

SUICIDE IN MODERN IRELAND
NEW DIMENSIONS, NEW RESPONSES

Suicidal Thinking
Saturday Morning 13 November

CONVERSATIONS THAT KEEP US ALIVE

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Teresa Mason: I want to now introduce to you Dr Tony Bates who will be known to many of you. He is the Principal Clinical Physiologist in St James Hospital and also a Course Director in the Department of Psychiatry in Trinity College with the coveted MSC Course. You may know him through his work within the media on the Marian Finucane Show and also in the Irish Times. Tony really would like to try to disseminate more of the useful findings from the field of Psychology to help the general population. I take pleasure in introducing him.

Tony Bates: I have a small difficulty here in that my laptop is not connected up. I had wanted to show you a short video clip as part of my presentation and it won't work on this particular laptop.

One of the things President McAleese said yesterday was that we all bring to this conference a different perspective on suicide. If you like, we all man a different lookout tower and so if you like, we have a unique perspective on this subject and each of you today has your own perspective that you can bring. My "lookout tower" is psychology, so I am speaking from that perspective.

There are many factors that can lead someone to choose to commit suicide. No matter what the particular route to suicide it is without doubt one of the saddest events in human experience. It leaves devastation in its wake as relatives, friends and loved ones struggle with the trauma of inexplicable loss and shock. When my cousin took his life at 24 years, I watched his parents slowly retreat into an unspeakable pain that broke their hearts, until death released them both, prematurely, from the inexorable pain of unanswered questions.

Many factors contribute to suicide and this conference will review a broad range of these, from constitutional/biological to social/cultural factors. Each of us has our own particular perspective on this problem, depending on the particular station we inhabit in life. Each of you here today has something valid to contribute to the broad conversation that constitutes this conference.

My lookout post is psychology. What I want to focus on is what happens psychologically when a person reaches a point of despair in their life. That moment of waking up in your life when you can see no way out, no way forward. The opening lines of Dante's divine comedy echo through history and capture the essence of this experience.

*In the middle of the road of my life,
I awoke in a dark wood
Where the true way was totally lost.*

That middle is not to be taken as a middle age thing, but the middle of wherever we are in our life. I would like to consider how to engage with these moments, to converse with them, how we can take care of each other and ourselves as we live through them, and maybe learn from them what they may be trying to tell us.

The conversation may be one we need to have with ourselves, because often we find ourselves isolated and alone in these moments. Or the conversation may be one we need to have with someone we care about in such a predicament.

The essence of these conversations is that they are courageous. They are unafraid to acknowledge the full intensity of the pain that is present and to stay with it. As clinicians we are required to bring an ethical awareness to such moments with our patients, to consider immanent risks and to take steps to put in place protective factors that can help someone to navigate their way safely through such a crisis. I'm assuming those of you at the coalface of mental health know how what is expected of you at those moments. This is not the conversation I want to address today but I don't want to suggest that that need not be there. Rather I want to talk about conversations that help us to stand our ground, to recognise and to validate distress in another, to be present to another at a level where there is a real connection with their experience that provides a channel through which pain can be released, sometimes in tears, sometimes in laughter, sometimes in silence.

Just listening last night to the 10 O'clock news, they were covering John Peel's funeral yesterday. Many of you will remember him as I do growing up. He seemed to be there at different points in my life. They said about him that he was extraordinary because he had taken the stories of ordinary people and made them feel special. I was thinking that that is a little bit about the quality that I want to feel we bring in a conversation with someone in distress.

When you hit rock bottom and when everything seems meaningless and have someone else there to affirm that experience, you see that it's not the whole story. The challenge of working with people in a crisis where their lives seem to hang in the balance is to engage them in a conversation where their experience is validated but also where there is this *felt* experience of a more liberating perspective.

One of the most common fears people mention on consulting a psychologist is their concern that there must be something 'strange', 'weird' or 'sick' about them because of the some particular distress they are in. They often feel stuck in their lives, distressed by feelings they don't understand, beset by fears that constantly seem to trip them up, depressed about the prospect of ever being free of their past, which seems to keep repeating in their life, over and over. They want someone to help them understand and make sense of what's happening. They may talk about suicide, many of them do, but often that's coded language for being very tired of oneself, exhausted by fruitless efforts to keep it all together. They want change. They want to shed the skin of an ego that is not working for them anymore and find a way of living where they're not continually banging their head of some wall.

I think Patrick Kavanagh was probably growing tired of himself when he wrote the lines:

*"Me I will throw away
me sufficient for the day
the sticky self that clings adhesions
on the wings to love and adventure.
To go on the grand tour
A man must be free of self-necessity."*

The self we want so dearly to hang on to cannot easily survive an encounter with real life with its constantly changing requirements of us. It is too small, too confining. It's a circle drawn too close to our history. It is often based on our ideas, our assumptions of what should be happening for us, and what we should have been able to avoid. It is a self-identity formed around beliefs about what we need to do to feel at home in the world, to know our place and to be confident about ourselves. When we set the conditions of belonging too high or hold to them too rigidly, they don't work for us when we find ourselves in a crisis, when the rug is pulled out from underneath us.

It can help to have some map of the territory when you are engaging with someone who hits suicidal despair. Some of you who are visiting this grand city of ours have probably picked up a tourist map. This locates some of the cultural highlights of the city on a simple road map that gives you just about enough information to get you around. But if you want to really get to know this city you will need more detail, you need a more subtle map. You need more information. Psychology is good with providing maps, or what we call models. These maps help to identify the more subtle aspects of our experiences of distress. They help us to see how different elements of our experience are connected, how our particular "symptoms" make sense and form a coherent pattern. This is important because it can restore our confidence that we are not utterly mad. And having a map can show us how to find our way home when we get lost.

CRY OF PAIN

The model that I want to talk about and that I think is very relevant in this conversation about suicide is the Cry of Pain Model of Mark Williams (1997). Mark proposed a model of what happens in a suicidal crisis that he calls the "cry of pain". In this model he views suicide as a reaction to finding oneself in a trap from which there seems to be no escape, where one feels both defeated and "locked in" and where there is no possibility of rescue.

Within this model, there is an experience of pain which I think is common in everybody's life prior to a suicide attempt. This feeling of being defeated or pain can arise from external circumstances such as conflicted interpersonal relationships or the absence of social support, economic stresses or unemployment, or from protracted inner turmoil, e.g. recurrent depression. It may be from external event, but what we know is that in people who recurrently attempt suicide, the evidence that there is some external event that provokes it gets less and less with each attempt that somehow the pain may not be so easy to locate externally and the pain may come from something that is happening within their own head.

The critical factor is that the individual who feels despair interprets the presence of psychological pain as evidence that they are defeated in some aspect of their life that is deeply important to them. Furthermore, they perceive that there is nothing they can do that to resolve this predicament ("no escape") and no possibility that other people or changing circumstances are likely to alleviate their suffering ("no rescue"). There is none of that support that Paul Soloff is talking about as being so critical.

People do not immediately succumb to this very despondent style of thinking. In the early stages of their struggles, they may be angry, protest and resort to multiple and often frenzied efforts to change their predicament. Eventually, repeated failure to alter their plight gives way to despair and helplessness. Like the behavioural sequence we observe in infants and animals faced with separation from secure attachments, or where there is a threat to their sense of safety in the world, adults often experience a progression from anxiety, to protest to despair.

The cry of pain model describes the subjective experience of someone who feels trapped, defeated and beyond rescue. Suicidal attempts in this model are seen as an expression of attempts to re-establish some escape from pain, a reaction to a grim combination of circumstances. The "cry of pain" model differs from the popular conception of suicide as a "cry for help", which views suicide as an attempt to purposefully communicate distress.

According to this model, the experience of despair unfolds through a number of stages that are a more painful version of what happens to any of us in an emotional crisis. The difference is that for someone who reaches despair and can see no way out, the elements of this experience seem to coalesce in a sinister way, that constricts their perspective of possible resolutions to their predicament.

I think of Virginia Wolfe who in her suicide note captures some sense of this:

"I want to tell you that you have given me complete happiness", she wrote her husband, "No one could have done more than you have done. Please believe that. But I know I shall never get over this, and I am wasting your life. It is this madness. Nothing anyone says can persuade me. You can work and you will be much better off without me. You see I can't write this even, which shows I am right".

William Styron, which in his amazing book on depression, his faith and deliverance and ultimate restoration is absent. The pain is unrelenting and what makes the condition intolerable is the foreknowledge that no remedy will come, not in a day, an hour, a month or a minute. If there is mild relief one knows it is only temporary, more pain will follow. It is hopelessness even more than pain that crushes the soul. At least for him that was what was happening.

What Marcus talked about, I think is intriguing is that in the depressed mode or what he calls the mindset that happens for someone prior to an attempt, there are a number of factors that happen and that happen normally for all of us. But there is a distinct difference e.g. there is some depressed mood and that depressed mood may be a reaction to an event but it could also be a very mild upset that triggers a depressed mood. For most of us, you know we get depressed, but for someone who has been severely depressed recurrently, a very small upset can trigger a fairly major catastrophe. Their mind begins to focus in on what their own experience is and they don't take in any other information that might be inconsistent, that might show the sense of a way out.

A) Presence of intense psychological pain

Most models of suicide behaviour agree that a central experience for the individual concerned is intense psychological pain. This may be provoked by loss, failure, rejection or any combination of these. But it isn't true to say that there is always an identifiable major upsetting life event prior to a crisis in the life of someone prone to depression or suicidal behaviour. For people who have had previous episodes of depression, very small changes in mood can activate large and potentially devastating changes in their thought patterns. John Teasdale (1988) called this phenomenon the "differential activation hypothesis".

B) Biased attention to negative information

When intense affect is provoked, it impacts on the way the mind functions in that moment, and limits our capacity for clear and reasonable thought. Attentional processes are hi-jacked as the individual becomes distressed and their perceptions become biased to only pick up cues in the environment that correspond with their sense of pain. Their mind increasingly focuses on elements in their world that are negative which, in turn, intensifies their sense of anguish and despair.

C) Rumination

They also start ruminate. Rumination is the curse. Rumination is probably what we do to try most urgently to avoid or to push any pain away. We begin to think of a way out of our negative mood; we try to push it away; we think how awful it is; we remind ourselves how badly we felt in the past when these moods took hold of ourselves and we say "we don't want this anymore". Instead of looking at what's happening and being there for ourselves in the heat of crisis we begin to weave our thoughts into a story line which gives rise to even more emotions.

Another aspect of mind that enters this unfolding drama is what has been called a "discrepancy monitor" (Segal et al, 2002). Evolution has hard wired this capacity within us to monitor where we are in respect to achieving goals we have set for ourselves. It comes into its own, for example, when we attempting to play a musical instrument and sound each note with the correct intonation. We know what we're trying to achieve as a desirable sound, and we monitor our playing until we have reached an acceptable standard of excellence.

Imagine how this capacity for self-monitoring reacts to the awareness of a negative mood state which is clearly escalating out of control. Clearly it perceives a serious mismatch between our current mood state and what we have always considered a desirable mood state. It is alerted to our growing dilemma and seeks to rectify it in some way. Unfortunately our discrepancy monitor is poorly equipped to deal with negative mood states. When it comes into play, it seeks to avoid or distance us from our negative mood state by a process of rumination. We begin to try to think our way out of our negative mood by "pushing it away", lamenting how "awful" it is to feel this way, reminding ourselves how badly we felt in the past when bad moods took a hold in us, and catastrophising all the negative consequences that will ensue if we don't "get a grip". Instead of simply looking at what's happening and being there for ourselves in the heat of a crisis, rumination weaves our thoughts into a story line, which gives rise to even stronger emotions.

Rumination is like a bellows we bring out to fan our distress and keep it inflamed. We sense we have lost our ground, that we are in no man's land, without that feeling of being real that we imagine is our true self. So we do everything to restore that sense of self. One writer (Chodron, 1997) has described this process of rumination as taking our feelings, marching them down the street with banners that proclaim how bad everything is. We knock on every door asking people to sign petitions until there is a whole army of people who agree with us that everything is wrong. We could just sit with our emotional energy. There's no particular need to spread blame and self-justification. But we throw petrol on our distress so that it will feel more real, so that we can recover that sense of ourselves that may feel horrible, but which at least feels real.

Many of our addictions stem from this moment when we meet our edge and we just can't stand it. We feel we have to soften it, to pad it with something, and we reach for whatever seems to ease the pain.

Instead of generating helping strategies to free us from the nightmare that is unfolding, rumination digs an even deeper hole than the one from which we are trying to escape. It also has a number of knock on effects. Rumination is relevant in a suicidal crisis because it has also been shown to impair our memory in ways that make us lose touch with what life has already taught us that may guide us through a crisis. Also rumination reduces our capacity for problem-solving, so that we find

it increasingly difficult to see a way forward when we are in distress. There is some evidence that rumination may be a more critical factor in suicidal behaviour than external stressors. Joiner and Rudd (2000) observed that external stresses are much less evident in repeated suicide attempters than in first time attempters.

The harder we insist on getting out of the mess we are in, the less able we become to see doors in the walls that surround us. Rumination intensifies the feeling that there is no escape from these recurrent lapses in mood and brings the individual one step closer to considering suicide as their only option.

D) Hopelessness

Hopelessness has been consistently identified as a strong predictor of suicide. Though suicide assuages present suffering, in most instances it is undertaken to avoid future suffering. If rumination reduces our capacity to access specific positive memories that gave meaning and direction to our lives, hopelessness refers to the inability to believe that the goals we aspire to in the future can ever be achieved.

Andrew MacLeod (2004) found in his research that people with a history of suicidal behaviour had virtually no confidence in being able to bring about good events in their lives. Unlike the non-depressed control group, they believed it wasn't smart to have hopes because you would only end up being disappointed. Contrary to his prediction that "hopeless people" are people who are disengaged from their future, MacLeod found that people who were vulnerable to suicide were those who were "painfully engaged" with their futures. Those who had resorted to suicide had the same dreams as those who did not, but they had very little idea about how to make them happen.

Cry of Pain: Summary

What Marcus talked about is that to some extent in the normal state of mind people feel all of those things to some greater or lesser degree. I imagine they would be familiar to some of you. What is different in somebody who has been depressed is that each of these components, intense affect, attention biases, rumination, and hopelessness can rapidly coalesce in a very sticky way together and create a state of mind which eclipses all sense of joy, value, meaning and attachment to others. They become lumped so that there is this awful sense of the familiar thud or kick in the belly where there is no way out. So that "No Escape" is the problem. This state of mind can be described as one of "entrapment". Repeated, futile attempts to avoid these states or to "think" their way out of them can understandably leave them with the idea of suicide as the only means of escape. Tendencies towards impulsivity and ready access to lethal options greatly increase the possibility of suicidal behaviour.

How does this model help us in thinking about ordinary people who are vulnerable to repeated episodes of despair and self-harm? I think it helps us to realise that what is happening is very real for them and what is happening may also be about something that they have to learn to take care of in themselves or something they have to take care of in their life, but at the moment in that mindset they can't think clearly. I believe what's this model points to is the need to slow down in the heat of a crisis and look at what it is we're trying to push away.

MARY'S STORY:

I saw a woman some time back. I am changing the details and so on just for her protection, but it was a story of a very ordinary woman in her early forties, Mary, who raised her family and who lived an imperfect family life but who managed to keep it all together until her husband announced he was gay. She was devastated and suddenly all her insidious feelings of failure as a woman and a wife which had been there for years began to make sense. She kept it all together until after her son's birthday, but afterwards there was no project to distract, no way to avoid the emotional storm that had been threatening for months on the horizon of her consciousness. Sunday was always a painful day, when the reality of all they couldn't be as family became unbearably obvious. A day came that was especially painful and she decided it would be the last Sunday she would bear this facade. Feelings of regret, failure and intense anger had reached a pitch and broke within her as she woke that day. No more, she had done all she could, there was no more she could give.

She had left the rope and the ladder in the outhouse some days before. She told her daughter she was taking a walk and headed down the garden to her personal gallows. Her goodbye note was in her make-up drawer, there was nothing more to do.

A neighbour who had heard the dog barking furiously found her. She was alive, just about. She was outraged at being rescued; she felt cheated and deprived of her escape from pain. A specialist who saw her in the wake of this event told her to cheer up, to promise not to do this again and to think of her children. It was recommended she buy a notebook and write down each day, something good that had happened for her. Medication was also prescribed and she agreed to comply. But while it restored her sleep and took the edge of her pain, benefits she greatly appreciated, it didn't change to real circumstances of her life. I think I want to always be aware that nearly always, mostly, there is something in their life, in their relationship with their own life that needs to be looked at. It sounds an obvious thing to say but I think it can be easy to over-psychologise or medicalise what is going on for someone in a moment of crisis. Two months later she made another near fatal attempt with the absence of any real resolution of real life problems.

When I saw Mary, she presented as calm and coherent, but her well-practiced social persona soon collapsed and gave way to spasms of crying. Two elements in her story struck me. When I spoke to her I was struck by two things. One was that sense of no escape – she saw her life continuing over and over forever and ever but the other was a sense that she kind of woken up in a very important way to something that was really happening, some real difficulty and I thought to myself how courageous that was to actually finally begin to acknowledge the full impact of the pain of living with this situation.

On the one hand she had acted out of a place where she felt that sense of entrapment, which Mark Williams, has described. She could see no escape, and she saw nothing happening that might rescue her from a lifetime of loneliness and bitter regret. Homicide had crossed her mind and she commented how much attractive Mountjoy jail had looked compared to the cramped space she lived her life in everyday. "He came out of the closet" she said, "but me and the children went in there".

I was also struck by an element of realism in her story. She had finally woken up to the full impact of a genuinely painful predicament for which there was no easy resolution. While it would be very critical and challenging to consider other less sinister options that those she had tried, it was very important to validate how difficult it must have been to let in the truth of her predicament penetrate. So we talked not so much about how terrible it was to feel despair and attempt to take her own life, but about just how important and courageous it must have been to finally acknowledge just how crazy her life had been. After a while, she was laughing and crying at how impossible things had been, for years. Her laughter was in no way a dismissal of the enormity of her situation, but a genuine and compassionate acknowledgement of all she had been through, she had carried it off heroically. Never telling anyone of the horrors she had known as a woman, forcing herself to keep going, to be a good mother and keep the show on the road for everyone.

I said to her at the end "you know your life is crap, it is really difficult" and at the end of the interview I asked had this been helpful and she said yes. I said that I had said nothing except that your life is really difficult and she said that she felt very grounded, very real. I think it was just a moment and there were many other interventions that would follow in terms of helping her to find ways forward and make small adjustments or just to discover her own power in that situation to act but I think what was good for both of us was that sense of just naming something and being there with it and not being afraid to look at it and not being afraid to say that things are hard when they are really hard.

Psychological help is most effective when given in the context of a relationship in which the suffering individual is undeceived about the nature and significance of a real, often complex and possibly insoluble predicament, and where they are encouraged to confront bodily those aspects of the predicament that afford any possibility of change. Later, Mary and I would explore small steps that she could take to find doors in the walls that surrounded her and to move towards recovering a sense of spaciousness in her life.

It is not so critical that we always know what to say. The more important point is that we are willing to approach rather than to avoid the reality of another's situation. In the film, *As Good As It Gets*, Jack Nicholson plays the role of a very antisocial neurotic individual who thinks mainly about meeting his own needs. His neighbour, a gay man who endured a terrible physical assault, only to return from hospital and find he is bankrupt, sits alone in his apartment at night, depressed and unable to sleep. In one scene, Jack behaves in a most uncharacteristic way and visits his neighbour at 3 am. He brings him soup, sits with him and they talk about the misery of being depressed and alone. No solutions are offered, no way out is strategised, but simply his willingness to sit with this man in his "dark wood", creates a powerful connection with him that becomes a turning point in

their relationship. It is funny to watch but I believe it is also a wonderful portrayal of a conversation that keeps them both alive. Sometimes we may not know what to say, but being able to sense the depth of pain in another and move towards it rather than away from it can be enough.

As well as being there for someone else, we need to consider what skills we can give people to be there for themselves, without getting pulled into rumination, despair, entrapment and impulsivity, when they are visited by emotional storms.

We know that people who, like that guy and like Mary that I talked about, go away and have to be with themselves and that they are very vulnerable to repeated attacks and assaults from their own mental processes. People who carry within them a vulnerability to depression are easily primed to experience this kind of negative mental state that throws them into despair. It is unrealistic to think we can remove their vulnerability to lapses in mood, but it is likely we can teach people ways to prevent the avalanche of negative psychological, emotional and physical forces which can take hold in such moments. In dealing with that one of the approaches that I have been very interested in has been the Mindfulness-based Cognitive Therapy which has been an attempt to bring something to people who have been constantly experiencing a recurrence of these mindsets and trying to help them to not fall into that deep hole which seems so compelling and so seductive and so magnetic for them. Mindfulness has been recently employed as a different strategy from conventional psychotherapy approaches that may offer individuals different options for responding to their emotional storms.

WHAT IS MINDFULNESS?

Mindfulness is the practice of being attentive to whatever you are doing, whatever you are feeling, in the present moment, being grounded, being stable in the moment. It is about using our breath, using our own awareness to come back into our bodies to anchor ourselves and it gives us a place to look at what is happening and to take care of ourselves in that moment of self-monitoring or self-observation. It is about waking up to your life so that you are fully living it in this moment. Mindfulness has its origins in both Eastern and Western spiritual traditions of meditation, but its application within psychotherapy has to do with its capacity to help us find calm and stability in the face of painful emotions. Therapies in recent years have emphasised change and self-control. While these approaches have their place, they fall short in helping us deal with emotional distress that recurs over and over, despite our best efforts. Often the most effective method of dealing with our negative moods, is to gently acknowledge what's happening and let them be, without becoming pulled into doing battle with ourselves. Using the breath as an anchor to bring your attention to the present moment, mindfulness encourages an attitude of acceptance and kindness towards your experience instead of one of self-criticism. It offers a way to be with your bodily sensations, your feelings and our thoughts without becoming overwhelmed by them. The foundation of mindfulness is a compassionate attentiveness to your experience, so that you can begin to be present to what is actually happening in your life in the here and now. Mindfulness meditation is essentially about taking time to be in touch with yourself, so that you feel embodied and grounded, instead of disconnected and alienated.

As one of our patients said, "it gives you a viewing tower from where you can see what is going on without becoming pulled into that place". In our work in St James we have begun to work with some people with very long term enduring difficulties but the model has been used very successfully with people with chronic recurrent depression and it has been found to reduce that by a factor of about 40%.

In Cluain Mhuire, Clare Kingston, who may be here and Grace Lawlor did work with two groups of ten people with depression and found that it also reduced that process of rumination. It allowed them to be aware but to stay with and to be able to disengage from all of that storyline that we build up. It has been shown that with borderlines

Mindfulness-based Cognitive Therapy (Segal, Williams and Teasdale, 2002) incorporates the basic practices of mindfulness meditation with some of the very practical methods of preventing relapse in those who have known deep depression. It assumes that "much of the unendurable 'psychic pain' experienced by suicidal people arises from their attempts to reduce, change, or fix their pain and from the thoughts that arise when such attempts fail" (Williams and Swales, 2004). For example, the depressive/suicidal mode of thinking is characterised by a strong desire to push away, to avoid, negative affect; focusing on discrepancies, a view of thoughts as reflecting reality, the experience of being pulled back into past negative memories and of being drawn into futuristic scenarios that are hopeless, and automatic physical and behavioural reactions. In contrast to this mode of thinking, a mindfulness mode encourages approach rather than avoidance, an attitude of acceptance and allowing of whatever feelings are present, a recognition of thoughts as mental

events rather than as accurate reflections of reality, and a focus on present moment experience as it unfolds, rather than allowing the mind to be pushed and pulled into the past and future.

By changing how we attend to our experience, mindfulness changes how we process that experience and connects us with our deeper capacity for discerning what is really happening and how we might best act to address our needs. Mindfulness intentionally disengages our discrepancy monitor and our natural tendency to ruminate. It focuses us on our direct experience rather than what we think is happening – or should/shouldn't be happening - and moves us into a gentler and non-avoidant relationship with our actual experience. It does not seek so much to remove our unwanted symptoms but to place us in a different relationship with them, one where we become calm enough to observe what is happening and bring compassion rather than self-condemnation to our inner lives.

By learning to simply observe rather than act on these thoughts, clients can be empowered to disengage from negative patterns of thinking by acknowledging their presence and bringing their attention back to the present moment by focusing on the breath. Mindfulness practice continually teaches us to re-direct our attention to the breath as a way of helping us to feel anchored and stable in the present moment. It allows us to steady ourselves in a crisis and read more wisely the feelings we are experiencing and what steps we need to take to address those aspects of our lives that are not working for us.

EPILOGUE

Chesterton said of us Irish that all our love songs are sad, all our war songs are merry. Our literature, our songs, our capacity to celebrate has been built not so much around success and who has won through on a particular day, but around who is still standing there with their honour, their dignity and their integrity, in the midst of loss, when things have fallen apart. We have been able to own the story from which we've emerged and tell it, no matter how difficult, no matter how fierce that story has been. We have managed to celebrate in the midst of incredible losses; we have been able to hold on to a sense of self-esteem that is not contingent on some external measure of success, on having always made it, and come out on top. This is an amazing legacy to draw on when it comes to our own lives. We have within our collective unconscious and in our cultural mythologies (including our spiritual traditions, from which we have become estranged for understandable reasons), many stories that reveal our resilience as a people. But when I look at the dominant conversations of our culture, shaped by TV, materialism and perfectionist standards we can never sustain, I wonder have we lost our nerve as a society?

On TV this week, I listened to an explanation of the recent epidemic of suicides in Middleton in terms of a change of values in our society. One speaker pointed to the addiction we have developed to pleasure and material gain. Whatever about the addiction to pleasure, it also strikes me that we have certainly lost our confidence as a society make sense of and face pain and loss. To be real with one another about what hurts in our life, what's not working out, rather than relate superficially about how 'fine' it all is.

The conversations that ultimately keep us alive are those that give us the courage to hang tough in difficult moments, to lighten up in the face of things going haywire. Life can always be relied upon to pull us out by the ears and shake us to our core. In those moments we wake in the middle of Dante's wood, where the way forward is obscure. These are the moments we need someone to hold faith in us, or to hold faith in our own goodness as individuals. We need encouragement to hang tough and to become really curious about what's happening. If we could only learn to let the dust settle in the heat of a crisis, we might begin to read the message inherent in our "symptoms"; to update our sense of identity, to one that includes lots of feelings we would rather disavow, and to reconsider how our relationship with the world needs to change.

This requires that we, the health professionals, are honest with ourselves about our personal dark moments. We need honest conversations where we can really grapple with our experience so that we can be there for our patients.

McCarley (1975) worked for a number of years with psychotherapists who attended his workshop at the American Psychiatric Association conference. He identified three dominant themes reported by individuals at the coalface of psychiatry: these included an oppressive feeling of being overwhelmed by the responsibilities of caring, a realisation of how burdened they were by their belief that they constantly give to others and an inner sense of deprivation.

Professionals struggle long-term with the blunt instruments of therapy against the unyielding clay of illness, dysfunctional personality and inhuman social systems. This work holds both the potential for personal growth as well as for the wearing down of morale and self-esteem. To continuously

function in the role of compassionate witness to the suffering of others requires that therapists consider their personal need of resources and the conversations that can sustain them. At the very least therapists need to equip themselves with a philosophy that embraces both the inevitability of suffering and the inherent resilience of human beings to overcome life's obstacles and challenges. I would like to end with a poem of Seamus Heaney that encourages us to step outside our comfort zone. Co. Clare might be a place we visit, as he suggests in this poem, but for our purposes I would like you to think of it as any place where you can go to allow yourself be opened to a larger vision of what your life can be. It may even be a place that scares you.

Postscript

*And some time make the time to drive out west
Into County Clare, among the flaggy shore,
In September or October, when the wind
And the light are working off each other
So that the ocean on one side is wild
With foam and glitter,
while inland among stones
The surface of a slate-grey lake is lit
By the earthed lightning of a flock of swans.
Their feathers roughed and ruffling, white on white,
Their fully grown headstrong-looking heads
Tucked or cresting or busy underwater.
Useless to thing you'll park and capture it
More thoroughly. You are neither here nor there,
A hurry through which known and strange things pass
As big soft buffetings come at the car sideways
And catch the heart off guard and blow it open.*

Conversations that keep us alive are conversations that bring spaciousness to our experiences and release us from cramped, distorted perspectives that imprison us. Conversations where our hearts are blown open; where a larger and more creative vision of our lives is revealed than the one we see through the lens of our despair. We find ourselves not by holding tight to who we think we are but through trusting ourselves to meet life at whatever frontier it has brought us to; maybe some painful edge where the way forward is not clear. This is the only place where we can discover who we really are, where we come alive, and experience our lives to. Thank you, may these few days blow your hearts open and help you to see wonders in your own life, at whatever edge you are on just now.

Teresa Mason: I want to thank Tony for that very interesting presentation and for challenging us to bring the hearts to the work and were on the coffee time but I think it would be great just to take the opportunity to take a couple of questions or to ask our presenters to take a couple of questions before we move to coffee.