be difficulties in obtaining the subject's informed consent. This to include but not be limited to the following examples: with vulnerable people, including children; and those with learning difficulties; when proposing to use covert observation; or when employing a methodology in which the practicalities of obtaining signed consent forms are infeasible.
13. This type of research at PG level, would require full application and approval from ORECNI, the NI regional Health & Personal Social Services Ethics Committee.
14. Only if and when the School or University Ethics Committee has approved the research can it commence.