Loss, trauma and post-traumatic growth

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THESIS CONTAINS

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Section A: Preface

The central theme of this thesis is the promotion of understanding of the potential effect of a loss or a traumatic event on the individual. The thesis aims to raise awareness of the unfortunate reality of client death by suicide, how clinicians react to clients who are suicidal and how a client suicide may be experienced, including the threat to their professional identity. The thesis illuminates a range of possible individual response to trauma or to loss. It is claimed that the profession of Counselling Psychology arose from a concern with the fulfilment of potential (Woolfe & Dryden, 1996) and on well-being, rather than pathology. While some suggest that psychology has put too much attention on the negative aspects of human behaviour and on pathology, it is, perhaps, necessary to appreciate both aspects, and to view individual responses to trauma and loss as part of a continuum. Thus, the thesis portfolio explores the diversity of responses to a loss or traumatic event and the potential for individual growth.

The profession of Counselling Psychology stresses the importance of research and the scientist-practitioner model, based on the idea that an essential aspect of the role of the Counselling Psychologist is to engage in an ongoing process of research, in order to evaluate practice (Woolfe, 1996). One of the aims of the profession is to find ways of combining research and practice that are grounded in the primacy of the counselling relationship (British Psychological Society, 2005). The scientist-practitioner model takes an integrated approach to developing knowledge, recognising the links between theory, research and practice. Counselling Psychology developed as a branch of professional psychological practice influenced by human science research, as well as the psychotherapeutic traditions. It draws upon, and seeks to develop, phenomenological models of practice and enquiry, in addition to traditional scientific psychology. The aim of most qualitative research is to produce knowledge which is relevant and useful at a particular time and place, that is, local knowledge which derives from, and will be applied to practice. This philosophy is reflected in the research study, as it derives from the experiences of clinicians and may influence clinical practice.

In qualitative research methods, the researcher is constantly mindful of the social and historical context within which the enquiry is taking place. Phenomenological approaches employ methods which emphasise the unique experiences of the individual, including interpretative phenomenological analysis (Smith, 1996). As a researcher, the position had similarities of that of an empathic therapist. In order to explore the participants' view of the

world, like the therapist, the researcher needs to hold an 'insider' and 'outsider' position simultaneously. As the analysis is the result of a dynamic interaction between the participant's accounts and the researchers' interpretative framework, it is inevitable that the position of the researcher influences the study. Throughout the thesis, several attempts are made to identity the researcher. These attempts do not lead to transparency of the inherent biases and personal history of the researcher. They can offer only a small portion of my relevant life, as although a researcher may consciously accept that their processes are inextricable from their personal histories, we have value systems and ideologies which we may not ever be able to fully describe (Forshaw, 2007).

This portfolio consists of three main sections, each focusing on different areas related to the central theme of the effects of a traumatic or loss event and the recovery of the individual. Firstly, the exploratory research study examines the psychological effect on Counselling Psychologists and other mental health clinicians of clinical practice with suicidal clients and their experiences of client suicide. The second section examines the literature surrounding the validity of the construct of post-traumatic growth, which is said to occur in some individuals following a loss or major trauma. Finally, a reflexive exploration focuses on the challenges of working therapeutically with an individual who was struggling to cope with the adverse effects of her experience of a traumatic event. While some negative psychological responses emerge from the clinicians' experiences of client suicide within the research study, an increase in self awareness and many positive outcomes were also reported. Therefore, each section is connected, as they all shed light on different aspects of the effect of loss or trauma.

Section B: Research

The research study explored the lived experiences of clinicians' practice with suicidal clients and following the death of a client. The perspectives of Counselling Psychologists, Consultant Psychiatrists, Community Psychiatric nurses, and a Cognitive Behavioural Therapist were examined. When engaged therapeutically with suicidal clients, some clinicians have described themselves as being deeply affected (Richards, 2000). Following the critical, often traumatic event of client death by suicide, the effect may be personal and professional (Horn, 1994). Unfortunately, there is some research evidence that the majority of psychologists question the adequacy of their training as preparation for this event (Valente, 1994, Trimble, Jackson & Harvey, 2000). Additionally, some clinicians report that they feel unsupported after a client suicide (Kleespies, Penk & Forsyth, 1993). Therefore, the

research aimed to explore the participants' perceptions of the preparation and support that they received and the type of emotional support that they desired in the future. As the suicide of a client may lead to anxiety in clinicians when accepting future referrals of suicidal clients (Little, 1992; Hendlin, Lipschitz, Maltsberger, Pollinger, Haas & Wynecoop, 2000), any effect on the future practice of participants was explored. Further attention was paid to any subsequent involvement in formal and legal procedures, which may include an investigation into the cause of the client's death.

Four main themes emerged from the data, entitled: *Understanding the client and self, Impact of client death, Subsequent influential experiences* and *Evolving*. Contradictory accounts emerged of experiences with suicidal clients, as some felt confident, while others became very concerned about their client and the unknown outcome of whether their client might die by suicide. The responses of the participants to client suicide emerged as a major part of this research. Several participants felt they had failed their client, and reported initial disbelief, shock, fear and anger. The experience of client suicide emerged as being perceived as a threat to the continuity of professional identity. The accounts are discussed in the light of the empirical literature and theories of loss, including Janoff-Bulman's (1989) assumptive world's theory and Breakwell's (1986, 1996) identity process theory. The study outcomes provide some very useful insights for Counselling Psychologists and other mental health care clinicians who practice with suicidal clients and may, therefore, also be affected by a client death by suicide.

Some of the participants indicated how their self perception had changed in a positive direction after their experiences, leading to the researchers' curiosity about why some individuals may discover positive perspectives following a loss or traumatic event, but others do not. Thus, it was decided to examine the evidence base for the concept of post-traumatic growth.

Section C: Professional Practice Piece

This section presents a client study that explores working therapeutically with a female client with Post Traumatic Stress Disorder (PTSD). The focus of this piece of work is on the professional practice of Counselling Psychology within my chosen therapeutic model. This client study was presented because it proved to be a valuable learning experience, both professionally and on a personal level. The clients' difficulties are formulated within the appropriate treatment model and evidence of critical reflection and specific learning from the

case is presented. The case demonstrates how Cognitive Behavioural Therapy can be used to both reduce symptoms in PTSD and to promote greater client self-understanding concerning the role of appraisal and underlying core beliefs. Within this case, I also attempted to be mindful of the possibility of the emergence of post-traumatic growth once the initial symptoms of distress had reduced. While relief from symptoms is an important outcome for clients, positive mental health and optimal functioning are also considered to be important outcomes by clients (Kuyken, Padesky & Dudley, 2009). In recent years, a strengths-focused approach has been advocated within Cognitive Behavioural Therapy case conceptualisation (Mooney & Padesky, 2002; Padesky, 2005; Padesky & Mooney, 2006; Kuyken, et al., 2009). The collaborative case formulation helped to identify the clients' strengths and the clients' characteristics, including her sense of humour, served to develop and strengthen the initial formulation. This case interlinks with the other sections within the portfolio by illustrating the range of potential responses to trauma. It provides an example of my clinical intervention with an individual who was affected by severe symptoms of PTSD, where the case formulation served to both help to reduce client distress and facilitated the client to focus on re-building her existing strengths.

Section D: Critical literature review

The aim of this piece of work is to present a critical appraisal of the literature on a topic that is relevant to the profession of Counselling Psychology and which links to the other work within this portfolio. The critical literature review is entitled '*The challenges of traumatic loss: the phenomenon of post-traumatic growth.*' The development of post-traumatic growth following a loss or trauma within individuals is particularly important to Counselling Psychologists as it may be overlooked by clinicians. Symptoms of distress may often co-exist with post-traumatic growth, although clinical interventions have not generally been explicitly aimed at increasing the individuals' perceptions of post-traumatic growth (Park & Helgeson, 2006). Although loss and trauma are not intrinsically positive events that will necessarily build human strength, the experience of loss or trauma can become a profound means for revealing human strengths and potential (Miller, 1981). Some of the theoretical models offering an explanation for the development of post-traumatic growth are examined. In addition, an integrated theory of post-traumatic growth (Joseph & Linley, 2005), and Rogers' (1957) humanistic psychological theory are examined and the differences are highlighted. The pertinent literature concerning post-traumatic growth is reviewed, and the methods that are currently employed to assess post-traumatic growth are critically discussed. Finally, some of the clinical interventions that may enhance individual post-

traumatic growth within the practice of Counselling Psychology are proposed.

In conclusion, the implicit theme of loss and of recovery within this portfolio is integral to the profession of Counselling Psychology, as much of our work is concerned with enhancing psychological functioning and effectiveness. As Counselling Psychologists, we may be in an optimal position to develop the more positive aspects of psychology, grounded in the assumption that individuals can overcome many adversities.

Section B: Research: 'A phenomenological exploration of clinicians' lived experiences with suicidal clients and following client suicide'

Supervised by Dr M.C. Cross

Abstract

This study explored the lived experiences of twelve mental health care clinicians working therapeutically with suicidal clients and following client suicide. The participants included six Counselling Psychologists, two Consultant Psychiatrists, three Community Psychiatric Nurses and a Cognitive Behavioural Therapist from an opportunity sample. The study took place within a National Health Service Mental Health Trust located in the South East of England. All the participants worked with suicidal clients. Nine had experienced the suicide of one or more clients.

Employing interpretative phenomenological analysis, four key themes emerged: *Being with suicidal clients, Impact of client death, Subsequent influential experiences* and *Evolving.* Therapeutic intervention with suicidal clients emerged as being a source of anxiety for some participants, while others felt confident in wanting to explore the clients' concerns in depth. Following client suicide, shock, initial disbelief, fear, guilt and anger were apparent. Therapeutic relationships were influential in the participants' interpretations and understandings of the death. The attachment to the client was considered, by some, as being almost shameful, while others had tenuous therapeutic relationships. Some participants expressed potent feelings of grief arising from the loss. Past experience of bereavement by suicide emerged as shaping the views taken of suicidal clients and the responses to client suicide. Subsequent events, including involvement in an investigation into the cause of the death, were considered as being influential factors in the overall experience. Relationships with others which provided comfort and affirmation were considered to be a protective factor. While several participants gained support from clinical supervision, others felt that it did not meet their needs.

An attempt was made to offer explanatory frameworks in order to situate the participants' experiences. Together with the effects of a loss, some participants' perceptions of failing as a competent professional added some support to the notion of threatened identity, due to rupture of the 'continuity' of professional identity. Transformative processes included gains, such as being considered as an 'expert.' The changes that are described are consistent with the reflexive practitioner position of Counselling Psychologists. The implications of the findings include Counselling Psychologists' involvement in the development of support systems. Finally, a suggested method of providing information to clinicians (Appendix 11) has been drafted as a result of the study outcomes.

Chapter 1. Introduction: Literature review

1.1 Client suicide: 'an occupational hazard' for clinicians in mental health care

The prevalence of suicide and its emotional impact have implications not only for surviving loved ones, but also for those involved in their mental health care. Shneidman (2001) noted that the individuals who kill themselves are not the only victims of suicide, as the 'survivors' are also victims. An individual death by suicide can be likened to a stone thrown in a lake, causing many ripples, which turbulently affects the surface of the water.

The average annual suicide rate of England and Wales was 9.2 deaths per 100,000 of the population in the three years from 1995/6/7 (Department of Health, 2008). The government has made a concerted effort to reduce the substantial mortality and morbidity burden associated with suicide and suicidal behaviour, leading to several sweeping national strategies (Taylor, Kingdom & Jenkins, 1997; Department of Health, 1999; Department of Health, 2002). One strategy was to set targets to reduce the suicide death rate by one fifth by the year 2010, a claimed saving of 4,000 lives (DoH, 2002). Encouragingly, the most recent figures available indicate a reduction to 7.9 deaths per 100,000 of the population during the three years of 2005/6/7 (DoH, September 2008).

The mental health care professionals that are affected by the death of a client by suicide include psychiatrists, psychologists and counsellors. Kleespies, Smith and Becker (1990) found that 19% of former trainees in psychology had a client attempt to die by suicide, and 17% had a client die by suicide. There is evidence that counsellors may also be affected, as of 376 counsellors responding to a national survey, almost one quarter (23%) had experienced the suicide of a client they were treating (McAdams & Foster, 2000). Research indicates that approximately 20-25% of psychiatrists' patients have died by suicide, and psychiatry residents have higher rates of patient suicides (Kleespies, Penk & Forsyth, 1993). Therefore, it appears that the possibility of client suicide is ever present (Schwartz & Rogers, 2004) within these professional domains.

Approximately a quarter of those individuals who die by suicide had been in contact with mental health services in the year before their death (Appleby, Shaw, Amos, McDonnell, Harris, McCann, Kiernan & Davis, 1999). Their primary diagnoses were depression, schizophrenia, personality disorder and alcohol dependence. Clients with these types of mental health problems are frequently seen by clinicians within community mental health

services including those who took part in this study. Thus, it seems logical that a client death by suicide has been deemed to be an 'occupational hazard' for both students and qualified practitioners in the disciplines of psychiatry and psychology (Chemtob, Bauer, Pelowski & Muraoka, 1989). The introduction to this important topic firstly includes the position of the researcher. It will also set the context for the research study by examining associated issues including ethical concerns and clinical supervision. The pertinent literature concerning the effect on the clinician of practice with suicidal clients and client suicide will subsequently be reviewed.

1.2 The place of the researcher

Qualitative research is 'essentially, an interpretative endeavour,' (Parker, 1998) placing great emphasis on subjectivity and reflexivity (Burman, 1994). As the researcher is central to the study, it is important to recognise the background knowledge, inherent biases and assumptions that are brought to the study by the researcher (Brocki & Weardon, 2004). This section introduces the researcher, within the context of the methodology of the study.

IPA research aims to capture and to explore, in detail, how participants make sense of their personal and social world (Smith & Osborne, 2003). IPA incorporates pertinent theoretical concepts from phenomenology, hermeneutics and ideography. Phenomenology is the philosophical approach to the study of experience (Smith, Flowers & Larkin, 2009). The investigation of a phenomenon starts with what is experienced, which is taken as being 'reality' (Ashworth, 2003).

The active role placed on the researcher in the research process connects IPA with the theory of interpretation or hermeneutics (Eatough & Smith, 2008). Hermeneutics was originally concerned with the interpretation of texts. A recognised early discussion of hermeneutic method is found in the work of Heidegger (1962), a leading figure in phenomenological philosophy. For Heidegger (1962), phenomenology is concerned, in part, with the examination of something that may be hidden or disguised as it emerges into the light with visible meaning. What appears is considered to be connected to the deeper, latent form, being both a part of it and apart from it, illustrating the dual quality of the notion of appearance for Heidegger (1962). Following Heidegger (1962), IPA is concerned with examining how a phenomenon appears, and the researchers' analysis attempts to make sense of this appearance, through interpretation. However, access to others' experiences is partial, complex and will depend on the researchers' own perceptions (Smith & Osborne, 2003). Our view of others is influenced by the shared, overlapping and relational nature of

our engagement with the world (Larkin, Watts & Clifton, 2006). Intersubjectivity is the concept that aims to describe this relatedness and to account for our ability to communicate with, and make sense of, each other (Smith, et al., 2009).

From the perspective of IPA, cognitions are considered to be part of the complex process of sense and meaning-making. Cognitions are accessed indirectly, through accounts, stories, and language (Smith, et al., 2009). What is said can be considered to be affected by what is required of the participant (Smith, Harre & Van Langenhove, 1995), such as their role as an employee within the National Health Service. IPA assumes that the meanings that people ascribe to events are the products of social interactions (Willig, 2001), as the individual is embedded within a particular social context. The third major theoretical influence in IPA is the idiographic (particular) level that is taken when attempting the understanding of a particular phenomenon, situating particular individuals within their context, and exploring their personal perspectives. The goal in IPA is to understand and to interpret participants' meanings of an experience and to consider how meanings are constructed in both a social and a personal world (Smith & Osborne, 2003).

The interpretation of the participants' experience is considered to be dependent on and implicated by the researchers' view of the world (Willig, 2001). Thus, a dynamic two-stage interpretative process or double hermeneutic is emphasised, as 'the researcher is trying to make sense of the participant trying to make sense of what is happening to them' (Smith, et al., 2009, p.3).

My professional background as a Chartered Counselling Psychologist in adult mental health settings including crises teams and community mental health teams has involved practice with many suicidal clients. I provide clinical supervision to other Counselling Psychologists. My theoretical background includes Cognitive Behavioural Therapy. Both my professional background and my awareness of the current literature surrounding the impact of client death by suicide may inadvertently affect my interpretation of the accounts and being mindful of this is one precaution to misrepresenting the perceptions of my contributors.

A factor that influenced this study is that I have personal experience of death by suicide. A member of my family, one of my grandparents, died in this way. I did not know him and I initially felt shocked and saddened. I wondered what had caused him to feel so desperate. I am left with many questions which cannot be answered. In addition, my experiences include one of my clients dying by suicide, when in hospital some months after I met with him. This experience shook me, and I felt for him and his family. I saw him on only one occasion.

Essentially, driven by curiosity about how others coped with the suicide of a client, I decided to focus on exploring others' experiences. It was, however, very important for me to consider some of the possible difficulties of conducting research with participants from within the same Trust in which the researcher practices. Inadvertent exploitation may occur, due to the inevitable power imbalance in the research relationship (Hammersley & Atkinson, 1993). Additionally, although a qualitative interview can be therapeutic, some participants might later regret confiding in the researcher (Small, 1999). Although I was employed by the same Trust, I did not have working contact with the participants, and these issues were addressed following the recommendations of the Ethics Committee. Letters of support for the study from the managers of potential participants were received before the study commenced. Those who wished to participate approached the researcher directly. Therefore, it was intended that those who took part did so completely voluntarily, and they were comfortable in this. The procedure that was followed is presented in detail within the Method Section.

Before carrying out my research, I was aware of the National Health Service 'Serious Untoward Incident' investigation procedure, where the circumstances of the suicide death are examined, and individuals are questioned about their involvement. Some of my colleagues have found this to be stressful and challenging. This awareness of others' experiences and feelings led to an assumption that people might be hurt or angered by this process. I was concerned that people would not want to talk to me about it, or that they might feel judged and thus feel defensive, as this is a sensitive area. However, I was very curious to find out how they coped with a clients' death.

My own thoughts about clients dying by suicide are that I have a role to play in exploring this and taking all steps to prevent it if possible. However, my ideas about suicide have changed since becoming a Counselling Psychologist. Before this, I felt that individual death by suicide resulted from a person's choice. I realise now how mental health difficulties will influence thinking, and people may feel so helpless and disempowered that the decision to continue to live becomes less of an option. I see my role as to be empowering and supporting of individuals, and, if necessary, arranging for their admission to hospital. This is an attempt to be critical and reflexive of what may influence my interpretations, seeking to make explicit bias arising from formal knowledge and professional experience drawn from the context in which I have and continue to work, as well as my underlying personal experiences which influence me and may influence my understanding of my contributors.

It is also recommended that the position of the researcher is located within the construction of the research findings (Banister, Burman, Parker, Taylor & Tindall, 1994). Thus, my

reflections, following the interviews, were made after conducting each of the interviews (Process Issues: Reflexive Diary, Appendix 10). Finally, in my attempt to demonstrate my learning from the research experience as a whole, a 'Personal Reflexivity' section was included after the study finished. This can be found at the completion of Chapter 3: Analysis and Discussion. However, despite the inclusion of these sections, when conducting qualitative research, researchers may be driven by their unconscious needs and drives, which cannot be publically articulated.

Finally, within this study, consideration was given to the language used to describe suicide, as the language used is said to be linked with the shame of being associated with suicide (Sommer-Rotenberg, 1998). In order to address one aspect of the language that is used, Sommer-Rotenburg (1998) suggested that individual suicide is not described as 'committing' an act, as acts that are usually 'committed' tend to be heinous ones, such as adultery. The connotation with dishonour or illegality of suicide intensifies the stigma attached, and does not convey that suicide may be the result of severe illness. Sommer-Rotenberg (1998) proposed that changing the use of this expression may prepare for a change in attitude, and that instead, we use terms such as 'ended one's own life', or 'self-inflicted death'. The use of neutral, compassionate language may send a powerful message to both clients and society at large. Throughout this paper, therefore, the researcher will use the term 'death or died by' suicide, rather than 'committed' suicide, where possible.

Having introduced the context of the study and the researcher, legal and ethical issues within the context of client suicide are an important consideration. The professional responsibilities of Counselling Psychologists and other clinicians surrounding their interventions with suicidal clients will firstly be explored.

1.3 Ethical and legal issues

1.3.1 Professional responsibilities

The term 'clinical accountability' covers a range of individual professional codes of conduct and clarity of roles in the changing structure of interdisciplinary teamwork within community settings. Clinical accountability is no longer the ultimate responsibility of a consultant psychiatrist within mental health teams, as each team member exercises individual responsibility towards the clients that they care for. This is, however, framed in the context of realistic expectations and mental health workers cannot give a complete guarantee of risk elimination when in practice with suicidal clients. Clinicians are bound by their professional

codes and by policies regarding the prevention of self harm and /or suicide, which outline the steps to be taken in the provision of care for the client.

Mental health professionals should reasonably anticipate and take actions to prevent 'foreseeable risk' to clients, which is generally defined as 'the reasonable anticipation that some harm or injury is likely to result from certain acts or omissions' (Simpson & Stacy, 2006, p.185). While clinicians are not expected to predict a client suicide, they are expected to recognise and intervene in order to prevent foreseeable suicidal behaviour. The legal and clinical standard of care involves the completion of a thorough evaluation of the risk to the client and the implementation of proper interventions (Moss, 2005). Having briefly examined some of the issues within the broad area of clinical accountability, consideration of some of the ethical dilemmas that clinicians may face will now be addressed.

1.3.2 Confidentiality

Several ethical issues are relevant to the management of suicidal clients, including client confidentiality, in terms of when and what to tell others about the client at risk. Within an organisational context such as the National Health Service, the clinician is bound by their contractual obligations to the organisation and to their professional codes of conduct. Client confidentiality is central to developing a trusting relationship with the client. It is the clinicians' responsibility to inform the client of the degree of confidentiality that can be promised with regard to all issues including suicide risk. The degree of confidentiality is usually set by the organisation. In general, it is accepted that concerns must be shared when it becomes clear that clients might do serious harm to themselves or others. If, however, the client does not clearly articulate their suicidal intent, but the clinician feels sure that they are intent on dying by suicide, this becomes problematic.

Corey (1996) notes that breaking confidentiality has been viewed by many practitioners as being good practice in homicidal risk, suicide risk, and child abuse (Pope, Tabachnick & Keith-Spiegal, 1988). However, there may be a difference between what clients expect and what is commonly accepted as good practice. Miller and Thelen (1986), when exploring the understandings of clients on entering therapy, found that the majority of respondents (69%) in their study believed that everything that was discussed with a mental health professional would remain confidential, reinforcing the importance of agreeing the limits of confidentiality with the client at the start of therapy.

1.3.3 Dilemmas concerning suicidal clients

When a client expresses suicidal ideas, this may raise dilemmas within clinicians. In one of the few qualitative studies concerning the issues and dilemmas of clinical practice with suicidal clients within experienced clinicians, Reeves and Mintz (2001) interviewed four female counsellors. The interviews were transcribed and examined, extracting threads, themes and meanings. Two main categories emerged, including the counsellors' experiences of responding to suicidal ideation and the impact of training and organisational factors. Feelings of anxiety, fear, panic, impotence and doubts about their ability to work safely and appropriately emerged. There was a need indicated for affirmation of the counsellors' specific clinical interventions. Responses were influenced by the counsellors' views of suicide, the threat of litigation and accusations of malpractice. The counsellors did not feel that their training had prepared them effectively in terms of their skill and theoretical knowledge. They reported struggling with issues of confidentiality and were anxious about the implications for the organisation if the client were to die. When their client expressed suicidal intent, they reported an apparent loss of professional perspective and doubts about their ability to practice safely and appropriately. A tension arose, involving some interviewees' personal views about suicide. In those who 'did not approve' of suicide, they were clear about telling others, but conversely, some struggled in knowing when to tell others when they personally 'agreed' with suicide as an individuals' choice. Organisational policies were seen as shaping the choices made about when to tell others of their clients' intent. In conclusion, within this study, particular dilemmas faced by clinicians with suicidal clients are highlighted. Some of the responses of fear and panic are similar to those reported following the actual death of a client by suicide (Boakes, 1993; Menninger, 1991; Valente, 1994), which appears to draw attention to the intensity of reactions that may be experienced by those in clinical practice with high risk clients. Some useful recommendations for practice include the key areas of assessment, contracting, risk issues and the need for discussions about client confidentiality. There is, however, a difficulty in generalising the subjective experiences of four female counsellors across all counsellors and situations, which was acknowledged by the authors. The qualitative approach of Reeves and Mintz (2001) provides a view of the particular issues faced by clinicians in practice with suicidal clients. Expanding such studies to include male participants and those of different theoretical orientations may provide a wider perspective of the potential difficulties. These aspects will be addressed within the current study.

A further qualitative study was conducted in the United States of America (Knox, Burkard, Jaxson, Shaak & Hess, 2006) with thirteen trainee psychologists, in order to elicit their

beliefs about the right of individuals to choose to die. Prior to undertaking their research, the five Counselling Psychologist researchers completed interviews, in order to discuss any biases and their beliefs concerning suicide. Four of the researchers indicated that those who die by suicide see it as a last option, and as a means of escape. Three of the authors felt that suicide was ultimately the choice of the client, and was not under the control of the therapist. It emerged that the participants largely believed that suicide occurred due to despair and suffering, considering suicide to be 'neither a sin, nor a sign of weakness' (Knox, et al., 2006, p 3). Instead, dying by suicide was viewed as arising within the context of marked pain.

Bond (1993) usefully discusses striking the balance between the ethical responsibilities of the clinician, respecting autonomy and confidentiality, and protecting clients' self-disclosure. He concludes that 'best practice with regard to suicidal clients works in ways which respect the client's autonomy and right to choose, until there are substantial grounds for doubting a client's capacity to take responsibility for himself; and there is a serious risk of suicide and the possibility of an alternative way of intervening' (Bond, 1993, p. 122). Contracting about confidentiality and risk assessment in order to inform decisions and to provide evidence that the duty of care to the client has been honoured is considered to be vital. Liability generally becomes an issue if clinicians fail to intervene in ways that could have prevented the suicide, or if they intervene in a way that could contribute to the suicide. This discussion has emphasised some of the legal and ethical obligations of clinicians and indicated how personal beliefs may cloud the issue of when to alert others of a possible suicide risk.

1.3.4 The right to die

Interestingly, within this context, a case has been made against suicide prevention (Corey, 1996). Szasz (1986) challenges the commonly accepted notion that clinicians have an absolute professional obligation to prevent client suicide. In his view, clients are ultimately responsible for their actions. Thus, mental health care professionals who keep clients alive are depriving them of their rightful share of accountability for their own actions. Szasz (1986) believes that clinicians have an ethical and legal obligation to provide help to those suicidal clients who request it, in order to help them to find ways of coping. However, for those who actively reject help, the professional's duty is either to persuade them to accept help or to leave them alone. For Szasz (1986), coercive methods of suicide prevention, such as forced hospitalisation, deprive people of their liberty and responsibility.

Considering the capacity of individuals to choose to die, The Mental Capacity Act (2007)

created legislation regarding the way that decisions are made on behalf of those aged 16 years and over who lack the capacity to make those decisions themselves. In brief, some of the issues emerging from the Act include advance decisions to refuse treatment, lasting powers of attorney and research in relation to people who lack capacity.

1.3.5 Assisted suicide

A debate currently rages concerning the issue of assisted suicide. The intentional taking of someone else's life or assisting in the taking of another person's life currently remains illegal (The Suicide Act, 1961, Section 2), although many people may be confused by the law. The current debate concerns whether in some circumstances, a person should be assisted to end their life (assisted suicide). According to a recent report, over 100 Britons have reportedly ended their lives at the Dignitas Clinic, a centre for assisted suicide in Switzerland (Amandras, 2009). The law in Switzerland appears to be that assisting suicide will not be prosecuted unless the assistor is acting out of self-interest. As yet, no friend or relative has been prosecuted (Taylor, 2009), and, in a move to protect those who assist in suicide, the first guidelines to the Suicide Act (1961) were issued recently (Crown Prosecution Service, 2009). The guidelines illustrate several factors that will be taken into account when deciding on whether to progress a case to prosecution, including the motives of those involved. If the person had a severe, incurable physical condition from which there was no possibility of recovery, including terminal illness or a severe degenerative physical condition, then prosecution would be less likely (CPS, 2009). This debate is relevant to Counselling Psychologists as it may affect clinical practice. It may also be important to explore ideas, concerns and other existential issues in order to become more self-aware and reflective of our own views and those of others.

The arguments for and against assisting suicide are well documented by the two main protagonists within the United Kingdom, the organisation 'Dignity in Dying,' who believe in greater patient choice at the end of life and argue that this provides choice and dignity in dying, and 'Care not Killing,' who called for the government to reject assisted dying, and to instead move to better palliative care for all. Unbearable pain is often cited as the main reason for individuals' making the decision to end their life, but research suggests that the reasons may be much broader than physical pain. Physical conditions that impact on quality of life were cited, but psychological factors included depression, loss of control and dignity, loss of hope, and feelings of being a burden were particularly evident (Hickman, Tilden & Tolle, 2004; Sullivan, Hedberg & Fleming, 2000).

There is both fierce support and opposition within the debate regarding the amendments to the law, showing the extent to which any softening of the legislation is seen as a 'slippery slope' (Godlee, 2009, p.1). Some see the changes as being 'permission' to help families to aid seriously ill loved ones make the decision to end their lives, while supporters say that immunity for helping people travel abroad can be kept separate from the law on assisted dying. Supporters of assisting suicide feel that this may allow the principles of beneficence and dignity to be more fully realised. The promotion of autonomy and to utilise their right to make choices about dying is argued as a primary reason many request this, providing an individual to make a dignified, empowered decision. Several concerns are juxtaposed against the potential benefits of assisting suicide. Some believe, for example, that assisting in suicide death is immoral and inconsistent with the medics' curative role. It is also argued that deeply held ethical positions divide society and professionals, and the medical system rather than religion, ethical culture or family has dominated perspectives of illness and dying. Hence, medicine and healthcare often see dying as being a failure of science, technology and human mastery of the environment (Valente, 2004). Finally, concerns exist about premature choice to end life and uncertainty and errors in diagnosing illness in those with co-existing psychological disturbance.

Counselling Psychologists may be in a position where clients will want to explore their thoughts and feelings about the ending of life, and will need to remain open-minded and sensitive to the many interpretations that people may make. While the consideration of a wide range of concerns regarding death and suicide may be vitally important for clinicians, Knox et al. (2006) noted how some clinicians reported that issues related to suicide 'seemed to receive attention in a reactive, rather than a proactive way' (Knox, et al., 2006, p. 8). In addition, Litman (1965), when interviewing over 200 psychotherapists, found at first that it was very difficult to elicit their thoughts about the suicide of a client. The participants were described as being philosophical, casual or flippant, or introduced ethics as reasons for not talking about it. While the psychotherapists to be quite philosophical about death, having a tranquil attitude, it was suggested that the same person might describe a different emotional experience after a direct encounter with client death as an actual event (Litman, 1965). As such findings are consistent with those of other researchers (Dexter-Mazza & Freeman, 2003; Ellis & Dickey, 1998; Kleespies, et al., 1990; 1993), it appears that the open discussion of issues concerning suicide may present a challenge to some clinicians within mental health care.

Summary

This discussion calls attention to some of the issues that affect clinicians, including clinical accountability, client confidentiality and individuals' decisions to choose to end their life by suicide. Awareness of the current changes in legislation and the relevant literature by Counselling Psychologists may enhance and guide our clinical practice. In addition, reflections on our personal values concerning choice and individual circumstances, with the recognition that others' decisions will differ to our own may increase reflexivity and ultimately enhance our therapeutic skills. It is claimed that one of the most highly anxiety-provoking situations that a clinician can be faced with is the prospect that one of their clients is planning to die by suicide (Cross & Papadopoulos, 1999). Therefore, the pertinent literature and theoretical perspectives regarding the effect of clinicians' practice with suicidal clients will be examined within the following section.

1.4 Therapeutic intervention with suicidal clients and the effect of client suicide on the clinician: a review of research and theoretical perspectives

Clinicians working therapeutically with suicidal clients have described being deeply affected, both personally and professionally, with feelings of hopelessness, helplessness and a sense of failure (Aldridge, 1998). Several research studies have explored the significant emotional impact on therapists of treating suicidal clients and following a client suicide (Brown, 1987; Kolodony, Binder, Bronstein & Friend, 1979; Litman, 1965; Menninger, 1991). The research literature within this review has been selected according to its relevance to the research topic. Thus, the effect on clinicians of working therapeutically with suicidal clients will be examined, followed by an exploration of the pertinent literature concerning the effect of a client suicide on mental health care clinicians. In particular, some of the factors that have been found to increase the distress of clinicians in the aftermath of a clients' death will be examined, and the effect of patient suicide on those within psychiatry. Finally, the literature regarding clinicians' experiences of clinical supervision and other sources of support will be reviewed, including whether there is reluctance to utilise support.

The literature concerning the responses of mental health care professionals to clinical practice with suicidal clients is limited, consisting mainly of retrospective surveys of trainees within the professions of psychiatry and psychology. One such study was that of Kleespies et al. (1993), which replicated an earlier study (Kleespies, et al., 1990) within the United States of America. A series of telephone interviews with 307 by trainee psychologists was conducted, including the participants' experiences of client suicidal ideation, client suicide attempts and client deaths. Of their sample, 97% had worked with suicidal clients or experienced the death of a client by suicide. The emergent findings, perhaps unsurprisingly, revealed that the severity of client suicidal behaviour was associated with more severe responses, as the participants reacted with disbelief, failure, sadness, self-blame and depression when a range of client suicidal behaviour was included. Less severe client suicidal behaviour, including client suicidal ideation was found to be associated with more attenuated responses. Clinical supervision was found to provide a safe venue in which to explore the feelings of the trainee psychologists, being particularly helpful when the supervisor assured that their responses were clinically appropriate, and they shared responsibility for the case. The researchers recommended that on hearing of a client's suicide, an immediate, supportive response might prevent further traumatisation and reduce the isolation of the clinician. Kleespies and colleagues (1993) were the first researchers to consider the effect of a broad spectrum of suicidal client behaviours, and their associated effects on clinicians. The study provides some insight into the distress experienced by

trainee psychologists depending on the severity of client behaviour. The investigators suggest that greater preparation of psychologists in training for a client suicide and for coping with these episodes would be useful. However, the survey method employed by Kleespies and colleagues (1993) possesses some inherent flaws, as responding to items on a questionnaire cannot not capture the full experiences of clinicians. A further limitation of this study is that the sample group consisted of trainees in psychology and had those practitioners with longer experience been included, this may have yielded different findings. Much of the existing literature concerns the psychological impact on clinicians who have encountered a client suicide, yet many clinicians will work therapeutically with suicidal clients during their professional career (Kleespies, et al., 1993; Mc Adams & Foster, 2000). Therefore, the effect of clinical practice with suicidal clients is worthy of further development. It will be explored further within the current study.

A client death by suicide has been considered to be one of the most difficult issues faced by psychologists and therapists in their professional lifetime (Rudd, Jobes, Joiner & King, 1999). Shneidman (2001) describes how 'the 'survivors' of the individual, the friends, relatives and possibly carers, become the 'victims', sentencing the survivors to deal with many negative feelings, and become obsessed with thoughts regarding their own actual or possible role in having precipitated the suicidal act, or having failed to abort it' (Shneidman, 2001, p.154). These reactions resonate with those reported by clinicians, as doubts about professional competence may result following client suicide (Anderson, 1999; Litman, 1965; Alexander, Klein, Gray, Dewar & Eagles, 2000; McAdams & Foster, 2000; Marshall, 1980; Menninger, 1991). The initial shock is frequently followed by grief, guilt and fear of being blamed for the death (Hendlin, et al., 2000; Hendlin, Haas, Maltsberger, Szanto & Rabinowicz, 2004; Kleespies, et al., 1993; Sacks, Kibel, Cohen, Keat & Turnquist, 1987). Additionally, intense feelings of anger may stem from feeling rejected, as a therapist, by the client (Hendlin, et al., 2000). It appears that client suicide affects those of different disciplines and the impact on those within psychiatry will be explored below.

1.4.1 The impact of patient suicide on those within psychiatry

Consultant psychiatrists have been found to have higher levels of work related exhaustion and depression than those of physicians and surgeons (Deary, Agius & Sadler, 1996). However, the impact of suicide by patients had not been investigated within the United Kingdom before a study undertaken by Alexander and colleagues (2000). Although the issue had been studied in the United States of America, Canada and New Zealand, (Chemtob, Hamada, Baurer, Kinney & Torigoe, 1988a; Chemtob, Baurer, Hamada, Torigoe & Kinney,

1988b; Litman, 1965; Menninger, 1991; Gralnick, 1993; Kaye & Soreft, 1991; O'Reilly, Truant & Donaldson, 1990; Little, 1992) many of these studies are limited by the use of small or selective samples, case histories, and anecdotal evidence.

Alexander and colleagues (2000) employed confidential questionnaires in a non-selected group of senior psychiatrists in Scotland. The participants were asked to complete details about personal information on a postal questionnaire and identify the 'most distressing' suicide they had encountered as a consultant, its professional impact on them, and what helped them to cope. Throughout the questionnaire there were free text sections. Of 315 questionnaires that were sent, 247 completed questionnaires were received, a response rate of 78%. However, not all the respondents completed all the items. Since becoming a consultant, 167 (67%) of the 247 participants who responded had a patient die by suicide, but 19 consultants did not indicate the number of patient suicides they had experienced. Of the remainder, 31 (21%) had one patient die by suicide, 97 (66%) had experienced two to six suicides, and 20 (13%) had seven to fifteen patients die by suicide. A total of 159 consultants provided information on their 'most distressing' suicide. Half of the patients who were involved (79) were outpatients, 71 (45%) were inpatients, seven (4%) were day patients, and two died in prison. The interval between the suicide and the survey ranged from 1 month to 20 years (median 3 years).

Fifty four participants (33%) reported that the patient death had affected their personal lives, becoming irritable at home, unable to deal with routine family problems, with poor sleep and low mood, preoccupation with the suicide and decreased self confidence. Although none took time off work, many of the effects were persistent. Among the 48 consultants who reported a time scale, four stated that the effects lasted up to a week, 15 up to one month, 15 up to three months, and 14 over three months. In addition, 69 (42%) stated that the event had affected their future professional practice, with more structured management, heightened awareness of suicide risk, more use of suicide observation, more detailed communication about records, more willingness to use mental health act legislation and a more cautious defensive approach to patients at risk. No consultant declined to take on high risk patients. The events caused 24 (15%) of the participants to subsequently consider taking early retirement; five considered it 'seriously'. Of 56 consultants who were aware of publicity in the media, 8 found the publicity 'extremely distressing' and 19 'moderately distressing'. 12 consultants were 'extremely distressed' at the prospect of litigation. Legal and disciplinary proceedings and fatal accident inquiries, although uncommon, were generally viewed unfavourably. Intervention by the Mental Welfare Commission was generally also found to be unhelpful. Support was received from team members, other

psychiatrists and family and friends, although General Practitioners and spiritual leaders or clergy were rarely consulted. It was indicated that the support received from family and friends was found to be particularly helpful. In conclusion, from the details provided, many of the patient deaths were sudden and relatively unexpected. This study illustrates how the event is experienced as distressing by some consultant psychiatrists, affecting their work and relationships. A weakness of the study, however, is that not all the participants completed all the items on the questionnaires. Although space was included for open texts, the employment of questionnaires may restrict the data available and can result in low response rates.

A subsequent survey to assess the impact of patient suicide in 109 training psychiatrists was undertaken by Courtenay and Stephens, (2001). In response to a questionnaire, it was indicted that 54% of the participants had experienced the suicide of one or more of their patients. Their experiences and the impact of the suicides were graded by the researchers as minimal, moderate or severe, depending on the narrative responses; for example, words such as 'devastated' fell into the 'severe' category. Of the 109 participants, 74 (86%) believed that the suicide had affected their future clinical practice. In 57 of these cases, this was judged as beneficial and in 17 as being adverse. Negative reports included subsequent fear of clinical contact, isolation, disillusionment, vulnerability, lack of confidence. The beneficial outcomes reported included the development of more thorough risk assessment skills. Other changes, including increased thoughtfulness about termination, taking more clinical notes, seeking second opinions, being vigilant about comments about hopelessness, and being quicker to hospitalise patients were reported. The main criticism of this research may be that the divisions within the questionnaire depicting the categories were overly subjective. A further restriction of the sample was that the participants were in training. These shortcomings are to be focussed on within the current study. Despite the limitations, this study illustrates some of the potential benefits to future clinical practice. Survey methodology may restrict the emergent data in both the studies of Alexander and colleagues (2000) and Courtenay and Stephens (2001), although they provide some evidence of the potential effects of patient suicide in both qualified and training psychiatrists. As many investigators focus on the effects of client suicide in trainees of different disciplines, this raises the question of whether the experience of the clinician affects their reactions.

1.4.2 Does the experience of the clinician affect their response to client suicide?

Differing findings emerge regarding whether the length of experience and the level of qualifications of clinicians may affect their reactions to client death. It has been suggested that trainees in psychology may be protected by the level of clinical supervision that they receive (Knox, et al., 2006). Alternatively, it has been argued that the reactions of trainees are stronger than those of qualified individuals (Brown, 1987; Foster & McAdams, 1999), as trainees are more likely than experienced professionals to feel they have failed as a person, perhaps because they are less able to separate 'personal failure from the limitations of the therapeutic process' (Foster & McAdams, 1999, p 24). In order to determine the reactions of both qualified and trainee clinicians to a client suicide, Hendlin et al. (2000) examined the experiences of twenty six psychiatrists, psychologists, and a psychiatric social worker. Seven of the participants were trainees. The methodology involved completion of a narrative description of the client, demographic questionnaires and a semi-structured questionnaire eliciting the participants' reactions to the suicide. Each therapist discussed the case and their reactions at a day-long workshop. All the cases were 'real' patients. Half of the participants were initially very shocked and disbelieving to hear of their clients' death. Grief was most commonly reported. In some, this was pervasive and long lasting. Thirteen of the twenty six participants reported feelings of guilt, which was closely aligned with fears of blame. In twelve, feelings of anger and betrayal followed. Six participants reported feelings of shame and embarrassment. Twenty one participants identified a change they would have made in their treatment, including medication, hospitalisation and consultation with the clients' previous therapists. Several participants reported being more alert and sensitive to the possibility of client suicide and six felt apprehensive about receiving referrals for suicidal clients in the future. The intensity of the emotional responses reported were independent of age, years of experience or the practice setting. The investigators noted how the requirement to attend day long workshops may have influenced those who took part, as the participants appeared to need to explore their feelings about the suicide. As the study undertaken by Kleespies, et al., (1993), examined earlier, reported that stress levels of trainees within psychology following client suicide were significantly higher than those of professional psychologists, it appears that whether the experience of the clinician affects their response may benefit from future investigation, in order to corroborate these findings.

1.4.3 Aspects that may increase the distress of the clinician

The therapeutic relationship with the client may be fundamental to the response of the clinician following the client death. According to Gitlin (1999), a psychiatrist affected by the death of one of his patients, the therapeutic relationship with the client is one of two main factors affecting the clinician. The first factor is said to be the therapeutic relationship and the second factor, the psychological makeup and personality of the clinician. When examining some of the aspects that may lead to increased distress following client suicide, Hendlin and colleagues (2004) conducted a further study following an earlier study (Hendlin, et al., 2000). Thirty four participants included psychiatrists, psychologists and a psychiatric social worker. Seven of the psychiatrists and psychologists were trainees. A similar methodology was employed to the earlier study of Hendlin et al. (2000), involving participation at a workshop. For most of the data analysis, the therapists were divided into two groups; those who experienced 'severe distress' and those who did not. Over half of those in training at the time of the suicide were found to be severely distressed, comprising thirteen of the thirty four who took part, compared to one-third of the other therapists. In virtually all cases, the distress related to their connection to the client. Four factors in particular were cited as contributing to their distress, including failure to admit a patient to hospital, a treatment decision, negative reactions by the therapists' institution, and fear of litigation. Neither the therapists' professional discipline, the period of time over which they saw their client or their organisational context (private practice or institutional setting) was related to their distress. While those with longer experience assumed that this would protect them from self-doubt, they were shaken to find it did not. In conclusion, Hendlin et al. (2004) provide some insights into the aspects that may contribute to the distress of clinicians following client death. One of the strengths of the study is the inclusion of experienced practitioners within their sample, as well as those still in training, with a range of professional experience, therapeutic orientation and personal styles. A limitation of the study, however, is that the duration of the distress levels of the participants were not systematically measured. This indicates the need for further comparison studies.

Although there is limited literature on the effects that patient suicide has on nurses, there is some evidence that nurses may feel unprepared for their often intense grief reactions. Midence et al. (1996) employed survey methodology when investigating the responses of twenty three qualified nurses to patient suicide. The majority (seventeen nurses) reported feelings of sadness, frustration, shock, fear, anger and guilt. Two nurses felt responsible for the death and blamed themselves. Following the patients' death, it was reported that senior staff were unaware of the emotional impact. The importance of regular multi-disciplinary

meetings to discuss patient suicides was emphasised. The need for training and formal assessment of patients at risk also emerged. While these findings raise ethical and practical concerns, a limitation of this study is the questionnaire that was employed, as it did not have valid reliable standards, although being relevant to the study and the concerns of the nursing staff.

Clinicians have reported that they receive little training in the area of client suicide (Dexter-Mazza & Freeman, 2003; Ellis & Dickey, 1998; Kleespies, et al., 1990; 1993; Knox, et al., 2006). Given the likelihood that both trainee and experienced clinicians may experience client suicide (Chemtob, et al., 1988a; 1988b; 1989; Kleespies, et al., 1990, 1993; McAdams & Foster, 2000), it has been suggested that the apparent little attention paid to the preparation of clinicians to manage a client suicide may contribute to their subsequent distress (Knox, et al., 2006). Finally, a potential unexpected difficulty for clinicians after client suicide is that the media may become involved, leading to intrusive, unwanted publicity for the clinician (Alexander et al., 2000; Midence, et al., 1996).

1.4.4 Client suicide: a traumatic event?

It appears that distressing symptoms may remain for some time following a client death. While client suicides are generally considered to be extremely stressful, rather than traumatic events, they are frequently unexpected, sudden and violent. Some clinicians may experience symptoms similar to those of Post Traumatic Stress Disorder (PTSD), which is characterised by the re-experiencing of an extremely traumatic event, accompanied by symptoms of increased arousal and the avoidance of stimuli associated with the trauma (Diagnostic & Statistical Manual of Mental Disorders, 2005, p. 429). Studies using the Impact of Event Scale (IES) have indicated that intrusive symptoms of stress are comparable to post traumatic stress symptoms found in patient groups (Chemtob, et al., 1988a; 1988b; 1989). Considering the length of time that distressing symptoms may remain, Kolodony et al. (1979) employed descriptive reports in their study of four therapists. Feelings of guilt, disbelief and shame, a need for privacy, and a sense of 'why me?' emerged. Anger and worry about other clients continued for some months afterwards. Sadness and dreams about the client continued until about ten weeks after the client death. The group went through a process of mourning over a long period, convinced that no support system could relieve their pain and self-examination (Kolodony, et al., 1979). The need for support for clinicians, both through clinical supervision and open discussions, was recommended. Although a small number of participants were involved, these findings are reported within other studies (Brown, 1987; Kleepsies, et al., 1990).

1.4.5 Perceptions of lack of support following client suicide

Following the experience of client suicide, some clinicians may feel that their need for support is not met. For example, Midence et al. (1996) found that some senior staff were unaware of the emotional effects on the nurse participants and the designation of a Psychologist to provide support was suggested by participants. There is some evidence that other clinicians, including psychiatrists, similarly feel unsupported (Courtenay & Stephens, 2001). Within 203 trainee psychiatrist participants, it was found that 77 participants subsequently expressed the need for help in coping. In 46 (60%) of cases, they were given individual consultant supervision or support, which was appreciated, but others reported that their needs were not addressed.

In the aftermath of client death, the usefulness of subsequent discussions, which have been termed 'institutional psychological autopsies' (Goldstein & Buongiorno, 1984), has been examined. For example, Alexander et al. (2000) reported that consultant psychiatrists attended team meetings that were commonly held following a patient suicide, and these were found to be helpful. Critical incident reviews occurred in only half the patient suicides, but the reviews were viewed as often leading to improved management of suicidal patients. Similarly, Kleespies et al. (1993) found that only a third of trainees in psychology participated in a case conference, although those who did so found it to be helpful, suggesting that perhaps this method of processing has been underutilised.

1.4.6 Reluctance to seek professional assistance

Many of the effects of client suicide on clinicians may be wide-reaching and persistent (Alexander, et al., 2000). Furthermore, those within mental health settings are potentially at increased risk of experiencing some form of mental health problems (Caplan, 1994; Gilroy, Carroll, & Murra, 2001; Norcross, 1990; Pope & Tabachnick, 1994), whether categorised as symptoms of stress and/or anxiety, or, arguably, more severe problems (Galbraith & Galbraith, 2008). Within the National Health Service, the moral, legal and economic implications of stress are of increasing concern to employers, employees and government alike. Some clinicians feel that their need for assistance is ignored by the organisation (Courtenay & Stephens, 2001; Midence, et al., 1996). However, workplace counselling is usually available to employees and there may be several reasons that some clinicians fail to utilise this. Some doctors still resist the ideas of support 'in spite of both training and common sense' (Salter, 2003, p.3). Fears of seeking professional help (Gilroy, Carroll & Murra, 2002) may be due to their wanting to retain their self-image, as psychiatrists generally

see themselves as healthy, effective and useful practitioners (Dewan, Levy & Donnelly, 1988).

Some of the other reasons for a reluctance to seek assistance may be that those within mental health settings are concerned over the disclosure of their mental health status (Salter, 2003; Galbraith & Galbraith, 2008). There may also be some emotional difficulty in 'becoming a client', embarrassment, fear of loss of status and clients, and the potential for losing their rights to practice (Galbraith & Galbraith, 2008). Part of this problem may be due to skewed understanding amongst mental health professionals that therapeutic practitioners should personify the vision of 'perfect mental health' (Gilroy, et al., 2002, p 6).

While the value of sharing difficult experiences with colleagues has been indicated, some clinicians may fear that informal conversations could subsequently be used against them (Kleepsies & Dettm, 2000). There may be fear of stigma in seeking help. There is considerable evidence that the survivors of death by suicide feel 'more isolated and stigmatised than other mourners' (Jordan, 2001, p. 93; Cvinar, 2005). Additionally, those bereaved by suicide have scored more highly on feelings of stigmatization than people bereaved by other means (Harwood, Hawton, Hope & Jacoby, 2002). The potential loss of respect by colleagues (Gilroy, et al., 2001), and the potential stigma of association with death by suicide may be a powerful combination in contributing to failure to seek professional support.

Stigmatized individuals can feel diminished, as 'tainted' persons (Goffman, 1976, p. 12). The experience of stigma is said to emerge from an interactive process, as a negatively valued aspect of an individual's life dominates their social identity (May, 2000). However, there may be a difference between the perception of stigma and the reality of others' responses (Knieper, 1999). Thus, the notion of being stigmatised may be anticipatory rather than actual. However, as there is some evidence that those bereaved by suicide are subject to stigmatisation (Lucas & Seiden, 2007) it is difficult to assess the extent of stigmatisation. In conclusion, while counselling is frequently provided and it is inevitable that those without support may be more vulnerable, there appear to be several contributory reasons for the failure of some clinicians to utilise this.

In summary, some of the existing research concerning the effect of providing therapy with suicidal clients indicates that clinicians may experience self doubts regarding their level of competency and have fears of repercussions by their employing organisation, should the client die (Reeves & Mintz, 2001). Aspects that may increase the distress of the clinician

following client suicide include the therapeutic relationship with the client, treatment decisions that were made and fears of litigation (Hendlin, et al., 2004). While some clinicians may perceive that they are subsequently unsupported, failure to utilise the services may include fear of stigmatisation, fears associated with being a client and loss of status and self-image.

Areas such as whether the level of experience affects the clinicians' response are worthy of further investigation, as the majority of studies involve trainee participants. A restriction of some quantitative studies is that many researchers use survey methods to gather their data (Chemtob, et al., 1988a; 1988b; Alexander, et al., 2000; Courtenay & Stephens, 2001). Qualitative research studies help to capture the depth of experiences of those involved, and the current study intends to build on this. Considering the difficulties that may be experienced by those working with suicidal clients, the support of clinical supervision may be considered as essential. The integral place of clinical supervision will now be examined in more detail.

1.5 The integral place of clinical supervision

Clinical supervision ideally provides a valuable opportunity to reflect and identify the boundaries of therapist skill and knowledge (Falender & Shafranske, 2004). When clients present with risk issues, the supervisor has a main role in educating and responding to the concerns of the clinician, as supervision may improve their competency and confidence in managing the suicidal client. An investigation of the relevant literature may best be articulated by first establishing the reported characteristics of effective clinical supervision, followed by clinicians' experiences of supervision following the a client death by suicide.

Clinical and Counselling Psychologists receive clinical supervision in order to support, evaluate and develop their professional skills (British Psychological Society, 2005). Several authors have explored the types of behaviours, processes and styles that characterise effective supervision (Henderson, Cawyer & Watkins, 1999; Shanfield, Hetherly & Matthews, 2001; Shanfield, Matthews & Hetherly, 1993). Carifo and Hess (1987) identified the traits and skills characteristic of effective supervisors. Specifically, ideal supervisors are said to possess the depth of knowledge and practical expertise necessary for guiding clinicians, establishing clear goals and demonstrate 'respect, empathy, concreteness and self-disclosure in their dealings with supervisees' (Carifo & Hess, 1987, p 245).

Trusting supervisory relationships are, perhaps, particularly vital when some clinicians may

struggle to manage high risk clients, as the supervisee generally needs to feel free to discuss any difficulties that they have openly. When client problems are particularly complex, errors in decision-making may occur (Garb, 1998). Such errors may include clinical decisions for clients who are considering ending their life. Clinical supervisors can help both those in training and those with more experience to develop the case formulation and to plan appropriate interventions. During a qualitative study (Shanfield, et al., 1993) of psychologists in training, the researchers analysed transcripts derived from weekly supervision sessions. The investigators concluded that effective supervisors permit supervisees to freely express the challenges and dilemmas they encounter, affirm and deepen trainees' interpretations of client problems and offer recommendations. The researchers corroborated these findings in a subsequent study, concluding that effective supervisors discuss and provide guidance for the difficult clinical interventions and the personal concerns of trainees (Shanfield, et al., 2001).

Fewer studies, however, focus on those working in clinical environments where their clinical supervision is deemed to be inadequate (Greer, 2002). Allen, Szollos and Williams (1986) surveyed 142 doctoral psychology students, concluding that poor supervisory experiences are 'more easily characterised by what they fail to provide, than by what actually occurs' (Allen, et al., 1986, p 95). It seems to be essential that clinicians practicing with high risk clients are able to explore their concerns within a supportive supervisory relationship. In addition, following the death of a client, the supervisor may assist by providing a safe space in which the clinician may explore their emotions and reflect on their decisions.

Some studies of the effect of client suicide on clinicians make specific recommendations for clinical supervision, as clinicians may subsequently experience doubts about their clinical decisions and suffer reduced self confidence (Alexander, et al., 2000, Hendlin, et al., 2000; 2004). For example, Knox et al. (2006) specifically addressed the implications for clinical supervision following client suicide. Twenty six psychologists in training completed a semi structured interview, exploring their overall thoughts about a client suicide that they had experienced. A follow-up interview took place two weeks after the initial interview, before any data analysis began, providing an opportunity for the participants to clarify any areas of confusion. Clinical supervision was found by thirteen of the participants to be the most supportive aspect. Most of the participants felt that they had a good relationship with their supervisor. Both positive and less helpful experiences of supervision were reported, with positive experiences of clinical supervision including viewing it as providing a safe environment in which they could express their feelings, normalising their reactions, and obtain reassurance that they were not responsible for the death. Sharing of the supervisors'

experiences of client suicide was also helpful. Most felt that supervision played a major role in helping them to cope. What was less helpful was the way in which a few participants were told of the suicide (such as in the clinic between sessions), the circumstances in which they were encouraged to process their feelings about it (for example, in a meeting), or their supervisors' apparent unresponsiveness to the suicide. Knox and colleagues (2006) noted how negative responses arose when, for example, some of the trainee participants received the news of their clients' death by hearing a message on their answering machine, which was perceived as being callous and uncaring. Therefore, the delivery of the news of a client death may need to be conveyed with some sensitivity. A further negative aspect was the supervisor attending less to the needs of the supervisee than to possible legal ramifications, through checking of the client's documentation. This study offers some helpful insights into key supervisor responses, although the sample, as in those of previous studies, is restricted to those in training. Further limitations include the data being collected retrospectively, as it is possible that participants' memory of the events may have changed over time. However, it is usefully indicated how both the immediate and subsequent response of the supervisor may be influential.

A theme of the appreciation the supervisor sharing their own experiences of client suicide emerges from these findings, as most of the participants within Hendlin et al.'s (2004) study, reviewed earlier, indicated that they valued this. According to the findings of both qualitative research (Knox, et al., 2006) and quantitative studies (Kleespies, et al., 1993), sharing of responsibility and personal experiences and providing affirmation appears to be appreciated by some clinicians.

Summary and future directions for research

The clinical implications of these studies reinforce the importance of the supervisor being guided by the needs of the supervisee, carefully considering the timing of discussions, and sharing their own experiences, if appropriate. These considerations may ultimately have a positive impact on practice, as, if clinicians feel supported, more accurate interventions with this vulnerable client group may emerge. If a client dies, a trusting relationship, where supervisees are given sufficient time to process their concerns, may be very helpful (Brown, 1987; Kleespies & Dettm, 2000). Supervisors may also need to ensure that they are informed about current research outcomes concerning the needs of supervisees with high risk clients and following a client suicide.

Although the majority of research concerning clinical supervision when working

therapeutically with suicidal clients and following a client suicide has been conducted with trainee participants, it may be that the principles of what is helpful applies to staff with longer experience. However, if future studies included experienced practitioners, a different understanding of the role of the supervisor may be achieved, providing clinical supervisors with further guidance. Finally, as the longer term impact of clinical supervisors' responses following client suicide remains unclear, future longitudinal studies might yield interesting insights. Further research is also indicated in order to develop existing quantitative literature and provide a deeper appreciation of clinicians' experiences of clinical supervision at these critical times, which is another aspect which the current study intends to develop. Following a client suicide, for those practising within the National Health Service, an investigation into the circumstances of the death may take place. This aspect will be addressed within the following section, and the literature concerning the experiences of those who have taken part in formal subsequent events is reviewed.

1.6 The National Health Service investigation following a client death by suicide

The framework of Clinical Governance aims to create an environment in which excellence will flourish within the National Health Service (Department of Health, 1998). The Department of Health (1999) set out the government plans for promoting safety, following a growing recognition that health services around the world had underestimated the unintended harm experienced by patients in health care settings. The National Patient Safety Agency, established in 2001, co-ordinates the efforts of all those involved in healthcare in order to learn from 'errors and near misses' and to promote an open, fair culture. A serious incident triggers a process which aims to take the appropriate steps in the best interests of patients, staff and the National Health Service as a whole. In England and Wales, there is a strict definition of suicide which requires proof of intention to die. When there is doubt over the deceased's intent, a coroner is obliged to bring in an open verdict, or a verdict of accidental death. When carrying out an investigation into death by suicide of a person engaged with services, the policies within the organisation generally define the procedure to be followed.

The term given to the way that serious incidents are investigated, 'root cause analysis,' derives from the field of quality management where many techniques are based in concepts of problem solving (Neal, Watson, Hicks, Porter & Hill, 2004). According to root cause analysis, the investigation involves looking at what happened (the unsafe act) how it happened (human behaviour) and why it happened (the contributory factors). Taking a 'systems approach' to incidences allows for discovering whether poor organisational design

may contribute to people failing rather than viewing them as being careless or at fault. Clinical Risk Management Departments deal with events regarding deliberate or accidental self-harm and suicide in mental health settings. After an investigation, staff and management receive feedback on how and where failures of work systems may increase clinical risk. This may include poor communication, breakdown of communication, ill defined responsibilities, poor inter-agency working, and non-reporting of incidents.

The research literature indicates that some clinicians find taking part in an investigation and court appearances to be difficult. According to open texts from consultant psychiatrists (Alexander, et al., 2000), many referred to a 'blame culture', and to 'witch hunting' within the medical profession. There is some evidence that others share these views. For example, McCullogh, Sykes and Haut (2004) investigated the experiences of 40 junior doctors in Scotland, using a retrospective questionnaire methodological design. Of those who were involved in an investigation and in disciplinary and legal action, 76% reported that they did not receive support from management and that they felt they were part of a 'blame culture'. The participants were unaware of the probable sequence of events within the investigation process. Most of the respondents reported that their experience had affected them professionally, leading to over-cautious decision making (62%), decreased self confidence (57%), and preoccupation with the event and how it could have been prevented (33%). Most of the doctors (62%) considered they had changed their practice as a result of the incident and nearly a third (29%) reported a change to their career path following the event. Four main areas were identified as being particularly problematic. These included delays intrinsic to the process, the adversarial nature of giving testimony, a perceived need for debriefing after the court appearance, and issues concerning media publicity. The distress experienced when appearing in court was ranked on a Likert scale (0= no distress; 10=severe distress) giving a median rating of 6 (range 2-10). Whilst providing an indication of some of the effects of taking part in formal procedures following patient suicide, there are limitations to this study. For example, the questionnaire was distributed by the Medical Protection Society and the Medical and Dental Defence Union of Scotland rather than by the authors, thus precluding responses by those otherwise represented. The anonymous nature of the questionnaire did not permit comparison between respondents and non-respondents or comparison between the findings of the Fatal Accident Inquiry and the responses, including whether the respondents' practice had changed. Furthermore, the number of respondents was small because of the limited number of junior doctors called as witness in fatal accident inquiries. As noted by the investigators, the respondents may represent a group of doctors more able than others to tolerate the revisiting of their experiences, despite their distress. This study illuminates the adverse effect of involvement in formal procedures in junior

doctors, although further examination of the effects on mental health clinicians of different disciplines would help to develop these findings. The current study intends to explore the experiences of formal and legal procedures in clinicians of different professional backgrounds, including psychologists and therapists.

While some find taking part in formal and legal processes to be difficult, it has been argued that an investigation may also help to point out the uncertainty surrounding client suicide (Hodelet & Hughson, 2001). If clinicians can appreciate how little ultimate control they have over the outcome of client death by suicide, as those individuals who are affected by mental health problems may die regardless of steps taken to prevent it, then the clinician may be in a position to offer invaluable advice and support to others (Hodelet & Hughson, 2001). However, there may be some inherent difficulties in communicating with others, as those involved in client suicide may fear stigmatisation. This leads to the more detailed exploration of clinicians and stigma.

1.7 Stigma from a sociological perspective

When considering the potential for experiencing stigma following client suicide in mental health care clinicians, Elizabeth Breakwell, (1986, 1996), a social psychologist, in her work on Identity Process Theory (IPT), provides an integrative framework for understanding identity, threat and coping. Based on the empirical findings from two research projects, identity is defined through its structural components and dominant processes. As individuals, we value being unique and different to others. However, 'distinctiveness' has to be in ways which are positively valued. When a client dies by suicide, this may constitute a distinctive event, but it may be negatively valued, and hence pose a 'threat' to the identity of the clinician in their professional role. As the professional role is affected when a client dies by suicide, this threat may be relevant to the clinician. A threat to identity is said to occur when the processes of assimilation-accommodation and evaluation are, for some reason, unable to 'comply with the principles of continuity, distinctiveness and self esteem which habitually guide their operation' (Breakwell, 1986, p.47). A break in the continuity of identity may lead to a change in self-perception, and others' perception of the individual, as a 'competent' professional. An event such as client suicide may lead to affect the individuals' perception of their work, as an adverse effect on self efficacy and confidence may occur. There are strong indications that self-efficacy is important to maintain good mental health at work (Booth & James, 2008). Thus, the effect of self-efficacy beliefs may be wide-reaching, encompassing the overall sense of ability of the clinician. Self-efficacy beliefs are important, argue Fear (2009), when we consider that skills or abilities alone do not predict performance, but 'what

you believe you can do with what you have, under a variety of circumstances' has the greatest impact on performance (Bandura, 1997, p.37).

Breakwell's (1986, 1996) identity process theory provides an explanation of how an identity threat occurs. The types of 'threats' experienced may include loss, such as the loss of employment, other loss of a role, or bereavement. Hoffman (2000) suggests that social identity is broken down into sub-identities, which are arranged hierarchically in terms of their value, their centrality, and their salience (the frequency with which they are called into use). As the role of clinician is used frequently, it may be considered as a central aspect of identity. After an adverse event, the individual instigates various coping strategies to manage the disruption to their identity, one of which is support-seeking (Breakwell, 1986, 1996). Some strategies, however, such as denial, are considered less adaptive A qualitative study utilised Breakwell's (1986, 1996) identity process theory (Thrift & Coyle, 2005), to explore the implications of losing a child by suicide for maternal identity. It emerged that various strategies were used by the mothers in order to manage the threat. Breakwell (1986, 1996) may therefore provide a theoretical explanation for a threat to professional identity, and for the potential experience of stigma.

1.8 The concept of loss and theoretical underpinnings

There are a range of psychological theories which may provide an explanatory account of the experiences of clinicians in practice with suicidal clients and following client suicide. Some of these theories have been selected for this review, on the basis that that they may offer some explanation for the psychological experience and processing of these events.

1.8.1 Humiliation and shame

Research by George Brown and colleagues (1995, 1998) emphasises the power of a sense of humiliation on the likelihood that a major loss can be a causal influence on the development of clinical depression. Because this research seems relevant to this study, the following section sets out to describe how this could be connected with the potential effect on the clinician.

Losses, including major life events, have been linked to the development of depression and anxiety disorders by Brown and colleagues (Brown, 1998; Brown, Harris & Hepworth, 1995). For clinicians caring for those who are suicidal, the main aspect of the clinician role, the core role and professional identity of the clinician, is to help the individual to survive mental

illness; therefore, following the death of a client, the clinician may subsequently experience feelings of shame, guilt, and humiliation. Given that these sorts of feelings are linked to consequences for mental health, it is perhaps unsurprising that clinicians could become depressed.

In a series of major empirical studies conducted over the last twenty years, George Brown and colleagues studied the role of life events on social functioning underpinning depression. In his 1995 paper (Brown, et al., 1995), 149 women who developed depression are contrasted with an NHS treated series of depressed patients. The rigorous methodological approach derived from case notes and the prospective design contributes to the strength of this study. The findings confirm the importance of a severely threatening event for the onset of depression with humiliation and entrapment playing a key role. The sense of humiliation could be linked to the perceptions of some clinicians following client suicide, as the term was used to convey the likelihood of an event rendering a person devalued, both with others and the self, including elements of failure. Life events were defined as being the loss of a person and of loss of a role, which may link to professional identity. The aspect of humiliation and shame, linked to professional identity, may resonate with clinicians' perceptions of loss of clinical competency when in practice with suicidal clients (Reeves & Mintz, 2001) and following a client death (McCullogh, et al., 2004; Alexander, et al., 2000). Brown et al. (1995) noted that entrapment events arose from ongoing difficulties of at least 6 months, which may link to the experiences of clinicians awaiting outcomes to determine if they were deemed to be responsible in some way, as was found by Hendlin et al. (2004).

The analysis within Brown et al.'s (1995) work concentrated on whether at least one significant event occurred within a defined period. The severe events involved a 'core role' or a relationship. It was found that a separation with humiliation was more likely to be followed by depression than any other loss. A loss, including the loss of a role, has been confirmed as being important in the onset of depression. As almost two thirds (52/84) of the severe events involved being humiliated or trapped, this enabled fresh light to be thrown on the role of loss. Other theories of loss, which may further illuminate the potential effects on the clinician of practice with suicidal clients and following client death, will be examined below.

1.8.2 A social-contextual theory

The pre-existing identity of the individual may help to explain why some clinicians feel vulnerable and powerless in clinical practice with suicidal clients. The suicidal client may challenge the beliefs of the clinician in an orderly, predictable world. Following an experience

such as client suicide, deeply held assumptions may be shattered. Janoff-Bulman' s (1992) social-contextual theory offers some explanation for the shattering of assumptions, proposing that individual functioning is guided by assumptions and all our experiences are adapted to fit into our existing schemas. The revision of core beliefs occurs as a last resort. Three of the assumptions individuals are said to hold include: 'the world is benevolent,' 'the world is meaningful', and 'the self is worthy'. The 'meaningful world' schema, which assumes that events are predictable, is shattered following a crisis. The 'crisis' could include practice with a client who is suicidal or the death of a client. The 'worthy self' schema, relating to personal attributes rather than event characteristics, is said to hold the three self-evaluative aspects of self worth, self controllability and luck. The self-evaluative aspects of the clinician may be adversely affected if the client is suicidal or dies. The characteristics of the trauma are claimed to affect different schemas; for example, if a client dies, both the benevolent and meaningful world schemas may be affected, as these situations may contradict individual assumptions of self-worth, benevolence and meaning. Janoff-Bulman (1992) suggests that self-blame is a key feature, as it may heighten the adverse effect of the incident. Both automatic processes and intentional efforts to restructure the assumptive world are distinguished. People are said to be intrinsically motivated to find meaning in stressful events, and to live more meaningful lives (Janoff-Bulman & Frantz, 1997). Thus, it appears that Janoff-Bulman's (1992) theory of responses to adverse, traumatic or loss events provides a useful conceptualisation of the trauma process, including both shattering and revising of deeply held individual assumptions. It also offers an explanation for the variability in individual response, as, depending on the pre-existing schema and the depth of belief of assumptions about the world and themselves, the clinician may be deeply or less affected. In integrating the changes, depending on the degree of accommodation needed, these may be either dramatic or subtle. As some individuals may be aware that the client is at serious risk, some psychological preparation for the event of suicide may have occurred. Alternately, clinicians may be hopeful they may positively influence their client and should the client die, further integration of the new information is required.

The individual appraisal of events, according to Beck's (1976) model of cognitive processing, influences individual distress. Negative, automatic thoughts may occur in the clinician if an 'unhealthy' schema is activated, such as: 'I can't cope with this client'. Beck (1976) provides a multi-factorial explanation for the acquisition of emotional disturbances. The therapists' schemas, including their beliefs and assumptions about themselves, others and the world, may be influenced by a situation such as a suicidal client or client death. The appraisal may lead to emotional disturbances if, for example, a subsequent global appraisal is made that they are 'useless' in their professional role.

The term 'schema', within Beck's (1976) work, resonates with the same term within Janoff-Bulman's (1992) theory. However, in cognitive theory, the individuals' schema is considered to be unhealthy when it is negative and absolute (Beck, 1976). Alternatively, Janoff-Bulman (1992) conceptualises the individual as believing in a benevolent, meaningful world and in a worthy, competent self. Thus, within these theories, the contents of the schemas of individuals are in opposition, although both theories offer an explanation of the underlying processes of adaptation.

To summarise, theories of loss, including Janoff-Bulman's (1992) social-contextual theory and Beck's (1976) cognitive model indicate how individual adjustment may occur following a traumatic event. The findings of Brown et al. (1998), regarding humiliation and loss, may connect with Breakwell's (1986, 1996) identity process theory because some clinicians may perceive the threat to their identity following a client suicide as being a humiliating experience. Both Janoff-Bulman's (1992) theory and Beck's (1976) cognitive model show how the pre-existing beliefs and personality of the individual affects the appraisal of such an event.

Considering the potential for the development of depression following an adverse event, Breakwell (1986, 1996) noted that one of the values of the discoveries of Brown et al. (1995) was to underline that the pre-existing identity of the individual will influence whether stressful events are treated as subjectively threatening. The identity of the person will 'dictate whether they can cope with the threat, or whether it results in depression' (Breakwell, 1996, p.50), which appears similar to the underpinnings of cognitive theory and schema shattering (Janoff-Bulman, 1992) which highlight the importance of the individuals' pre-existing identity. In conclusion, this section has reviewed some of the theories of loss and identity, and considered that they may be connected with clinicians' experiences of treating suicidal clients and client suicide.

1.9 Summary of findings and limitations of existing research

Within this review of the literature concerning clinicians treating suicidal clients and following client suicide, it emerges that some intense responses have been reported and the value of practice supported by clinical supervision is accentuated. Some of the factors leading to increased distress include their connection to the client, treatment decisions, and negative reactions by their institution (Hendlin, et al., 2004). There are reports that following client suicide, some clinicians feel that they are unsupported (Courtenay & Stephens, 2001;

Midence, et al., 1996). Amid these studies, however, several limitations exist. Firstly, the majority of research has been undertaken with trainee psychologists and psychiatrists in training (Hendlin, et al., 2004; Knox, et al., 2006; Kleespies, et al., 1993; McCulloch, et al., 2004). Some researchers employ interview methods (Knox, et al., 2006) and descriptive methods or survey reports (Kolodony, et al., 1979; Litman, 1965; Menninger, 1991).

Quantitative methodologies, such as surveys, the primary method used by several studies (Alexander, et al., 2000; Chemtob, et al., 1988; Hamada, Pelowski & Muraoka, 1989; Kleespies, et al., 1993; Kolodony, et al., 1979; McAdams & Foster, 2000) assist in exploring issues such as the impact of client suicide depending on the profession of the clinician. However, they possess some inherent flaws. For example, questionnaires may be incomplete. Additionally, respondents are not always given the opportunity to elaborate on their responses and thus cannot offer any further suggestions for meeting their needs.

The contributions of qualitative research has helped to shed some light on the issues and dilemmas facing those working with suicidal clients, the aftermath of a client suicide, and the value of clinical supervision (Reeves & Mintz, 2001; Knox, et al., 2006). However, there are areas in need of further investigation. A number of qualitative studies have been carried out in the United States of America (Kleespies, et al., 1993; Hendlin, et al., 2000), and any potential impact of cultural differences may need to be further explored.

In the examination of specific areas, such as experiences of clinical supervision following client death (Knox, et al., 2006), this precludes the exploration of clinicians' overall experiences of both client suicide and the effect of therapeutic practice with suicidal clients. Furthermore, few studies other than survey reports (Alexander, et al., 2000; McCulloch, et al., 2004), have considered the involvement of clinicians in legal and investigational procedures. In conclusion, additional qualitative methodological designs may provide the opportunity to learn more about clinicians' phenomenological experiences. Studies addressing the views of clinicians may usefully explore how they cope with such situations, and those coping methods that are considered to be most helpful. Having examined the pertinent literature and some of the associated theories of loss and adjustment, the purpose of the present study is summarised below.

1.10 The purpose of the present study: research aims and questions

The purpose of the present study was to investigate experienced mental health care clinicians' practice with suicidal clients and following client suicide, including any influence of surrounding events, including their involvement in subsequent legal and formal processes. Subsequent theoretical frameworks may assist in understanding the effect on the professional identity of the mental health care clinician. As there is limited research of qualitative design to date, this study intends to build on existing qualitative studies. The present study sets out to explore and to learn from the experiences of mental health care clinicians. It is hoped that the understanding yielded by this investigation will influence both theory and practice, and may contribute to more effective training and supervision. The personal experience of clinicians within their therapeutic practice is to be taken as the starting point.

The aim of this study is, therefore, to explore, in some depth, the personal experiences of clinicians working therapeutically with suicidal clients and of client suicide. A further aim is to explore any effect of involvement in investigations and legal procedures. Particular attention is given to any effects on future practice. Finally, any support gained from others and the emotional support that may be desired will be explored.

Chapter 2. Methodology

2.1 Adopting a qualitative approach

For many years, discontent has been expressed with regard to the narrowness of research within the discipline of psychology, with the emphasis on laboratory studies, experimental design, and statistical analysis. A number of critiques appeared as long ago as the 1970's (Gergen, 1973; Harre & Secord, 1972) illustrating this. Increasing attention has been given to the value of the naturalistic paradigm and qualitative research methodologies within psychology. These principles include the recognition of:

1. Research conducted in 'the real world'.
2. Recognition of the central role of language and discourse.
3. Life and research perceived as processes or as a set of dynamic interactions.
4. A concern with persons and individuals, rather than actuarial statistics and variables.

A qualitative, or 'human science' approach is similar to the practice of Counselling Psychology, in that it focuses on subjectivity and the achievement of an understanding (Rennie, 1994). It stresses collaboration with participants, and emphasises holism rather than fragmentation. Qualitative research aims at an in-depth understanding of an issue, including an exploration of the reasons and the context for the participants' beliefs and actions. A qualitative approach involves the study of people in their own world (Willig, 2001), being concerned with how the individual experiences events and makes sense of the world, rather than imposing pre-conceived ideas and assumptions (Smith, 2003). While the researcher tries to get close to the participants personal world and tries to take, in Conrad's (1987) words, an 'insider's perspective', 'access depends on, and is complicated by, the researcher's own conceptions... required to make sense of that other personal world through a process of interpretative activity' (Conrad, 1987, p.218-219). These conceptions are needed to make sense of the other's world, as the joint reflections of both the participants and the researcher form the analytic account that is produced (Osborne & Smith, 1998; Smith, Flowers & Osborne, 1997).

Research methods including phenomenology, grounded theory, discourse analysis and narratology have been selected as the forms of data analysis most applicable to topics in Counselling Psychology (Woolfe & Dryden, 2004). The aims of this research are in keeping with a qualitative approach, being concerned with understanding meaning and processes,

rather than outcomes alone. It aims to encourage a deeper meaning of the lived experience of clinicians' responses to clinical practice with suicidal clients and adjustment to client suicide death. The resultant implications of the study may affect the provision of services for staff, which is consistent with the effect of clinical experiences informing clinical development. It is also hoped that this research may convey a deeper understanding of some of the issues facing clinicians, acting to develop further qualitative research studies.

2.1.1 Rationale for adopting interpretative phenomenological analysis (IPA)

Interpretative phenomenological analysis focuses on the exploration of participants' experience, understandings, perceptions and views and is phenomenological, being concerned with subjective reports rather than the formulation of objective accounts (Flowers, Hart & Marriott, 1999). For the purposes of this study, it could be argued that other qualitative methods such as grounded theory (Glaser & Strauss, 1967), might have been equally appropriate. However, grounded theory aims to build inductive theories from the data and this was not the intention. In capturing the material as a whole, a model or framework can be produced for understanding the phenomenon being studied. In addition, through focusing on creation of theory, the narratives tend to become transformed into general themes. This research, instead, focuses on the individual sequences of meaning that would be produced.

Discourse analysis places the main emphasis on the social functions of language (Wetherall & Potter, 1988). The typical difference between discourse analysis and IPA may be the perception of the status of cognition (Smith, 1996). Potter and Wetherall (1987) regard verbal reports as behaviours in their own right, although common ground is shared in the attention paid to the subtle ways that meaning is constructed. Within discourse analysis, the influence of the context of the participant has similarities to that within IPA. Rather than being concerned with whether the accounts of participants are 'true', IPA is concerned with understanding what the respondent thinks or believes about the topic, (Smith, 1996), with an examination of human lived experience expressed in its own terms rather than according to pre-defined category systems. Through the central analytic activity of the researcher, the interpretation, the position and the conceptions held by the researcher form an essential component of the research. This reflects the overall aim of the study, in the intention to explore rather than to define personal experiences. The Counselling Psychologist similarly works therapeutically with human experiences and the world-view of the client, within their social context.

2.1.2 Rationale for adopting an interview schedule

A semi-structured interview schedule (Appendix 7) was developed, as the questions can be varied to allow for a more detailed exploration of an area of importance to the participant (Smith, 1996), as they arise. Topics such this may generate particularly significant individual memories, and sensitive topics are considered to be particularly well suited to interview methods (Richards & Swartz, 2002). The interview schedule was derived from the existing research literature, following the guidelines of Smith (1996), addressing the areas encompassed in the research questions. Questions were neutral and open ended to avoid, where possible, questions that would lead to 'Yes' or 'No' responses. The more sensitive areas were explored later, so that if the participant had experienced a client suicide, this was 'led' into. A pilot study was carried out with two volunteer clinicians with the purpose of confirming that the questions lacked any ambiguity. This was confirmed in both cases.

2.2 Ethical considerations

Approval for the study was obtained from the Local Research Ethics Committee (LREC) (Appendix 1) and from the Trusts' Research Governance Steering Committee (Appendix 2). Initially, an on-line application form and letters outlining the study were submitted to the LREC. Following meeting with the Local Research Ethics Committee, extreme care was taken in the process of recruitment. Following their recommendations, letters of introduction were sent to the managers/team leaders of mental health teams (Appendix 3). The managers were requested to send a letter of support (Appendix 6) before the study commenced, which were sent to the Committee. Once these were received, the study commenced. The managers distributed Letters of Invitation (Appendix 4) and Participant Information Sheets (Appendix 5) to those within in their teams who expressed an interest in taking part. Those who wished to take part in the study subsequently made direct contact with the researcher.

Prior to commencing the interview, the participants were made aware that the information obtained during the interviews would remain confidential and would be used solely for analysis by the researcher. All material would be kept in a confidential, safe holding. The tapes would be stored securely and destroyed no later than two years after the final submission of the project.

Whilst it was intended that those who took part were given the opportunity to discuss their personal experiences and aspects of their professional role, the researcher was aware that this could be distressing and that some participants might want to subsequently explore issues further subsequently. Thus, at the end of the interviews, all the participants were given a de-briefing (Appendix 9) and reminded of the support services that are available, including telephone and face to face counselling.

During the process of arranging the interviews, two participants requested that they be interviewed whilst the other was in the room. In terms of confidentiality, as this was requested by both participants, it was agreed. The person who accompanied the first participant was subsequently interviewed alone. Finally, the participants were made aware that they would not be identified by where they worked or their occupation. In order to protect the participants, only a restricted amount of information of the sample is provided. The individuals' details are not given, and when presenting the themes, the professions of the participants are concealed.

2.3 Sampling and participants

In line with the ideographic method of IPA, a sample size of twelve participants was included in this study. A small sample is recommended, as the detailed analysis of a small number of cases aims to reveal meaningful structures in the data (Smith, 2004). These need not be generalisable, yet the meanings that are derived may identify patterns common to other groups and individuals. The participants were experienced mental health clinicians, including six Counselling Psychologists, three Community Psychiatric Nurses, two Consultant Psychiatrists, and a Cognitive Behavioural Therapist. Seven were male and five were female. All the participants worked in mental health care settings within a Trust located in the South East of England. A summary of the participants' characteristics appears in Table 1, within the Analysis and Discussion Section. The time since the participants' client(s) had died ranged from 9 months prior to the research interviews to several years before.

2.4 Interviews

At the start of each interview, the researcher clarified that the participant had read the Participant Information Sheet and understood the nature of the interview. Any questions they had were answered. The participants were asked to read the consent form (Appendix 8) and if they agreed with this, the form was completed, including consent to the interview being tape-recorded. Before the interviews began, efforts were made to put the participant at their

ease, by placing the tape recorder in an unobtrusive place and demonstrating warmth to the participants. A semi-structured, flexible schedule was used, in order to guide the interview process (Appendix 7). As the responses were made by the participants, the researcher gave verbal and non-verbal cues to establish rapport, (Mearns & McLeod, 1984) showing respect, congruence and acceptance. The questions began with asking about their experience and practice with suicidal clients, beginning with broad areas before exploring more sensitive experiences. The interview explored relevant areas, such as thoughts, feelings and perceptions of support. Summaries were made by the researcher to ensure that the meaning of the participant was understood and that it might be accurately represented. A summary of the responses of the researcher was made following the completion of the interviews (Appendix 10). The interviews lasted between 40 and 60 minutes and they were all recorded on audiotape for later transcription. At the end of the interview, each participant was de-briefed (Appendix 9) and information was given about support services. All participants were offered copies of the transcripts. In two cases, this was accepted. The interviews took place over a five month period from June-October 2005.

2.5 Analytic strategy

It is recommended that the audiotapes are transcribed in full, so that the text may be analysed thoroughly (Smith & Osborne, 2003). All the words spoken were therefore included in all of the transcripts, including false starts, significant pauses or laughter. Each transcription was allocated a pseudonym to identify the participant.

Following the recommendations of Smith, Jarman and Osborne (1999), when transcribing the interviews, margins were left on each side of the pages. The audio tapes were listened to carefully, to obtain any areas of particular emphasis by the participant. In the first stage of analysis, one transcript was looked at to begin with, and re-read several times, using the margin on the left hand side to note preliminary impressions; from these notes, theme titles emerged. Some comments were attempts at summarising or making connections. The right hand margin was annotated with very broad, unfocussed notes reflecting the initial thoughts and impressions of the researcher. After careful re-reading, the notes in the right hand margin were added to, elaborated, modified and edited. The emerging theme titles which encapsulated the core issues and ideas in the left hand margin were then written in the right hand margin. Key words were allocated to the emergent theme titles, such as 'support.' As clusters of themes emerged, the analysis of other cases continued and each transcript was read several times. The original transcript was referred to again, to check that the connections 'worked for the primary source material- what the person actually said' (Smith,

1999, p. 223). A master list for each interview and a consolidated list of master themes were produced. At this point, some of the themes were dropped, as it became apparent that it did not fit well into the emerging structure. Attention was paid to examining each transcript as an individual and separate case, as well as where themes emerged which were repeated by different participants. The initial list of emergent themes for each transcript was then analysed, alongside themes from other transcripts, producing a consolidated list of themes, with extracts from the transcripts grouped under theme headings. After all the transcripts were analysed, the final shared themes were translated into a narrative account (Smith, et al., 1995,1997,1999; Willig, 2001).

2.6 Credibility of the research

Credibility in qualitative research is said to correspond to internal validity in quantitative approaches. An evaluation of whether the research findings present a 'credible' conceptual interpretation of the data, drawn from the participants' original data, is required (Lincoln & Guba, 1985). This evaluation involved various activities, including extensive engagement with the transcriptions, researcher reflexivity and close involvement and discussions with the two research supervisors. The researcher attempted to establish some credibility for the findings by developing an integrated account, ensuring that all the interpretations offered fit the data (Elliott, Fischer & Rennie, 1999) and that what the participant said is distinguished from the researchers' account (Smith, et al., 1999). A validity check of the interpretative process was made by giving the two research supervisors a page of a transcript with the notes made by the researcher. They were asked to follow the analytic process and read the notes made by the researcher, in order to ascertain if these represented their understanding. In certain areas, the themes did not always reflect the text. Following some amendments, it was agreed that the themes were situated in the text. These checks were implemented in order to ensure credibility of the final account, rather than functioning as a check of objectivity (Yardley, 2000) as there cannot be one 'true' account in IPA.

Verbal reports can never be absolutely reflective of participant's underlying thoughts, yet it is widely accepted that they can allow for meaningful interpretations to be made about the person's thinking (Smith, et al., 1997). While it could be argued that because the data are retrospective, they are open to memory distortions and recall biases (Moss & Goldstein, 1979), subsequent research evidence suggests that retrospective reports and autobiographical memory are not necessarily and inevitably inaccurate and unstable (Blane, 1996, Brewin, Andrews & Gotlib, 1993).

2.7 Inherent subjectivity

The inherent subjectivity of bias is brought to the interpretation by the beliefs and values held by the researcher. As a co-constructor of meanings, this is important in determining the credibility of the data. Attempts to identify the researcher are made throughout the study, and these can be found in the Introduction and in Appendix 10. An overview of the learning that occurred within the researcher is found at the end of the Analysis and Discussion section. The background of the researcher influences the choice of theoretical perspectives offered and the order of the thematic presentation. As the integrity of the findings lies in the data, in terms of the guidelines of Elliott et al. (1999), it is evaluated in terms of the sample, the procedures used to obtain it and how well this is confirmed to the reader.

2.8 Transferability of the findings

This research will hopefully be useful in terms of widening awareness of client suicide and recognition of the effects of this on mental health care clinicians. Within qualitative research, while there are limits to the extent of the generalisability of the findings to the characteristics of the group that is under investigation, it is hoped that this research may serve to raise awareness of the likelihood of client suicide for Counselling Psychologists and other mental health care professionals. It may also serve to increase awareness of the possible psychological effects that may occur. The ultimate research outcomes may generate the improved care of clients, as clinicians may be better equipped to confidently support suicidal clients. Therefore, this research may be evaluated by its applicability to other situations and to others who are similarly involved in these areas of clinical practice.

2.9 The presentation of data

In the presentation of the quotations, (...) indicates the omission of material which might otherwise reveal the participants' identity. The use of ... indicates natural pauses within speech. The use of italics indicates where sentences are directly taken from the transcripts and quotation marks indicate quotations spoken by the participants. The use of bold font shows emphasis placed on words by the participants. The extracts have been reproduced exactly as spoken and have not been corrected for grammar. Finally, in order to preserve confidentiality, place names have been omitted, pseudonyms replace participant's names. In some cases, the gender of the participant and the client referred to has been changed.

Chapter 3. Analysis and Discussion

Details of the circumstances of the participants' experiences are shown below in Table 1. The participant's occupation has not been included, as this would risk revealing their identity.

Table 1: The participants' experiences of treating clients who were suicidal, and of client_suicide

Name *	Years of experience as a qualified clinician	Gender	Experience of working with suicidal clients	Number of client deaths	Circumstances of the client suicide	Involvement with a formal investigation
Jason	30	M	Y	5+	√	Y
Robert	20+	F	Y			
Alistair	24	M	Y	2	√	Y
Liz	2	M	Y	2	√	Y
Jim	7	M	Y	2	√	
Peter	16	M	Y	1	√	
Sally	15	F	Y	1	Died on w/list	
Pam	5	F	Y	1	Died on w/list	
Ben	7	M	Y	1	Died in hospital	
Jenny	18	F	Y	1	√	Y
Jane	10	F	Y			
Bill	12	M	Y			

*Pseudonyms replace real names throughout this analysis, in order to maintain confidentiality.

√ Indicates a therapeutic relationship with the client at the time of the suicide.

3.1 The participants' experiences of treating suicidal clients and of client suicide

Table 1 above shows how all twelve of the participants had experience of clinical practice with suicidal clients. Nine of the participants had experienced one or more clients die by suicide. Five participants had been subsequently involved in formal procedures. No apparent pattern emerged in the circumstances of the client suicides. One participant had worked therapeutically with her client briefly and was subsequently placed on the waiting list. Two other clients also died before being seen by the participant. Thus, six of the participants were in a current therapeutic relationship with their client when the client died.

3.2 Overview of themes: Working with and beyond client suicide

An explanatory model derived from the emergent data describes the participants' experiences before and following client suicide. This model (Figures 1-4) comprises four superordinate themes: *Being with suicidal clients, Impact of client death, Subsequent influential experiences,* and *Evolving.* Figures 1-4 are shown at the start of each theme, in order to indicate the theme to be presented, which is highlighted. The themes interlink and may overlap sequentially, but in order to present the experiences as clearly as possible, they are shown as separate themes. The analysis cannot include all the emergent themes of this study but intends to represent the most salient, representative aspects described by the participants. The themes include the questions that the research aimed to explore and the additional, unexpected findings of the study.

The first superordinate theme, *Being with suicidal clients,* presents the accounts of experiences and approaches taken by the participants when working therapeutically with suicidal clients. In some, the process of exploring difficulties with clients was valued and approached with confidence. Clinical practice with suicidal clients also emerged as a source of stress and led to intense anxiety in some participants. In order to highlight both aspects, this theme is comprised of two subthemes, entitled *Understanding the client and self,* and *Vulnerability.*

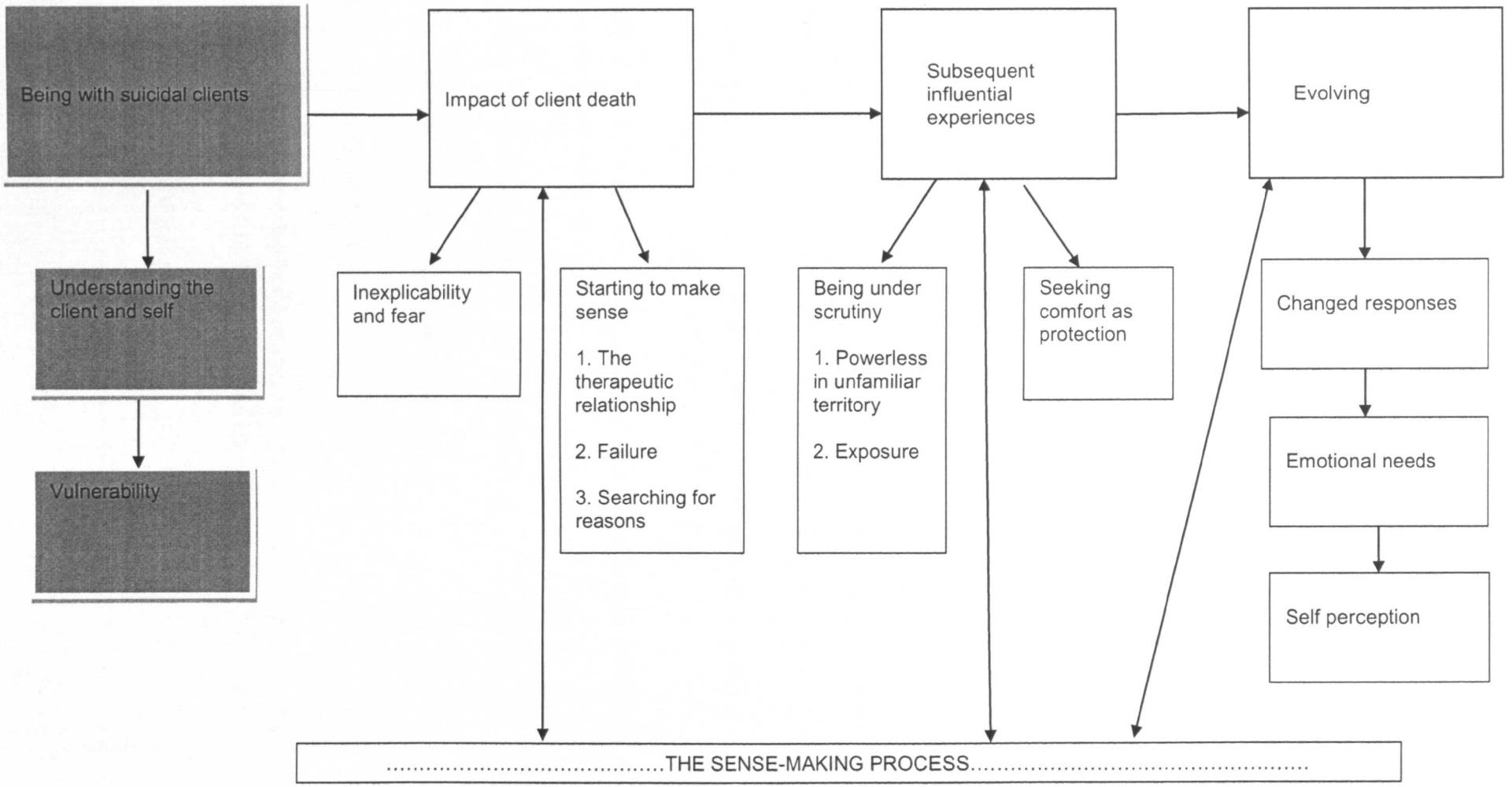
The second superordinate theme, *Impact of client death,* presents some of the initial responses of participants and their subsequent processing of the event. In order to demonstrate both the initial effects and later subsequent processing, there are two subthemes, *Inexplicability and fear* and *Starting to make sense.* The first subtheme, *Inexplicability and fear,* presents the participants' reactions soon after the event. The second subtheme, *Starting to make sense*, is divided into three parts in order to reveal the emerging

sense making process and some of the factors that influenced this, entitled: *The therapeutic relationship, Failure,* and *Searching for reasons.* This theme marks the start of a sense-making process which continues in the subsequent themes and is a continual thread running throughout, as shown in Figures 1-4. The reactions of the participants were considered to take place over a period of time.

The third superordinate theme, *Subsequent influential experiences,* shows the events and experiences that impacted on the participants' overall experience of client suicide. This theme is divided into two subthemes, *Being under scrutiny* and *Seeking comfort as protection.* The first subtheme, *Being under scrutiny,* highlights the experiences of those who were involved in a subsequent investigation. This subtheme includes two divisions: *Powerless in unfamiliar territory* and *Exposure.* The second subtheme, *Seeking comfort as protection,* shows how support served as a protective factor in the participants' responses to this event.

The final superordinate theme, *Evolving,* has three subthemes in order to present the different aspects of a gradual, fluid adaptation to the experience of client suicide. These are: *Changed responses, Emotional needs* and *Self perception.* Extracts from the transcripts, together with the number of participants contributing to each theme are shown in Appendix 12.

Figure 1: An explanatory model outlining the evolving process of working with and beyond client suicide. The highlighted area indicates the theme presented in the following section, Theme 1: Being with suicidal clients.



3.3 Superordinate theme one: Being with suicidal clients

The first superordinate theme, entitled: **Being with suicidal clients,** shown in Table 2 in abbreviated form, presents the accounts of approaches taken by the participants in practice with suicidal clients. It emerged that some participants considered the exploration of issues that contributed to the clients' suicidal intent to be very important. The process of exploration was perceived as requiring confidence in the clinician. However, the nature of the work with suicidal clients was a source of concern and anxiety in some, appearing to cause high levels of stress, leading to a sense of vulnerability. Therefore, in order to reveal these aspects, this theme is comprised of two subthemes, **Understanding the client and self** and **Vulnerability.** Unexpectedly, it emerged that in some participants, their understanding of the suicidal client was influenced by their own personal experience of bereavement by suicide.

Table 2: Being with suicidal clients

Understanding the client and self
I think- some level of despair or helplessness, to change things
The vast majority of problems are dynamic issues within communication and need to be understood at that sort of level. That requires a degree of confidence
Hold that situation and wait and see what's actually going on and spend some time talking about it. The issue begins to clarify itself
When you reveal that problem, you realise the depth of distress
What's useful is to understand the personal human dilemma
I probably have a high anxiety threshold
I need to believe I have done everything that's in my power to help that person and if they decide to commit suicide then there's nothing more I can do
I've got first-hand experience that this happens

The baggage we bring to every blooming client Personal experience of suicide influences my feelings about it Because (...) had done it I'm not sure what it was about (...) but it felt to be around my personal stuff Trying to regenerate some understanding within. Otherwise, you can't do your work
Vulnerability
You see the person, and they are okay. Then, you go home and review how you manage the risk, over and over It's the one thing in the work that stays with you, I think. You can't switch off at the end of the session, you do take it home with you I would talk about it at home, and I'd talk about it at work. I think: 'Here we go again, what's happening here?' The support is never enough. It doesn't matter what strategy you use, those who mean to do it, will do it. Is it going to affect your confidence? If there is somebody you are really uncertain of, what are they going to do? I don't see how you cannot have that affect you, that will affect your outside life You always question yourself. It only takes that one per cent Sometimes, you almost feel impotent, because there isn't anything you can do It can be some of our most anxious times I always worry about them He may take an overdose, and what if he's not found? If it happens, is it accidental?

3.3.1 Understanding the client and self

Within the first subtheme, the accounts show the different ways that participants viewed their interventions and the way they understood the suicidal client. Some narratives indicated that suicidal intent represented the client's helplessness, and was thus a means of the client expressing themselves. It is also shown how several participants perceived a limitation of control over the outcome of those who are intent on dying by suicide. An unexpected aspect emerged, as four of the participants' views of suicidal clients were affected by their personal experience of suicide bereavement.

The desire which emerged in the accounts of six of the participants to explore the client's underlying problems is shown in this quotation by Bill:

> *"I think some level of despair or helplessness, to change things, to draw attention to a dynamic where the suicidal person may feel isolated, or unheard in some ways. They may have got themselves into a dilemma, feeling caught, which is not a good situation. It reflects other issues, about emotional depravation, and not being heard"*

In his understanding of the clients' inner world, Bill suggests that he sees the clients' desire to escape by dying from a trap. Bill appears to demonstrate that he wants to try and understand his client. The accounts within this theme were rich with sensitivity towards the client. Another example of the importance that was placed on exploring with the client, in order to try and identify the client's difficulties, was also provided by another participant, Jane:

> *"The vast majority of problems are dynamic issues within communication and need to be understood at that sort of level. That requires a degree of confidence on the part of the mental health worker"*

Jane indicates in this extract that confidence is needed to explore and identify problems, and she also seems to imply that some clinicians may not have this. Bill also subsequently described his perception of the processes involved in practice with those who are suicidal and his subsequent interventions:

> *"It's about being able to hold that situation, and wait and see what's actually going on, and spend some time talking about it. The issue begins to clarify itself and*

suicidality then sinks into the background and other forms of communication take place, inspiring them with confidence, as well'

Bill demonstrates his intention to explore the client's difficulties, and he describes his perception that through this process, the clients' sense of urgency may be lessened. The holding of the situation may refer to his providing a safe base and containment for the individual. If the cause of the clients' despair is explored, he believes that this may lead to the client considering different ways of coping. Bill appears to be describing his view of the therapeutic process with clients who are in despair. Other participants, including Liz, echoed the importance that was placed on the exploration of client difficulties:

"So, when you reveal that problem, you see, you realise the depth of distress"

Liz's account further demonstrates the value of exploring the clients' underlying issues, and emphasises attempting to understand what contributes to the clients' emotional response. This, she feels, addresses the issues that may have been previously hidden and contribute to their despair. With the same implicit message, with an emphasis on attempting to understand the reasons for the client's state of mind, Bill said:

"What's useful is to try to understand the personal and human dilemma, because you've got to address those issues"

Bill describes how he, too, values exploring client difficulties, viewing this as a vital aspect of clinical practice. These extracts suggest that in their attempts to understand the world-view of the client, both Liz and Bill similarly view the exploration of client problems as being highly important.

In terms of his emotional response to those clients who are at high risk and suicidal influencing his approach, Robert said:

"I probably have a high anxiety threshold, but it doesn't worry me, let's think of other things that you could do, otherwise"

Robert appears to indicate his sense of efficacy and confidence when practising clinically with suicidal clients. He indicates how he wants to help, by providing the client with different, more effective methods of coping. Roberts' reference to his '*high anxiety threshold*' may imply that he perceives that the nature of this work may, by necessity, generate fears and

concerns within mental health care clinicians. Three participants indicated similar views. Jason, acknowledging the inevitability of some client deaths, also viewed a restricted degree of control over the ultimate outcome. He appeared to be philosophically accepting of this:

> *"I need to believe I have done everything that's in my power to help that person and if they decide to commit suicide, then there's nothing more I can do. We can always give them a big slice of ourselves. But realistically, is there more? For some people, it looks like the only way out"*

Jason refers to the limits of his influence, and indicates that for some, the decision to die is the only choice available. It appears that in this, the perspective of client autonomy is respected, providing that Jason can assure himself that all reasonable preventative steps had been taken. Mental health care clinicians are tasked with practicing ethically and the codes of practice and ethics adopt the four key ethical principles of respect for autonomy, beneficence, non-malificence and justice (Bond, 2004). Jason's views also appear to resonate with similar sentiments within existing studies, such as trainee psychologists viewing the decision to die by suicide as ultimately being the choice of the client (Knox, et al., 2006).

Interestingly, through the process of the research interviews, it emerged that four of the participants had experienced a personal bereavement by suicide. Two participants described their experience of bereavement of a family member, and two linked their response to the death by suicide of a colleague to their perceptions of suicidal clients. They explained how their understandings of suicidal clients were influenced by their own personal experience. Bill commented:

> *"Because I've got first-hand experience that this happens"*

Bill indicates his awareness of the reality that people die by suicide within the context of his concerns about a particular client he was seeing in therapy. Bill indicated how his experience of bereavement served to heighten his response to high risk clients. Similarly, Alistair also reflected on the influence of his personal experiences:

> *"I think that's something that we have to be aware of, that what's gone on in our, you know, in our past, it's the baggage we bring to every blooming client"*

This extract shows how Alistair seems frustrated at the effect of his previous experience on his interactions with clients. Other participants reiterated that previous personal bereavement by suicide had some effect on their responses and their views, as Liz said:

> *"I have personal experience here. Umm. But, I suppose that does influence some of my feelings about suicide"*

It appears that her loss may affect her view of suicide generally. It may be that it also affects her clinical practice in terms of her understanding of the client with suicidal intent. Janet commented, in a more specific way, about the influence of her experience on her thoughts about a particular client:

> *"Because, I kind of, it really felt like, because (...) had done it, you know, I kind of felt that (...) and I really didn't want it to happen to this client. That was my baggage, coming in to my concern around this client"*

Janet's awareness of her heightened anxiety about this individual functioned to help her to recognise her own inner processing. She expresses how much she cared about the outcome for this client and that her concern was driven by her own experiences, which she felt were carried as '*baggage*'. Janet's response to the risks to her client mirrors existing research findings, which indicate, perhaps unsurprisingly, how those who have experienced a death by suicide have identified client risk factors at a significantly higher rate than those who have not (Albright, 1995; Lussier, 2005). In being aware of this, the clinician can usefully recognise reactions that are generated by their interactions with certain clients. Janet later commented:

> *"I'm not sure what it was about, but it felt, at the time, to be around my personal stuff"*

This quotation seems to indicate how Janet was aware that some responses to her client were generated by her own experiences. When discussing her view of the importance of self-understanding and self-awareness, Liz emphasised:

> *"trying to regenerate some understanding within. Otherwise, you can't do your work"*

Liz perceives that her own issues may obstruct her practice, and that her clinical judgments could be clouded, without some self awareness and reflexivity. The clinicians' own thoughts and feelings towards the client naturally influence their interventions. There are many ways

that reflexivity processes may develop and mature, one of which is through personal therapy. The division of Counselling Psychology within the British Psychological Society requires Chartered Psychologists to gain an understanding of the perspective of the client role, because interpersonal skills and the use of the self are seen as important, active ingredients in the therapeutic process (Woolfe, 1996). It appears that within these extracts, a high level of self-understanding emerged.

The importance of self knowledge, in order to know another, is a requirement familiar to many mental health clinicians. Although we strive to understand another persons' mind, we may only attempt to know it with reference to our own, as we may interpret the other person's indications of their experience by referring to our own knowledge (Howe, 1993). As the relationship with the therapist has been considered to 'constitute the underlying theme of major portions of the entire therapy session', (Rennie, 1990, p.164) it is particularly significant that the therapist has some self-awareness.

The emergent discussions of personal loss were introduced by the participants, without prompting, within the research interviews. This may be because the research topic stimulated their memories of past events, or the interview might have been considered as an opportunity to discuss these connections. Knowing that the researcher was a Counselling Psychologist may have influenced the desire to share and explore.

In conclusion, the participants' accounts show an eagerness to explore the causes of client distress, and this process was viewed as being therapeutic. It was believed that through this, new perceptions within the client may be generated. Therefore, some participants saw their role as a facilitator of the clients' development of more effective coping skills. It was perceived by some participants that client suicide was, to an extent, beyond the control of the participant which was accepted philosophically. It was viewed by one participant that for some, this is the only option available. In six other participants, their practice with suicidal clients emerged as being a source of stress and anxiety. These accounts are now presented.

3.3.2 Vulnerability

The second subtheme emerged as being the concerns and fears that were articulated by other participants. When treating suicidal clients, their anxieties were pervasive, and haunted some participants. Their fears included whether their clinical assessment of risk factors was accurate. Apprehension emerged concerning whether a client they were seeing at the time

of taking part in the research might die accidently. Self-doubts about clinical decisions, combined with perceived lack of control and a sense of being powerless to influence the outcome appeared to indicate an underlying vulnerability. This theme underlines the high levels of stress experienced by some participants in their practice with suicidal clients.

Six participants described feelings of anxiety. The fears of four participants were invasive, as they were troubling both at work and at home. For example, a participant, Sally, spoke of her fears regarding a client she was seeing currently in therapy:

> *"you know, when you see the person face to face, and at that time, the person is okay, and previous to that, he was okay. Then, somebody says: 'He did not attend his appointment'. You then go back and review, at home, over and over, how you manage risk"*

Sally's fears appear to remain with her both at work and at home, illustrating their pervasive nature. As her client does not arrive, this leads to her feeling intense anxiety. Among the most widely reported stressors associated with the therapeutic relationship are the responsibilities for clients and the difficulty in working with disturbed clients (Farber & Heifetz, 1981). Several other participants reiterated similar reactions of pervasive anxiety and pre-occupation with thoughts about their client, as Jenny commented:

> *"It's the one thing in the work that stays with you, I think. You can't switch off at the end of the session; you do take it home with you"*

Ben also reiterated this:

> *"I would talk about it at home and I'd talk about it at work. I'd think: 'Here we go again'. The support is never enough. It doesn't matter what strategy you use, those who mean to do it, will do it. Is it going to affect your confidence?"*

Feelings of frustration and helplessness appear to arise and Ben indicates that the decision to die is with the client. This leads to an inner tension within, as his clinical role is to do his utmost to prevent it. The sense of Ben perhaps becoming depleted emerges when he says: 'the support is never enough'. It seems that he perceives that cannot give sufficiently to make a difference to his client. It has been noted that therapy with clients who are resistant or do not improve cause stress as they prevent clinicians from feeling competent and successful (Fontana, 1989). The helplessness Ben conveys may relate to beliefs about self-

efficacy, as Ben questions whether a client suicide will affect his confidence. Self-efficacy is said to develop over time and through experience. It may be best understood in the context of social cognition theory, which assumes we are active shapers of our environments (Bandura, 1986, 1997; Barone, Maddux & Synder, 1997). Our attempts to control our environment are the most powerful source of self-efficacy information (Bandura, 1977, 1997). Successful attempts at control that are attributed to individual efforts are said to strengthen self-efficacy for that behaviour. Perceptions of failure at control attempts usually diminish self-efficacy. Ben's perceptions may relate to his inability to control the outcome of his clients' decision. Some clinicians may struggle to accept that clients will remain preoccupied with death despite their input, thus confronting the clinician with their limitations (Brown, 1987a). The anxiety within these accounts is mirrored in existing studies (Reeves & Mintz, 2001) and those illustrating how the stress of the work of the therapist is accentuated with clients who are suicidal (Owen, 1993, Sherman, 1996). Ben had described how his concern for the client spilled over into his personal life. In a similar vein, **Jenny** continued:

> *"... if there is somebody you are really uncertain of, what are they going to do? I don't see how you cannot have that affect you. That will affect your outside life"*

Talking through issues from work with those at home may be a source of comfort, but could add strain to close relationships, which is alluded to when she says it will affect her life 'outside'. Preoccupation with worrying clients may mean that the clinician becomes too emotionally depleted to be available to others. Stress arising from work can be pervasive and significant, not only in its impact on the clinician, but also for their families (O'Driskoll & Cooper, 2002). Consultant Psychiatrists have reported that following a patient suicide, they experienced an adverse effect on their home life (Alexander, et al. 2000).

It was felt that despite many years of extensive clinical experience, concerns arose regarding the unexpected nature of client suicide, as illustrated by Alistair:

> *"Then you tell yourself, all my years of clinical skills. But what does research say about people with suicidal thoughts? You know, you always question yourself and then you say, in all this time, you know, maybe eight out of ten, you are correct. All it takes is that one per cent isn't it?"*

Alistair indicates that the doubt generated by the possibility of client suicide over-rode his knowledge gained from clinical experience, bringing doubt, as a client death by suicide can be sudden and unpredictable (Horn, 1994, Alexander, et al., 2000). The uncertainty of the

situation may contribute to the clinicians' feelings of vulnerability. The anxiety that is expressed by participants, in their role as clinicians, may relate to perceptions of the orderliness and predictability of the world (Janoff-Bulman, 1992). The unknown aspect of the situation presents a challenge to their beliefs. Should the client die by suicide, the clinician will face a loss and may become involved with an investigation into the cause of the clients' death, leading to the formal exploration of their clinical decisions. In addition, the beliefs of the clinician of their ability to make a difference to the outcome are possibly challenged, as are deeply held beliefs about being worthy as a clinician. Bill reiterated the feelings of Alistair:

> *"It can be some of our most anxious times, if we've got a client whom we think might top themselves"*

His reflection resonates with the sentiments of Goldberg, (1986) who noted how the very process of working intimately with human suffering may present the practitioner with psychic discomfort. A view of feeling 'stuck' and helpless was articulated by Sally, who said:

> *"Sometimes, you almost feel impotent, because there isn't anything you can do"*

It appears that Sally's sense of helplessness is combined with her resignation of the impossibility of affecting the ultimate outcome. The powerlessness that she conveys may also be what the client feels. Thus, the clinician becomes aware of this within herself. Regarding his responses with suicidal clients, Ben simply said:

> *"I always worry about them"*

Ben indicates that he generally expects to be anxious and apprehensive with clients who are suicidal, an expectation perhaps derived from previous experiences. Fear, impotence and helplessness are common responses amongst therapists working with suicidal clients (Menninger, 1991; Koldonony, et al., 1979; Reeves & Mintz, 2001). These responses are similar to those who experience a client death by suicide (Boakes, 1993; Menninger, 1991). Several participants shared concerns about clients they were seeing currently during the research interview. Details of the clients are not presented in order to protect their identity. One of the participants, Sally, said:

> *"This person I am seeing, was hoarding tablets for periods of time. He may take an overdose. My concern is what if he's not found? If it does happen, is it accidental?"*

Sally anxiously considers whether the client may die unintentionally. When the question of their client dying by accident arose, it filled some participants with doubts, both about the clients' possible actions and their own clinical role. The issue of accidental death may be a professional concern, as if the death is deemed to be caused by suicide, this may affect their position. Suicidal clients may thus challenge the beliefs of the clinician in an orderly, predictable world (Janoff-Bulman, 1989, 1992) and some individuals may feel powerless in this situation.

The stresses of working with high risk clients may feel overwhelming for some clinicians and clinical supervision may provide an essential venue for gaining support. Professional self-doubts may trigger stress (Horn, 1994, Alexander, et al., 2000). Ongoing, sustained or chronic stress at work may lead to 'burnout', a term first applied to the work setting in 1975 (Freudenberger, 1975). Since then, burnout has been widely investigated, particularly among human service occupations such as healthcare, in which sustained stress is thought to be due to the emotional nature of the relationship between staff and patients (Maslach, 1997). The term is often used as if it were a direct measure of stress, perhaps because there is a widely used psychometric tool for measuring it amongst groups of people (Maslach & Jackson, 1986). We may, however, be wary of applying the term to individuals, as no reliable method exists for identifying this within individuals (Maslach, 1997). Three primary features of burnout include becoming emotionally exhausted, where contact with clients feels draining with loss of energy. A negative or excessively detached attitude towards clients or colleagues may occur, and a loss of confidence in ones' accomplishments. This leads to low morale, withdrawal and inability to cope. Therefore, burnout may be an ultimate way of coping with stress (Maslach, 1997).

There are some critical points emerging from the extensive literature of mental health clinicians' experience of burnout, including the interactive effect of occupational stress and the clinicians' personality. It is not simply the stressful environment or solely the vulnerable person that may contribute to burnout (Norcross & Guy, 2007). The effects of working closely with suicidal clients may impact far more on one person than another. The accounts within the first subtheme indicate that those participants illustrated within that theme did not feel overwhelmed. Those who feel anxious and fearful during therapeutic intervention with suicidal clients were presented within this subtheme, where the stress at work appears to have an invasive quality.

Work stress has been examined within the context of a wide range of helping professions. A recent study of the stresses affecting Counselling Psychologists was conducted (Papadomarkaki & Lewis, 2008) employing a qualitative method. The views and experiences of the job strains of six Chartered Counselling Psychologists were analysed using thematic analysis, a specialised form of Interpretative Phenomenological Analysis. Four main themes emerged, entitled: uncertainty at work, relationships with others, being 'me', and criticism of professional identity. Unmotivated, demanding clients left some participants with strong negative feelings after the end of the session. Interestingly, the question: 'Am I sufficient?' concerned those Counselling Psychologists who faced problems in their work with challenging clients. This questioning process resonates with the accounts of some participants in the current study who articulated similar concerns. Papadomarkaki and Lewis (2008) noted how an inability to find a specific answer to their question left some Counselling Psychologist participants with feelings of insecurity and fear. Stresses that are experienced at work could not be left behind and affected their intimate relationships, which seems to mirror the experiences of some participants in the current study. It was suggested by the researchers that greater clarity of Counselling Psychologists' roles and responsibilities within the wider organisational system is an important factor.

In conclusion, the accounts of high levels of anxiety generated by the unpredictable nature of clinical practice with high risk suicidal clients led to participants' overall sense of vulnerability. While there can be profound rewards in the work of mental health clinicians, through alleviating distress and promoting growth in the lives of others, the negative effects of stress are well documented (NASS, 1992). These effects may be more apparent in those clinicians working with several high risk clients. A consensus has emerged that the amount of stress that people experience in relation to their work is related to three primary factors (Linzer, et.al, 2002) including the demands of the work, the degree of control they have over it, and the amount of support that people feel they receive in their personal and professional life, which seems to be particularly pertinent for those caring for suicidal clients. Staff may need to develop ways of sustaining their ability to care, rather than becoming burned out, with sufficient time to off-load in the workplace, rather than allow it to accumulate or be taken home (BPS, 2007).

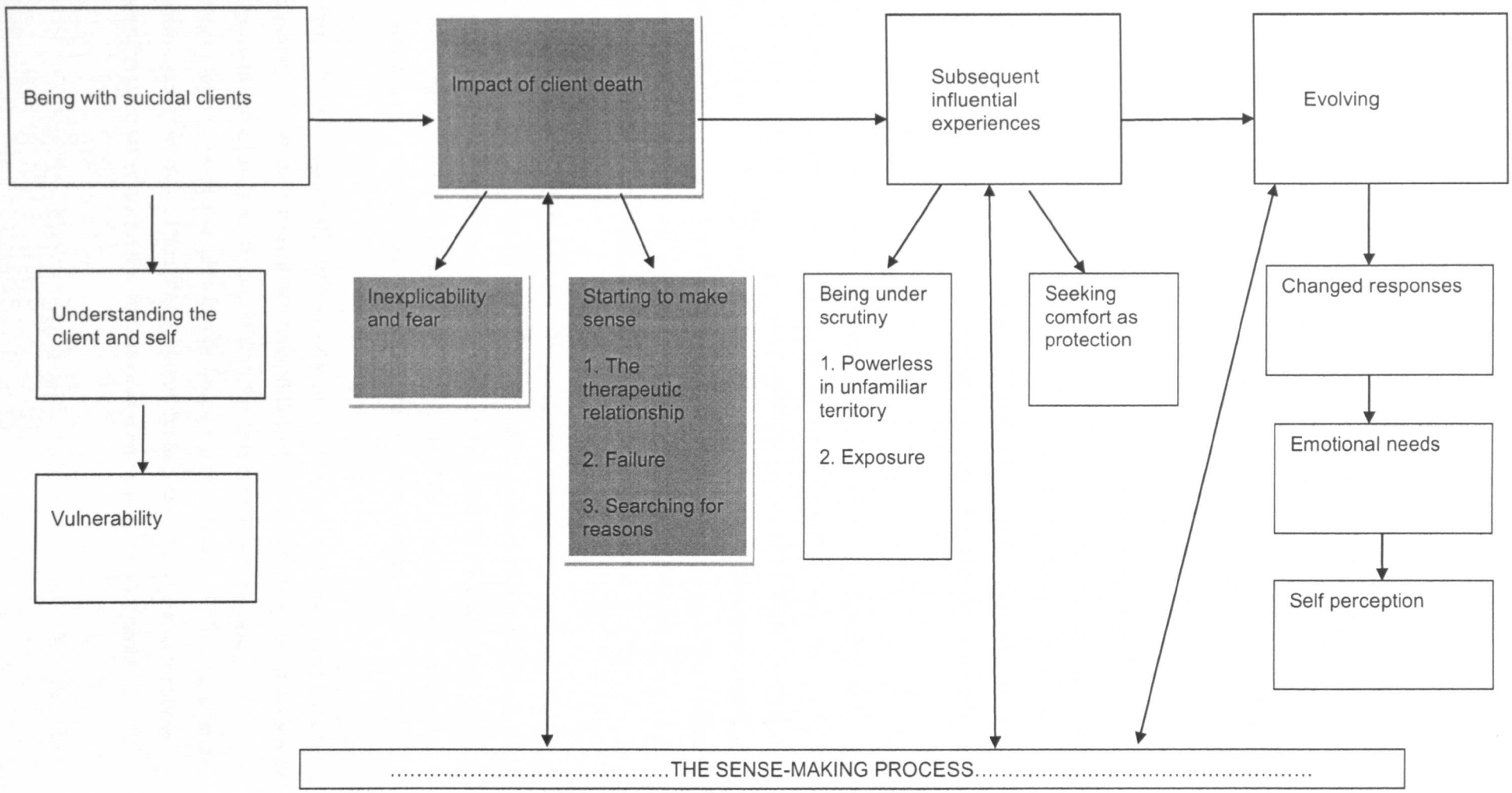
Summary

The first subtheme of the analysis, **Understanding the client and self** showed how the participants' narratives included a desire to explore the underlying causes of their clients' distress, which they felt capable of addressing. Also, the possibility of the clients' death was understood as being an unfortunate inevitability at times. In addition, some believed that their understanding of suicidal clients was influenced by their experience of personal bereavement by suicide. Thus, the importance of self-awareness was accentuated. Understanding our strengths and limitations as clinicians may create a more robust, stronger sense of self and may lead to the generation of more accurate, helpful interventions.

Within the second subtheme, **Vulnerability,** a number of concerns included uncertainty about whether the client may die accidently. The clinicians' perceived competence, influence, and their level of involvement with the client all contributed to their responses. Recalling the work of Cross and Papadopoulos (1999), therapeutic interventions with suicidal individuals may be typically stressful for many clinicians. Anxiety, self-doubt and fear may potentially lead to vulnerability in clinicians. This was considered with reference to existing research outcomes and theory, including the potential of individual 'burnout'. The accounts were also analysed in relation to threatened assumptions about safety and predictability (Janoff-Bulman, 1992).

The diversity of individual responses to therapeutic practice with suicidal clients is accentuated within this theme by the inclusion of the two subthemes, as, whilst some of the participants indicated that they felt confident to address the clients' difficulties, others perceived that practice with the suicidal client was a difficult and challenging experience.

Figure 2 - Explanatory model outlining the evolving process of working with and beyond client suicide. The highlighted area indicates Theme 2, Impact of client death, which is presented in the following section.



3.4 Superordinate theme two: Impact of client death

The second superordinate theme, shown below in Table 3, explores the overall impact of the suicide of a client, including both the initial and some of the subsequent psychological processing of participants. Although this theme is divided into two subthemes, **Inexplicability and fear** and **Starting to make sense,** there is interlinking between the two. The first subtheme, **Inexplicability and fear,** presents the immediate responses of the participants on first hearing that one of their clients had died.

The second subtheme, **Starting to make sense,** presents the factors that were considered to be part of the process of making sense of this event. This continues over time as a thread running through and connecting all of the subsequent themes. This subtheme is divided into three sections, in order to present the emerging sense-making process and some of the factors that influenced this. The three sections are entitled: ***The therapeutic relationship, Failure,*** and ***Searching for reasons.***

The first section entitled: ***The therapeutic relationship,*** shows how some participants' responses were shaped by interpretation of the clients' death, including relational interpretations, the perception that the event was somehow 'personal' to them. Feelings of anger, betrayal, grief and the strength and impact of the attachment to the client emerged. Various factors related to the nature of the client relationship appeared to contribute to the participants' understanding. These factors are discussed in relation to their influence over the participant's processing of the client death.

The second section entitled: ***Failure,*** presents the accounts of those who perceived that they had been unsuccessful in preventing the clients' death, with evaluations that they were, therefore, not 'good enough' therapists. In part of their understanding the event, one participant perceived that their involvement in the clients' care and the clients' subsequent death had permanently left a blemish on their professional career history.

In the final section entitled: ***Searching for reasons,*** questions were asked concerning why the death took place, and whether the client intended to die. Self questioning occurred about the clinical judgements that had been made. Within the sense-making process, comparisons were made between the participants' response to their clients' death and their history of bereavement by suicide. Thus, the accounts feature the both the loss that was experienced and the adverse effect on the professional identity of the participants.

Table 3: Impact of client death

Inexplicability and fear	Starting to make sense
She was a lovely lady... she was so well	***The therapeutic relationship***
It really upset me more, because she was getting better	She had a wonderful sense of humour...she made me feel welcome
I was gobsmacked. I would have put him at the bottom of the list	You do have an attachment, you can't help it
God, have I done something wrong here?	I suppose, professionally speaking, you don't have favourites
Are my notes up to date? which was an awful thing to think of	She was new to the service, so I think it was harder
	This was a planned attempt, over a period of time. I felt abused
	There was no concern for us, though
	He did not allow me in, not that one
	When she died, I realised, you almost go through a bereavement process, it does affect you
	I was very sad. I think it's important to grieve
	I had a similar reaction to that of (...)

	Failure I felt quite disturbed, and I felt- in some sort of way- I think there was a sense of failure around You cannot help, despite everything else, taking it in your track record as a failure Despite our good rapport, I wasn't able to help her I did feel that I'd failed him. It was awful
	Searching for reasons All the questions about whether it was deliberate Rattling around is that she hadn't meant to do it Should he have been a higher risk? You do go through that Her, as a sort of, risk (...) I still question my judgement

3.4.1 Inexplicability and fear

The first subtheme includes the participants' initial responses that the death of the client was inexplicable to them. Interlinking their intense shock were immediate fears for their professional position. Although some time after the event, indeed, for some, it was several years afterwards, in all of the participants their recollection of what took place was very clear and detailed. The participants reported responses encompassing disbelief, grief and doubts

about their professional actions. These initial responses marked the beginning of a sense-making process in relation to their experience. Nine participants had experienced the death of one or more clients.

None of the participants had expected their client to die. On the contrary, four of the participants indicated that their clients seemed to be improving during therapy. Their shock and sense of bewilderment was striking. One of those was Liz, who described her utter disbelief on hearing of the death:

> *"She was a very pretty, lovely lady. She was fabulous, she was so well. I was absolutely amazed, when out of all my clients, that she would commit suicide"*

Liz strongly portrays her affectionate impression of a lively, vivacious person, and her sense of disbelief is accentuated as she compares her presentation with that of other clients. Liz's initial intense shock seems to resonate with the shattering of her 'assumptive worlds', as the sudden nature of this event appeared to affect her beliefs of predictability (Janoff-Bulman, 1992). Ben similarly described incomprehension at his second experience of client suicide:

> *"The next one was (...) years afterwards, it was different. It really upset me more, because she was getting better. She was feeling better. I think something must have happened in her life, in between the sessions, that I didn't know about. It was much more of a shock"*

Ben compares his latest experience of client death with his earlier experience, finding the unexpected nature of this to be the most shocking aspect. Rando (1984) took the position that, generally speaking, sudden death is more difficult to grieve than an expected death, primarily because unexpected loss is more overwhelming to an individual's coping resources. Jenny similarly indicates how she found the news very hard to believe:

> *"I was gob smacked. I would have put him at the bottom of the list. I would really. That **really** caught me unawares"*

These accounts suggest that due to the unpredictability of the event, the impact on the participants was intense, especially as the clients appeared to improve psychologically, despite the presence of on-going concerns. This finding is consistent with some existing research findings (Gorkin, 1985; Kolodny, et al., 1979; Rogers, 2001b; Schnur & Levin, 1985; Valente, 1994). Within Courtenay and Stephens' (2001) study of 109 training

psychiatrists, reports indicated that reactions to the death of a patient included participants feeling 'devastated'.

In addition to the responses of shock on hearing that their client had died, four of the participants' indicated that they felt fearful. For example, Pam said:

> *"because, I mean, you can't help but think, I mean, God, you know, have I done something wrong here?"*

Pam's feelings of fear and shock appear to relate to anxiety concerning having made a mistake or an omission in her care. Being afraid immediately after this event can be understood in terms of the world no longer being a 'safe' place. It now becomes unpredictable, despite all the attempts, as a clinician, to engage in behaviours that kept it safe (Janoff-Bulman, 1992). The core assumptions regarding ourselves and the external world and the relationship between the two are the belief that the world is meaningful, the world is benevolent and that we are worthy, competent people. Also stressing her fear and anxiety, Jenny said:

> *".. make sure you document it and cover your arse, which is an awful footnote, but when I found out, the first thing I thought was, were my notes up to date? Which was an awful thing to think of, it was: 'Oh God, are my notes written?' "*

Jenny's emotional, anxious-sounding account appears to be based in fear for retaining her professional standing. Her use of strong language serves to emphasise the intense sense of threat that Jenny perceived to the continuity of her professional identity, related to identity process theory (Breakwell, 1986, 1996). If Jenny is found to be at fault, this may subsequently affect her position. She describes how her notes were her main priority on hearing of the death, which is then evaluated as being *'an awful thing to think of,'* perhaps implying that her main focus should, in her view, have been the client. Instead, it appears that her focus is her professional position. An audit by Hodelet and Hughson, (2001) found that poor documentation of clinical records may leave staff vulnerable to charges of neglect within subsequent investigations.

In conclusion, the initial reactions to the clients' death included inexplicability, shock and bewilderment, as the participants felt unprepared for this. Their responses also included fear of being found to be lacking in some aspect of their care, potentially leading to professional repercussions. The experience of the death of a client, within this context, seems to show

the activation of a threat to professional identity (Breakwell, 1986, 1996). Identity process theory suggests that changes in identity occur following movement within the social structure, which is suggested by some of the participants' expressions of anxiety.

3.4.2 Starting to make sense: The therapeutic relationship

The second subtheme presents the subsequent emotional responses, evaluations, interpretations and reactions to the death that were considered to take place over a period of time. The therapeutic relationship with their client emerged as being an extremely important factor to the responses of the participants. During the research interviews, participants spent some time describing details of the client. These details are not presented, in order to protect the client's right to anonymity. The lost relationships were described in many different ways. For example, four of the participants, including Jim, recalled his client with warmth and affection:

> *"...she had a wonderful sense of humour, she made me feel welcome (...) I enjoyed that relationship"*

Feeling that he was wanted by his client and that he mattered to her seems to be highly valued by Jim. Liz also highlighted her close connection to her client:

> *"You do have an attachment, you cannot help it. That lady spilled her guts to me, she told me things"*

In her reflections, Liz's warm feelings towards her client were described as if this was considered to be somehow forbidden. Liz's response to the loss of her client may have been intensified by the level of rapport that they had established. In a similar vein, Jason said:

> *"I suppose, professionally speaking, you don't have favourites-but the reality is, we do. It wasn't easy, personally"*

Both the extracts imply that the feelings towards their clients 'should not' exist, because they were not 'permitted' in a professional person. Jason differentiated between '*the reality*' and his professional self, as he alludes to his sense of loss when he says: '*it wasn't easy*'. In contrast to the close bonds with clients that are described, in three other participants, different responses occurred following their more tenuous therapeutic relationships. The

fragile nature of the attachment reflected the short time that the three participants had engaged therapeutically with their clients. An example of this is provided by Sally:

> *"She was new to the service, so I think it was harder. It was quite unusual; they had seen me for an assessment and then for (...) sessions afterwards, and then it was a 6 month wait. I heard they'd topped themselves, and I felt awful"*

A sense of deep disappointment emerges, possibly because Sally had lost the chance to engage the person. Sally's response differs to those described previously where the therapeutic relationships had been fairly well-established. Sally may be experiencing a loss of hope. Not being able to say goodbye to the person may feel bewildering, reflecting the experiences of those who are bereaved suddenly by suicide (Lucas & Seiden, 2007).

Three participants perceived that in their client planning suicide without their knowledge, they had been somehow excluded. For example, Jim felt that he was deceived:

> *"This was a planned attempt, over a period of time, and I felt a bit, if you like, abused, by what she planned, secretly"*

Jim appears to make a relational interpretation of the client's death, seeming to feel that being deliberately kept unaware of the clients' intentions disempowered him. Jim perceives that the death was somehow 'personal' to him. Relational interpretation may be considered as a result of interaction with others, as interactions affect our self-perception. Individual identity is considered as a result of symbiotic exchange which is modified and transformed by social encounters throughout life (Mead, 1934). It appears that Jim felt betrayed. Jim's sense of being angry is well known to be associated with loss or trauma, particularly when perceptions of injustice and unfairness are triggered (Harvey & Miller, 2000). The loss of a client by suicide appears to be potentially associated with shame, embarrassment and humiliation, which poses a serious threat to individual self-esteem. The world makes sense when we believe that others are trustworthy and we can bring about positive outcomes, and Jims' perception of being kept unaware of the risk to his client may threaten his assumptions. However, researchers have consistently demonstrated that we overestimate our control over events (Gilovich, 1991; Henslin, 1967; Langer, 1975; Wortman, 1975). Jim's professional self refers to highly valuing the client and to successfully managing their care. As the values of identity are said to be socially dependent (Breakwell, 1986, 1996), a change in the social position of the individual after such a threat is claimed to breach the continuity of identity, distinctiveness and self-esteem. During the evaluation of subjectively

threatening events, current identity and the prospective content of identity are revised. If his perceived competence, aspiration and integrated functioning are adversely affected, this may lead to a 'slump' in self-efficacy. Similarly, Alistair felt betrayed:

> *"There was no concern for us, though, there was no concern for the people who would find her (...) and I think, in her own little naive way, she's managed to lull everyone into a false sense of security"*

This extract seems particularly angry, with another 'relational' interpretation, as if the client had deliberately misled him. In referring to *'false security,'* Alistair may also be indicating that he felt safe and unaware of the risk that his client might die, and was thus unable to act to protect her. As after a client suicide, the clinician may subsequently be found at fault, Alistair's frustration may represent his sense of injustice. Following any death by suicide, those close to the person try to make sense of the death (Hawton, 2003), which may represent Alistair's processing. It is suggested that following bereavement by suicide, the role of anger is threefold; a rage at being rejected, at being abandoned, and at being accused (Lukas & Seiden, 2007). The survivor is rejected, as if the dead person were saying: 'you didn't do enough for me' (Lukas & Seiden, 2007, p 58). Finally, the accounts of Alistair and Jim also mirror the findings of Hendlin et al. (2000), as following client suicide, psychology trainee participants felt wounded by what was perceived as a 'personal attack' on their competence. One said: 'I was angry at being tricked; she hadn't let me help her, and she had made me look stupid' (Hendlin, et al., 2000, p. 6).

Peter reflected on his struggle to develop a therapeutic connection with his client:

> *"He did not allow me in...not that one"*

Peter appears to demonstrate frustration at his fruitless efforts to engage his client, reflecting his feelings of being excluded in constructing a sense of meaning from the death. It seems that Peter felt excluded from the clients' world-view, both during therapeutic intervention and then, possibly, through their unexpected death. Feeling 'excluded' by the client has been indicated as another cause of anger in reports of professionals' experiences following a clients' death by suicide (Litman, 1965; Kleespies, et al., 2000; Kolodny, et al., 1979; McAdams & Foster, 2000), reflecting these extracts.

Other reflections of the lost therapeutic relationship with their client included the perception that the loss of their client compared with their previous experiences of bereavement. Three participants expressed that they felt grief afterwards. One, Jenny, explains her feelings:

> *"When she died, I realised, you almost go through a kind of a bereavement process,* ***you really do.*** *It does affect you"*

It appears that in this account, Jenny wishes to convey the extent and the depth of her grief. Jenny's use of the word *'almost'* appears to be in comparison to the bereavement process that may be typically referred to when, perhaps, describing responses to the death of someone to whom she was very close, such as a good friend or a family member. Jenny perhaps also implies that others may be unaware of the profound effect, through her emphasis: *'you really do'*. Grief may be ranked in a natural order of those around the deceased. The 'right' or 'permission' to grieve is considered to be essential to the process of mourning and may be privately known, but not always made known or acceptable to others. (Peskin, 2000). Regarding the 'right' of therapists to grieve for their clients, it may be useful to consider Peskin's (2000) description of grief as being a social construct. It is proposed that we learn to support those whose 'right' to mourn holds a higher rank than our own, and we learn to expect support from those with lower rank. Typically, this social learning reflects the customary status of reference groups to which we and the deceased belong. The larger claim to mourn belongs first to the primary group, the family who grieves a lost member, and then to those of secondary groups, consisting of friends, colleagues associates and others, perhaps including the clinician. The less structured, more fluid and mutable organisation of 'others' than the family implies that 'rules' of ranking for bereavement are not self-evident, nor fall into place easily, as the 'entitlement' to grieve originates from the felt state of the relationship.

Later, Jenny reflected:

> *"I was very sad. I think it is important to grieve, I needed to grieve, this is normal"*

Jenny's self-evaluation conveys an acceptance of her reactions. The experience of grief when losing a client by suicide is mirrored within existing research (Kolodony, et al., 1979; Kleespies, et al., 1993; Sacks, et al., 1987; Schnur & Levin, 1985). Another participant, Sally, unexpectedly compared her response to her clients' suicide with her experience of the death of a colleague by suicide:

"when a colleague committed suicide (...), I did have a similar reaction to that of (...), in a sense. I mean, it was hard"

Sally notices the similarities of her responses to the deaths of those with whom she had a relationship, adding a new dimension to this theme by illustrating the making of connections between personal and professional experiences of loss and bereavement. It is known that stressors within the life of the clinician may cause considerable distress and disruption to the work of the professional person (Norcross & Guy, 2007). It appears that stressors within the workplace may similarly affect the lives of mental health care clinicians.

The attachments to their clients and the responses of sadness that emerge within the accounts appear to reflect the losses experienced. While bereavement and the processes of grief and mourning are widely described, the psychology of grief and mourning owes much to Freud's classic essay on mourning and melancholia (Freud, 1917). Freud drew attention to the psychological processes of undoing the bonds with the loved one, the process of internalization and sadness. He differentiated mourning from melancholia, where the internalization of the ambivalently loved object was seen to contribute to the evolution of depression. Much of our understanding of reaction to loss has been built from the framework of attachment theory. Bowlby (1969; 1973; 1980) described human attachments in terms of the mother-infant relationship and subsequently in adult attachment. Other 'affectional bonds' bring similar patterns, but usually with differing intensities, although the key element is the interactional, affectional nature of these relationships. Separation in the mother/child relationship results in specific forms of anxiety and distress, and with reunion, these effects settle. When this does not occur, the process of mourning begins, with feelings of sadness and loss, as indicated within some of these accounts. This conceptualisation is arguably the basis of the understanding of reactions to loss (Raphel & Dobson, 2000). While there may be an initial brief period of shock, numbness and disbelief, this gives way to intense distress or anxiety. Gradually, after a period of 'searching', the reality of the absence is progressively accepted, and a gradual returning to the world and relationships occurs.

A more individually based understanding of the experience of grief has been emerging. The idea of continuing bonds with the deceased rather than 'letting go' has been seen to have positive advantages for many bereaved people in aiding their ability to adapt (Wortman & Silver, 1989; Epstein, Kalus & Berger, 2006). The clarity of recall of details of their client by the participants indicates how they are still in their memories. Central to the making of an account are memories of the relationship. Horowitz (1986) describes the role of the completion tendency in matching new information to inner structures, based on older

information and the revision of both until they agree. As Harvey, Orbuch and Weber (1990) note, this mirrors Lewins' (1935) hypothesis of the importance of interrupted events creating a tension, leading to a completion-orientated drive state, which could be considered as being similar to Mandler's (1984) theory of a negative emotional state following the interruption of action plans. In this context, the plan was for the continuity of the therapeutic relationship and of the hope for a positive outcome for clients. Meaning-making actualises personal experiences or episodic memories (Tulving, 1983) and develops new, meaningful realities. In conclusion, it appears that some of this often difficult psychological processing is shown within the participants' reflections of their lost relationship with their client. As noted previously (Gitlin,1999; Hendlin, et al., 2004), the impact of the therapeutic relationship with the client appears to be highly influential in the participants' response to their loss.

3.4.3 Failure

Four of the participants who were in a therapeutic relationship with their client when the client died described feeling that what they provided had proved to be inadequate. For example, Ben reflected:

> *"I felt quite disturbed, and I felt, in some sort of way, I think there was a sense of failure around, and I somehow felt as if- if I'd been better at what I'd done, maybe, I could have made a difference- I mean you know, that's sort of, making oneself very omnipotent, which one isn't. But, there was a sense of failure around"*

Ben appears to feel responsible for not being able to change the outcome, yet he also indicates that he perceives this is impossible. The sense of loss that Ben expresses may be the loss of his chance to continue with the client and to positively influence their recovery. Thus, the anticipated outcome was dashed. In evaluating that if had he been more effective, he may have been able to affect the future outcome, this seems to resonate with research findings that many therapists subsequently feel that they were not 'good enough' to prevent the clients' death (Valente, 1994). Jim similarly reflected:

> *"You cannot help, despite everything else, taking it in your track record as a failure"*

Jim appears to see the event of the clients' death as impacting negatively on all that he has professionally achieved. In this context, Breakwell's (1986) identity process theory suggests that while being unique is valued, an event that is a threat to identity may lead to negative, rather than positive individual distinctiveness. Thus, Jim's view of the negativity of the death

threatens the high value placed on being competent. Reflecting a sense of inadequacy and sounding despairing, Jenny said:

> *"Despite our good rapport, I wasn't able to help her. What I had done hadn't made the slightest difference..."*

Jenny's expressed sense of inadequacy may relate to her perception of an inability to affect positive therapeutic change, despite her closeness to her client. Believing that we are worthy, good and competent reflects our ability to focus on our positive qualities, overvalue our strengths and exaggerate our responsibility for positive outcomes (Brown, 1986; Greenwald, 1980; Taylor, 1990; Taylor & Brown, 1988). Jenny is perhaps experiencing a 'jarring awareness' of the fact of death (Lifton, 1967, p. 35). Jane echoed the sentiments of others, as she said:

> *"I did feel that I'd failed him. It was awful"*

It appears that the participants experienced regret and professional self-doubt. Grief is linked with the loss of a future, and regret is often correlated with 'what might have been' (Lucas & Seiden, 2007). In conclusion, it seems that in their profound desire to make a positive difference to the client, the idea of being 'worthy' as a clinician is dashed. The sense of failure indicted within this section is also reflected the views of those close to individuals who die by suicide. For example, Calhoun and Allen (1991) found that those who are bereaved by suicide were thought to be more able to prevent the death than the family or social network of those who died by accidental or natural causes. The accounts of those who searched for an explanation for the clients' death are presented within the next section, the final section of this theme.

3.4.4 Searching for reasons

Attempts to make sense of the clients' death included participants asking questions about their client intentions to die. Questions were also asked by participants about themselves, and these included their feelings of responsibility. One participant compared the clients' death with their response to a previous bereavement. These accounts may be indications of searching for reasons or explanations, asking questions about whether the outcome of a traumatic event makes sense (Janoff Bulman & Franz, 1997). Gaining of meaning from an event is also achieved through understanding its significance and its value and worth.

'Meaning as comprehensibility' gets shattered by a trauma, leaving the survivor aware of their vulnerability and of randomness. Asking why a death occurred is a common response in those bereaved by suicide. The question asked first is the one that lasts the longest (Lucas & Seiden, 2007), and can, of course, never be asked of the person concerned.

In the accounts of six of the participants, the answers that were searched for included whether their client actually intended to end their life. For example, Jane commented:

> *"All the questions about the way it happened and whether it was deliberate, people are left with all that afterwards"*

A death by suicide violates the norms of self-preservation (Grad, Clark, Dyregov & Andriessen, 2004) and Jane tries to understand the reason for this. She infers that the death may be accidental. It is only in the last 40 years or so that it has been recognised that a person who tries to die by suicide is not always intent on ending their life (Gask, 2006). Alistair also expressed some doubt about his clients' intention to die:

> *"The only thing that has been rattling around is that she hadn't actually meant to do it. That's what I feel"*

Jane's reflections resonate with those of Alistair, regarding whether the client set out to end their life. The issue of rational suicide may present the greatest challenge for mental health care professionals, both individually and as a profession. As well as recognition of those who are seriously intent on dying from those who are considering this, recognition of the possibility of rational suicide requires the need to distinguish between potentially suicidal clients for whom suicide would be irrational and those for whom it would be rational (Mayo, 2000).

Two of the participants, including Robert, reflected whether they may have retrospectively made different clinical decisions in their assessment of the risk to the client:

> *"...should he have been a higher risk? You do go through that"*

Relentless self-questioning about whether something important was missed by the clinician following client suicide is mirrored within existing studies (Alexander, et al., 2000; McAdams & Foster, 2000; Marshall, 1980; Menninger, 1991; Hendlin, et al., 2000, 2004; Ness & Pfeffer, 1990). Experiencing self-questioning appears to be a painful process, as Robert

comments on *'going through'* this period of self examination. Another participant, Peter, perceived that he had possibly inadequately assessed the clients' level of clinical risk, implying that retrospectively he might have acted differently:

> *"Her, as a sort of, risk, she wouldn't have rated that highly (...) I still question my judgment"*

Sounding wracked with self-doubt, Peter appears to be processing doubts about his decisions over a period of time. Although the process appears to be difficult, it may be a useful part of reflexive practice to subsequently learn from the clinical decisions that were taken. This reflection appears to be part of the sense-making process, and searching for reasons in order to try to understand why the event occurred (Janoff Bulman & Franz, 1997).

Summary

This section of the analysis, **Impact of client death,** emerges as a major part of the study, as the psychological effect within some of the participants was intense. The beginnings of an understanding within the participants encompassed both their affective and the competence realms. The reflections illustrate how the impact of a client suicide may threaten the professional identity and shatter their assumptive worlds, being a personal loss and a professionally significant event. This section of the analysis sheds light on a number of responses, including fear, anger and self-blame. Within the first subtheme, **Inexplicability and fear,** several participants, being unaware of the risk to their client, were extremely shocked on hearing of their death. In their fear of subsequent reprisals, perhaps they saw themselves as being part of a malevolent world (Janoff-Bulman, 1992).

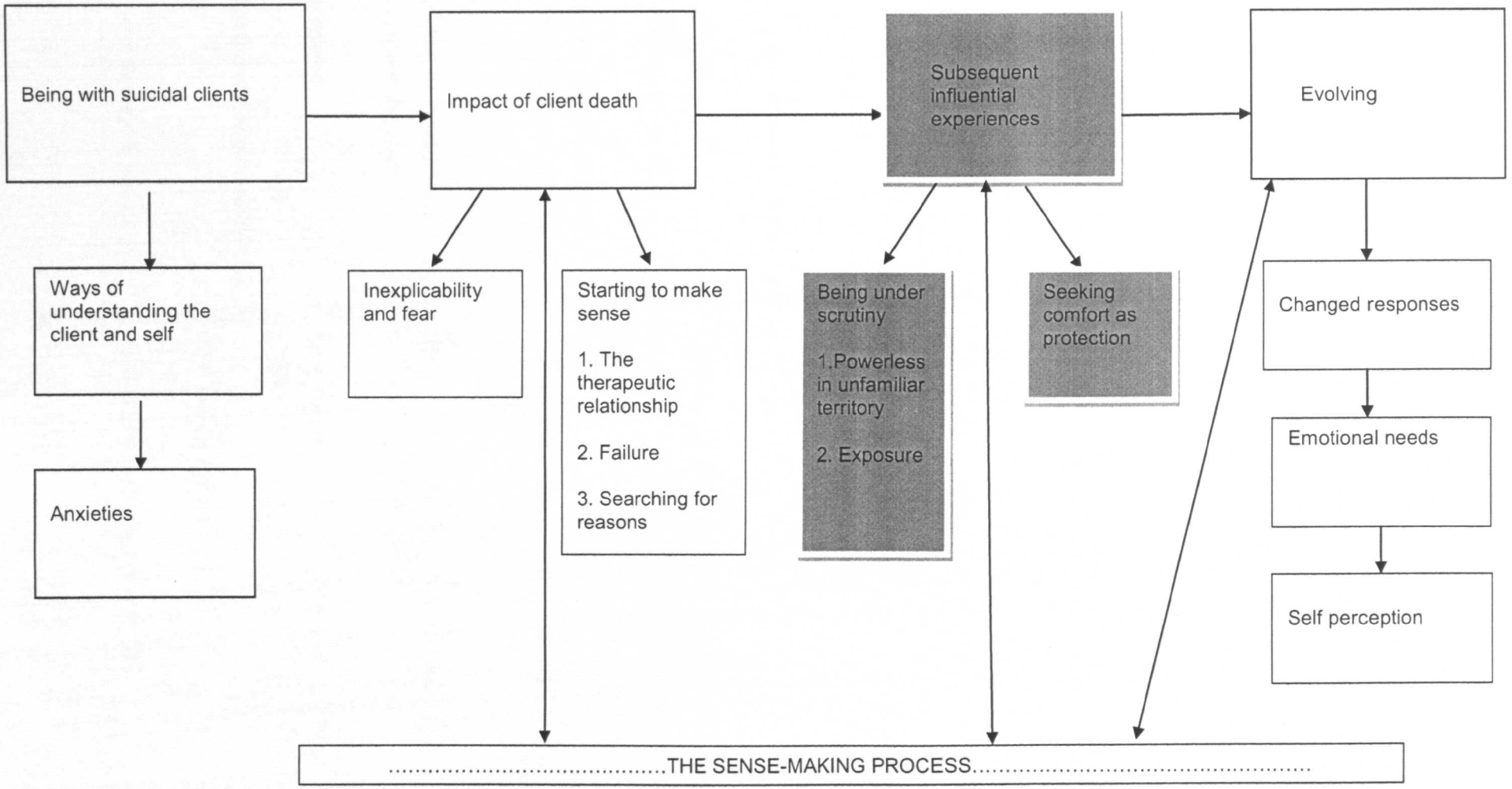
Within the second subtheme, **Starting to make sense,** the three sections entitled: ***The therapeutic relationship, Failure,*** and ***Searching for reasons*** included the aspects that were considered to contribute to the overall sense-making process. These factors were analysed in relation to their influence over the participant's processing of the client death. ***The therapeutic relationship*** included the accounts of the participants' attachments to their clients. Relational interpretations of the death led to anger and feelings of having been betrayed in some, which was analysed in the light of the possible threat to the professional identity of the participants. Some relationships with clients were described as being warm, with a sense of closeness, although these feelings towards clients were somehow unprofessional and thus shameful. Both intense and fragile therapeutic relationships impacted on the participants' reactions. It was perceived by some that they might have made

a difference. Thus, it was considered that as well as the loss of their client, the loss of an 'anticipated' outcome and the loss of hope took place. Expressions of grief concerning the client were considered in relation to theories of bereavement (Bowlby, 1969; 1973; 1980). All of the participants recalled their client in detail, possibly illustrating their continuing bond with the client (Wortman & Silver, 1989; Epstein, et al., 2006). An interesting aspect to emerge was the comparison made between the response to the clients' death and personal experience of loss by suicide. The search for an explanation for the death appeared to be attempts to integrate the event into participants' existing schemas (Janoff-Bulman, 1992).

Within the second section, entitled ***Failure,*** perceptions of failing the client were analysed in relation to shattered assumptions of being competent practitioners (Janoff- Bulman, 1992). In addition, Breakwell's (1986) identity process theory provided a method of conceptualising how the event may have contributed to self-perceptions of negative distinctiveness, in relation to the professional identity of participants. In the final section, ***Searching for reasons,*** the process of questioning was considered as being part of the sense-making process. Questions concerned whether suicide was intended by the client or if it could have been accidental. Participants also questioned their clinical judgements concerning decisions taken about the client, which seemed to indicate their search for an explanation for the death.

A common thread running throughout this theme was of some of the participants' perception of fear of no longer being seen as being competent, with concerns for the continuity of professional identity on hearing of the event. Subsequently, adverse changes to the continuity of professional identity, distinctiveness, self-efficacy and self-esteem (Breakwell, 1986) were indicated in the perceptions of having failed. Thus, the continual sense-making process is highlighted within this theme.

Figure 3 - Explanatory model outlining the evolving process of working with and beyond client suicide. The following section presents Theme 3, Subsequent influential experiences.



3.5 Superordinate theme three: Subsequent influential experiences

The third superordinate theme presents an exploration of subsequent experiences that were influential to the participants' overall responses, as shown in Table 4 below. This theme is divided into two subthemes: **Being under scrutiny** and **Seeking comfort as protection.** Within this theme, it is intended to illustrate how participation in formal and legal events impacted on those involved. The second subtheme, **Seeking comfort as protection** shows how receiving comfort from others functioned as protection against the perceived threat to professional identity, and affected their overall reaction and the sense-making process.

The first subtheme, **Being under scrutiny** is further divided into two sections, ***Powerless in unfamiliar territory*** and ***Exposure,*** as shown below in Table 4. Within the first section, ***Powerless in unfamiliar territory,*** the accounts show that some felt unprepared for taking part in the subsequent formal events. The second section, ***Exposure,*** presents the accounts related to experiences within a formal investigation, receiving unwanted media attention, and the experiences of those who subsequently attended a coroners' court, which appeared to lead to a sense of being exposed.

Table 4: Subsequent influential experiences

Being under scrutiny	**Seeking comfort as protection**
Powerless in unfamiliar territory	Working in this team, I really kind of felt reassured by the team manager
We had some lectures on suicide risk at college, but I had no idea of what comes after	The procedures were explained to me, I felt supported by my managers
I had no preparation for it, and I can remember being quite shocked	Our cluster is very supportive of each other We have a sort of 'group anxiety'
We were not prepared	Everyone starts looking at you, you feel quite terrible
I discovered that the relatives were there, it was distressing	Only the receptionist
If you haven't been through it, you don't	He was very good, he was very fair

know what it's like, and some of the newer ones, they have no comprehension	This is a form of support, this meeting this afternoon
Exposure A battery of questions, attempting to challenge my reliability as a practitioner. I felt it violated me Oh, it was a witch-hunt at the inquest, I had an hour and a half in the witness box It was awful, to have to justify absolutely everything that I did I don't like going to coroners court, I don't really like going to any court It goes through every one of my clients letter boxes. That was hard We get slated in the press, you know To basically say, wait for the complaint, which was almost like a threat	Supervision is absolutely essential At supervision and at home, I needed to have space to talk. Supervision helped me to detach I didn't have the opportunities, you know, to talk, I still met this person, and it was a lot of hurt The way supervision was, a lot of supervision is looking at current caseloads and once you have died, you are not on the current caseload

3.5.1 Being under scrutiny: Powerless in unfamiliar territory

The first section presents the accounts of those who felt that they were unprepared to take part in subsequent events. Five participants had involvement in formal processes. Four of the participants who had not been involved before felt they were not prepared, indicating their sense of disempowerment. When a client dies, there may be little individual control over the unfolding processes for the clinician, as the steps are pre-defined through existing policies. For example, participants such as Jason indicated that they had received formal lectures on managing suicide risk:

> *"We had some lectures on suicide risk at college, but I had no idea of what comes after"*

Jason indicates his lack of awareness of the aftermath, leading to his sense of powerlessness, as he is not equipped to deal with the demands of the subsequent events. He went on to explain how he felt when attending an inquest:

> *"I had no preparation for it, and I can remember being quite shocked at some of the questions. I just hadn't been prepared"*

The lack of knowledge may lead to a sense of the individual being weakened and helpless. He repeats that he was not prepared, thus putting emphasis on this. His anxiety may naturally be heightened by not knowing what to expect. This lack of readiness was reiterated by others, including Peter:

> *"We were not prepared"*

These comments suggest that if the participants had been given further information about the unknown events and processes, they might have felt stronger. Many clinicians are, understandably, concerned about how to manage the different expectations of legal and therapeutic processes (Bond & Sandhu, 2005). When giving evidence in court, Peter described his feelings of shock when unexpectedly seeing those who were close to the deceased client:

> *"...and then, I discovered the relatives were there. It was distressing and stressful"*

Being unprepared to see the family led to increased strain in an already difficult situation. Had he known about the possibility of this in advance, this may have increased his sense of power. Feelings of impotence link with powerlessness in this quotation from Jenny:

> *"If you haven't been through it, you have no idea what it's like, to have actually stood up in coroners' court. You have no idea, and some of the newer ones, they have no comprehension"*

In this emotional sounding extract, Jenny emphasises how difficult she found this experience. For her, it is as if only the actual, lived experience can illustrate this. In her role as an experienced clinician the process appears to be daunting and diminishing. These accounts resonate with reports by junior doctors (McCullogh, et al., 2004) who reported that their experiences of an investigation had an adverse professional effect, and giving testimony was found to be an adversarial process.

The powerlessness experienced by those within unknown, potentially threatening situations emerged within this theme. These sentiments reflect existing research findings regarding clinicians' reports of being unprepared (Dexter-Mazza & Freeman, 2003; Ellis & Dickey, 1998; Kleespies, et al., 1990, 1993; Knox, et al., 2006). Thus, being involved in formal processes without understanding the possible demands of the situation seems to influence the overall experience of the participants. This section highlights the value of giving information to those involved.

3.5.2 Exposure

In this section, participants' accounts of feelings of being exposed by the perceived scrutiny of the formal events are presented. Some of the participants appeared to perceive a sense of humiliation and violation. Being part of the processes were viewed by some as being particularly threatening to the continuity of their professional identity, which appeared to be related to the unknown outcome. Being part of an investigation seemed to be perceived by some participants as being another traumatic experience.

Within the accounts of four participants, it was indicated that the process rendered them with a strong sense that certain aspects were unjust. For example, Alistair indicted his anger and perception that the interviewer was searching for areas of weakness:

"...a battery of questions, attempting to challenge my reliability as a practitioner. Oh, they attempted to challenge how reliable my practice was, and my clinical judgement. I'm probably one of the best ones on the team. More stuff like that. I felt it violated me"

Alistair's use of the word '*violated*' by the questioning leads to connotations with a perception of infringement. In saying that he is '*one of the best,*' this may indicate a desire to re-establish his credibility. A desire to be credible may connect to attempts to cope with identity threat and to be positively, rather than as negatively, distinctive (Breakwell, 1996). The sense of injustice expressed appears to resonate with the work of Brown et al. (1995) where the term 'humiliation' included damage to a central aspect of self-identity. Thus, participation in the investigation process appears to function as an additional challenge to some. It further appears that the perception of threat may lead to an adverse effect on individual self esteem and self-efficacy. Two participants attended a coroner's court. They described feeling exposed. One, Jim, commented:

"Oh, it was a witch-hunt at the inquest, the inquest was horrid. I had an hour and a half in the witness box"

Jim's view is of his experience as being harrowing. While it is necessary for serious untoward incidents to be fully investigated, Salter (2003), a consultant psychiatrist, commented that formal inquiries, even when sensitivity conducted, may be experienced as being persecuting. Jim's comment, '*a witch hunt,*' can be found within existing studies (Alexander, et al., 2000). He continued:

"It was awful, to have to justify absolutely everything I did"

Jenny echoed the sense she had, of being in a potentially exposing situation:

"I don't like going to coroner's court. I don't really like going to any court. I've never liked court hearings, anyway, but going to the coroners' court is particularly unpleasant, because you see someone in the family, or the police, or the coroner"

Jenny has a vision of her past experience, being before members of the family of the deceased, which is recalled as being a daunting, difficult experience. It is well documented that the family's potential reaction to the death, as well as the prospect of litigation, may be a

source of anxiety for clinicians within mental health care (Kozlowska, Nunn & Cousens, 1997).

In addition to the experiences recalled by participants when in court and when being questioned, uncomfortable feelings emerged in Liz when she described the unexpected negative media publicity:

> *"Front page of the (....) that must have gave everyone a good laugh. That was awful, you know (...) and I had done nothing wrong. It was bad enough being tried by a coroner, but I was tried by the media as well. I know it is only a (...) but that's not the point, it goes through every one of my client's letter boxes. That was hard..."*

With painful memories, and sounding angry and helpless, Liz feels unjustly professionally exposed. The effect on Liz seems particularly profound. Her perception of being humiliated by the media resonates with the work of Brown et al. (1995) on the effect of humiliation and loss. This response to negative publicity is similar to those reported within other studies (McCulloch, et al., 2004; Midence, et al., 1996). Being 'exposed' to her clients through a newspaper article appears to be, for Liz, disgracing and shaming. Shame has been described as an inescapable sense of exposure about a personal flaw (Naso, 2007), involving the internalisation of standards, rules and goals against which behaviour is evaluated and global judgements related to identity (Lewis, 1992). As shame is directed towards the self rather than to one's actions, it differs from guilt (Smith, Webster, Parrott & Eyre, 2002). Smith et al. (2002) propose that two types of shame may occur, firstly resulting from a public exposure of defects, which is said to be characterised by a cluster of emotional appraisals concerning the loss of one's reputation, decrease in status, disapproval by others and consequent constraints in the future. It appears that the shame expressed within Liz's account may relate to fear of disapproval from others, as she desires to be seen as credible as a clinician and positively distinctive. The second type of shame is claimed to result from private self-evaluation, with self contempt and helplessness. Ben also commented, more generally, on intrusive publicity:

> *"We get slated in the press, you know"*

Being *'slated'* in this quotation may metaphorically refer to images of being attacked by others, and produces an image of slates being thrown at a person, wounding and injuring them, as they are helpless. The wounding occurs to the professional reputation of the

individual. It appears that Ben has an expectation that mental health professionals are to be subjected to negative reporting.

Additional strain may occur following a clients' death by suicide through the development of adversarial relationships with the family of the deceased client. This is not unusual, according to Hendlin et al. (2000). Three participants described their experiences. The details will not be expanded on here, in order to protect those involved. Jenny said:

> *"... to basically say, to wait for the complaint, which was almost like a threat. It was awful..."*

Jenny reflects that she felt afraid, partly by the way in which she was told about a complaint. Client suicide is said to be the most common reason for action against professionals in the mental health field (Simpson & Stacy, 2006). The anxiety that Jenny expresses may relate to her feeling professionally vulnerable, and fears are more acute as the outcomes are unknown. They may result in action being taken against a clinician. Three of the main negative effects to identity following a threat include rupture to continuity, distinctiveness and self-esteem. If Jenny is found to be at fault in some way, her professional identity will not continue towards the desired end state, characterised by competency, uniqueness and personal worth (Breakwell, 1986, 1996).

Generally, receiving complaints can be considered an adversarial process which is fundamentally at odds with the declared purpose of the therapeutic process (Casemore, 2001). In the early stages of an investigation, Salter, (2003) a consultant psychiatrist, noted that the threshold for making mistakes is lowered in an atmosphere of pending judgment. Facing complaints while being involved in an investigation has been found to add to a sense of loss of clinical competence (Casemore, 2001). In conclusion, in those involved with formal investigations and the media, their experience may contribute to a loss of self-efficacy and self esteem, due to the unknown outcome and the risk to the future of the individual. Thus, these experiences may be considered as another stressful event. While part of the function of the investigation of serious incidents is to ascertain if any mistakes were made, in order to learn from them, it appears that some participants felt that an additional impact was added to the loss of the client which would require further individual processing and integration.

3.5.3 Seeking comfort as protection

The second subtheme presents the participants search for support from others, which seemed to be influential in their overall experiences. The importance of emotional comfort after such experiences is emphasised, as the function of support may be to offer protection. While some participants felt that they were listened to and affirmed, others reported feeling that they did not receive adequate emotional support.

The participants' experiences were affected by the quality of their relationships, highlighting how affirming relationships led to a sense of relief and containment. Support emerged from colleagues, the teams, clinical supervisors and managers. The role of support in aiding individual acceptance and protecting against feelings of being 'different' emerged. Receiving affirmation from managers in particular led to a sense of relief. Possibly, this was seen as confirmation of their continued credibility as a capable professional. Affirmation thus helped to maintain a positive sense of individual self-efficacy. These experiences seemed to influence the on-going process of deriving meaning from the events.

Six participants reflected how their colleagues, teams, reception staff, clinical supervisors and their family provided them with comfort. These accounts will first be presented. One participant, Alistair, said:

> *"Working in this team, I think I had one incident, and I really kind of, felt reassured, in the sense where the team manager didn't put the blame and ownership on a particular member of staff"*

Alistair's self-confidence appears to be reinforced by the response of his manager. As managers may be involved in appraising the situation, their positive reaction may lead to the individual feeling reassured. Within this work environment, showing concern for colleagues and the stresses they have been dealing with in their professional lives may lead to benefits for both team members and their managers.

During the aftermath, those who reported receiving explanations about what was to follow indicated their deep appreciation of this. An example of the value of receiving information and its empowering quality is provided by Sally:

> *"The procedures were explained to me and I knew what was going on all the time, but I was kept informed and I felt very supported by my managers"*

This quotation indicates how explanations helped Sally to feel contained. The power of giving information to allay anxiety is illustrated, as this leads to unknown events being perceived as less anxiety-provoking. When describing what was found to be comforting, Alistair and Sally first mentioned their relationships with their managers, which seemed particularly reassuring to them, perhaps illustrating how they were valued. When examining the work stresses of Counselling Psychologists, Papadomarkaki and Lewis (2008) found that the need for approval was mentioned several times, and affirmation was considered to elemental for the self-esteem of the participants. Therefore, if approval is important generally, it could be concluded that when clinicians feel particularly vulnerable, approval and affirmation are very relevant for assisting in reducing anxiety.

Breakwell (1986) identified searching for support as being a coping strategy. Coping strategies include any thought or action that eliminates the threat, whether or not it is consciously recognised as being intentional, enabling the person to operate with continuity, distinctiveness and self-esteem. Four of the participants described how their relationships with their colleagues were a comfort to them. For example, Jason said:

> *"our Cluster is very supportive of each other, and we would be given the opportunity to talk about it (...) I think that the support is there, from my colleagues"*

Jason appears to expect to receive support from his colleagues, and his expectation may reduce the threat to his professional identity, as sharing with colleagues who may have had similar experiences may help to normalise the reactions of clinicians. A central concept in the bereaved person is resilience (Bonnano, Neria, Mancini, Coiffman, Litz & Insel, 2007). Some of the factors that may buffer the worst effects of grief include the ability to talk about and remember the deceased, having a good social support network and appropriate contextual emotional expression (Bonnano, et al., 2007). The value of receiving support by colleagues is also reflected in the findings of Hendlin et al. (2000), as when colleagues shared their experiences of client suicide, this was more useful than assurances from others that the death was inevitable.

The reciprocation and mutuality of self-disclosure may not be provided by other relationships, and meaningful interpersonal interactions may lead to developing a sense of individual empowerment. Exchanges in disclosure may cement a relationship, keeping the balance of power equitable. Having several people within a team around the individual may be very useful as the social network is positively related to success in overcoming bereavement (Breakwell, 1986, 1996). There may be more opportunities for self-disclosure if

there are a large number of people in whom to confide. Gaining positive feedback from others can help to validate the most central aspect of the self-concept (Breakwell, 1986). Another participant, Ben, described his relationships with his colleagues:

> *"We have a sort of 'group anxiety' "*

Sharing his fears gives the sense of Ben's emotions being diluted or dissipated within several people, emphasising how the effect of a supportive team may provide a buffer against individual stress. Studies of social support suggest that people are more willing to ask similar others (i.e., relatives and friends) than they are to ask professionals for help. Wills (1992) reported that people with emotional or personal problems were two to three times more likely to ask for informal help from people in their social network than to ask for help from a professional.

In a creative way, some participants searched for someone with whom to share their feelings and two of the participants spoke with reception staff. Jason described this:

> *"Really, only the receptionist. He had tried and not been able to get an appointment and then he killed himself"*

Jason's use of the word '*only*' perhaps suggests that no one else was available to talk with. However, two participants, including Pam, subsequently felt isolated. She said:

> *"Everyone starts looking at you, you feel quite terrible"*

It appears that Pam perceived that others were judging her critically. There is some evidence that those bereaved by suicide score more highly on feelings of stigmatization than those bereaved by other means (Harwood, et al., 2002). However, whether this is an example of feelings of stigmatization or of anticipating stigma is unknown. Following patient suicide, Courtenay and Stephens' (2001) reported that feelings of isolation and vulnerability emerged in some of the training psychiatrist participants, appearing to be similar views to this extract by Pam.

Unexpectedly, Jason and Sally experienced the research interview as being a safe space in which to confide, as Jason compared the research interview with his experience of being interviewed by a manager during the investigation into his clients' death:

"He was very good, he was very fair. We sat and had a conversation, like we are having now"

It appears that Jason felt that the manner in which both the formal procedure he had involvement in and the research interview put him at ease. In this context, the fairness Jason referred to seemed to mean to him that he was not pre-judged and he was treated in a relaxed manner. Sally also commented on the benefit of the research interview process:

"This is a form of support, this meeting we're having this afternoon, is a form of support. I think it's an on-going thing; it's an on-going process, really. It can be by your peers or by your seniors"

It can be seen that active listening is valued by Sally and Jason who perceived they had positive experiences through discussing their experiences and Sally sees support as continuing beyond individual meetings. Colleagues are consistently identified as an important source of support following patient suicide (Chemtob, et al., 1988; Alexander, et al., 2000; Courtenay & Stephens, 2001).

In seven of the participants, the function of clinical supervision emerged as being crucial in providing support, as most clinicians require a safe place in which to process the effects of a client suicide (Brown, 1987, Kleespies & Dettm, 2000). For example, Liz said:

"I think that supervision is absolutely essential, if you're worried about a suicidal client. If I felt that a client was suicidal I definitely wouldn't see them in isolation"

Liz sees herself as functioning within a context where issues can be reflected on within a supportive supervisory relationship. A work culture that encourages staff to talk through difficult clinical experiences, such as high risk clients, and to mutually support one another, is one which enables professionals to remain emotionally involved in their work while continuing with other fulfilling areas of their lives (Figley, 1998). If the clinicians' anxiety is reduced through supervision, this may naturally impact on their therapeutic relationships with other clients. Ben described meeting his need for support thus:

"At supervision and at home as well, to people who are close to me and with colleagues as well, I needed to have space to talk it through. At the time, I had good supervision, which helped me to detach"

Ben and Liz both indicate how supportive, affirming relationships enabled them to explore their responses, gaining more objectivity. Therefore, receiving support through space to talk played an important role in the conceptualisation of Ben's experience. Ben may have felt less overwhelmed by his emotions as he describes feeling assisted to 'detach'. Once we are able to make sense of our experiences, we have the capacity to feel more in control, which can be empowering, bolstering our self esteem and confidence. The accounts of positive experiences of supervision are consistent of those within trainees in psychology and psychiatry (Burman, 1994; Hendlin, et al., 2000; Kleespies, et al., 1990; 1993; Courtenay & Stephens, 2001). The value of clinical supervision for Counselling Psychologists was recently reinforced, being described as being 'an asset for Counselling Psychologists' professional and personal stability' (Papadomarkaki & Lewis, 2008, p. 45).

Contradictory views emerged, as three participants indicated that supervision did not meet their needs. Jim felt that he did not have a place to discuss his emotional connection to his client:

> *"I didn't have the opportunities, you know. And I still met this person and it was still a lot of hurt, and I questioned myself, professionally. I didn't have the chance to sort of, talk about that. To talk about, how it, sort of, affected me, that sort of support"*

Jim infers that his self doubts and the attachment to his client might have been positively influenced by a supportive relationship. It seems that Jim wanted to feel that he could explore his emotional responses, his pain. Sally also commented:

> *"The way supervision was, a lot of supervision is looking at current caseloads and once you have died, you are not on the current caseload. So, that is somewhere it could have been brought up, but maybe I didn't think about bringing it up there, because you deal with the stuff that is left"*

Sally infers that what could be discussed followed a pre-defined agreement. Thus, as a place for exploring the effects of client suicide, supervision was considered ineffective. Sally felt she was left alone to process her emotional reactions to the client. It is well known that trauma and loss generally induce acute emotional distress, and one of the central ways that social support aids distressed individuals is by enabling them to talk about their situation in ways that assist them in improving how they feel (Harvey & Miller, 2000). Greater self-efficacy may also result from talking specifically to another, more experienced mental health care clinician. The lack of such a relationship may impact on the general sense of well-being

at work, which can affect overall life satisfaction (Hart, 1999; Higginbottom, Barling & Kelloway, 1993; Judge & Watenabe, 1993).

In conclusion, both affirming, positive supportive experiences took place and others felt that support was not available to them. A solid, trusting supervisory relationship may form a secure place for crises such as client suicide to be explored, consistent with the existing literature (Holloway, 1987, Pearson, 2000). As the participants in this study were of different professional backgrounds, they would receive different forms of support although on-going supervision is becoming embedded in the broader spectrum of mental health professions, most noticeably in nursing (Butterworth, Faugier & Burnard, (1997). A safe place to confide in others may be invaluable in helping clinicians to process their responses, assisting in the overall sense-making process and helping to foster resilience (Bonnano, et al., 2007).

Summary

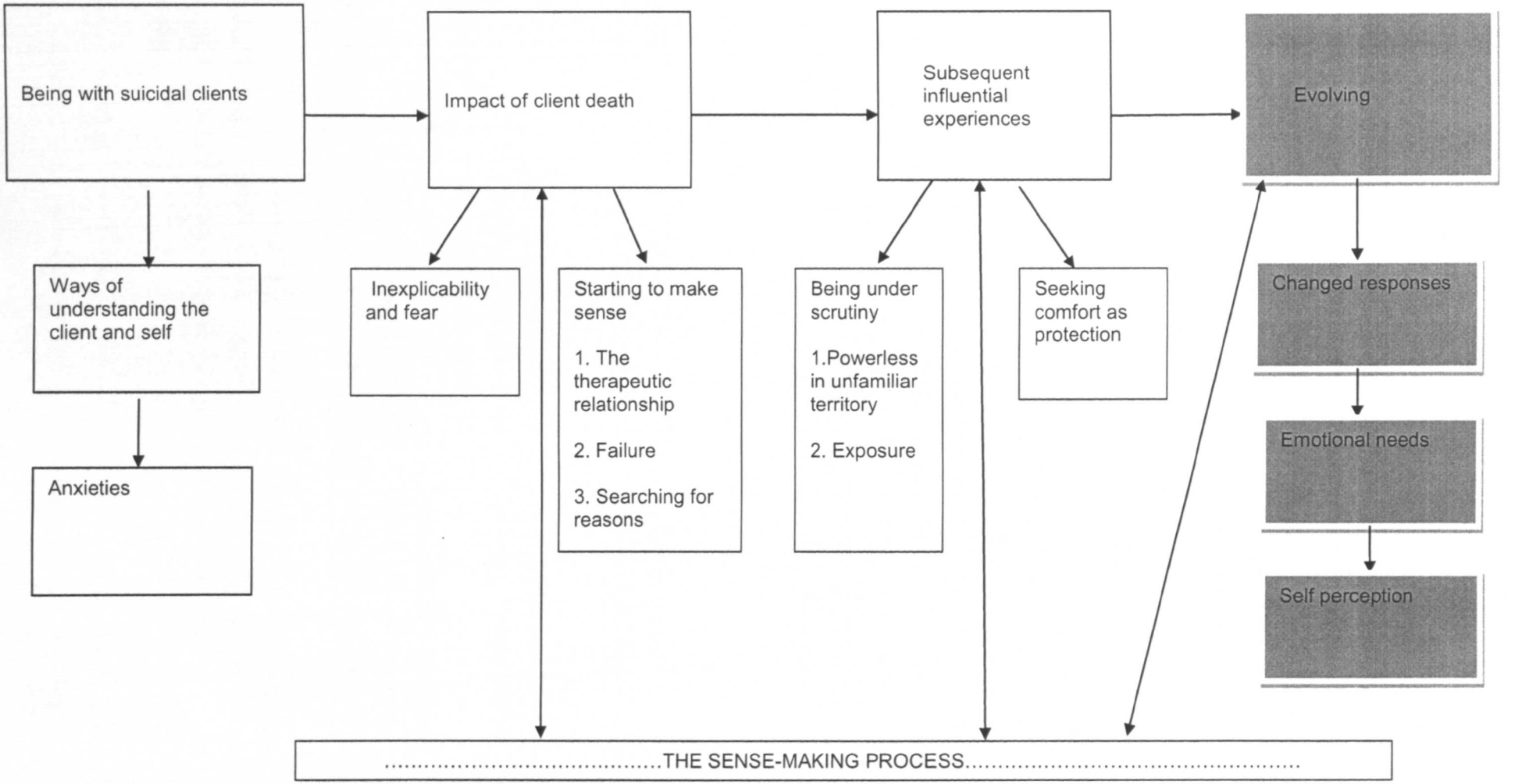
The theme shares the commonality of subsequent experiences influencing the participants' overall response. The first subtheme, **Being under scrutiny** presented experiences which took place over a period of time following the clients' death. Feelings of powerless and of being exposed emerged. Negative experiences during investigatory processes, including the media, court appearances and with relatives of the deceased were analysed in relation to identity process theory (Breakwell, 1986, 1996), shame (Smith, et al., 2002) and humiliation (Brown, et al., 1995). The analysis showed the effect of experiences such as being questioned in relation to the perceived threat to identity and the effect on self esteem. It emerged that those who were given information about what to expect found this to be extremely helpful. During an investigation, the manner of the interviewer was seen as being important to the clinician. Finally, the value of providing information to enhance individual awareness and to reduce anxiety is emphasised.

Within the subtheme entitled **Seeking comfort as protection**, helpful relationships with managers, supervisors and colleagues were considered to have a protective function. Affirmation from the managers was particularly important, as it appeared to function to validate the individual. The support of colleagues within teams was analysed in relation to the protection that may be offered from a number of individuals, drawing attention to the value of comfort provided by 'similar' others (Nadler, 1987).

Conflicting experiences of both helpful and less helpful clinical supervision emerged. The importance of some form of support was emphasised. In those who subsequently received

'helpful' supervision, the benefits to both the confidence of the clinician and to empower the clinician were evident. Clinical supervision appeared to contain the individual, providing an accepting space in which to reflect. This section adds further support to the notion that desired adjustment to a loss or a traumatic experience such as this is achieved in relation to others. Supportive relationships are seen as a continuing protective factor and a buffer against painful responses.

Figure 4 - Explanatory model outlining the evolving process of working with and beyond client suicide. The highlighted area indicates Theme 4, Evolving, to be presented.



3.6 Superordinate theme four: Evolving

The final superordinate theme aims to account for the developments and consequences, both personally and professionally, of clinicians who survive the suicide of their clients. It is divided into three subthemes as shown below in Table 5. The process of re-building the threatened sense of self and identity and beliefs in how the world works is featured within this theme. This continues a thread throughout the themes, and will possibly continue into the future. This theme is divided into three subthemes, in order to fully illustrate the different emergent aspects.

The first subtheme, **Changed responses**, illustrates the re-building of the sense of self, including acceptance of the inevitability of client suicide. It also shows how some participants felt vulnerable and anxious following their experiences. In addition, the suicide death of a client also led to heightened awareness of the need for accurate recording. In the second subtheme, **Emotional needs**, reflections on the optimal type of emotional support that would best meet the needs of those who took part are revealed. Finally, in the section entitled **Self-perception**, the re-evaluation of roles and responsibilities through transformational and reflexivity processes are presented. The changes appear to be part of an evolving process.

Table 5: Evolving

Changed responses	Emotional needs	Self perception
I get quite anxious, you know, if someone has a history of suicide	A group is what is needed	I have become more fatalistic
It's left me with a lot of anxiety with suicidal people	We need adequate follow-through, a group where we can share these issues	I don't know how I will react, how it would challenge me
It's always there and it makes me worried	I've always had my doubts about the value of de-briefing	How would I feel? I-I would **hope** that I would be okay. That would affect me greatly
I don't angst about it, I feel quite clear about it, if I put everything into place	I see this as part of my de-briefing. I think that de-briefing is absolutely crucial	I was left with an effect on my confidence as a practitioner

I usually see it coming, it's part of the territory now If I didn't have some anxiety I'd be almost negligent It does challenge your practice I've only had one client top themselves. I was upset at the time, but we have to live with that My risk profiles are immaculate, purely because I now understand that people do kill themselves I have now have very clear boundaries with people who are suicidal	The support you need gets lost. We need someone neutral and more objective, impartial, the personal touch. It needs to be delivered by a skilful person, a psychologist We need lots of communication, you could employ somebody full time	You try to make yourself tough over the years, not to make yourself over compassionate It's real work, life and death, it's a privilege, despite the difficulties Deal with suicide more pragmatically. Maybe I'm doing a marathon I suppose I've got more used to it, as times gone by Somebody said to me, 'treat it as a learning experience' It was much, much later, when I had a supportive supervisor, that helped me come to terms with it Everyone now comes to me

3.6.1 Changed responses

The first theme illustrates how changes to practice included anxiety when seeing or receiving referrals for suicidal clients. In some, however, client suicide became seen as being 'part of the territory' and an integral aspect of their role. Thus, the anxiety that was experienced was felt to be necessary. Six participants reported becoming more anxious when treating suicidal clients, as their expectation of another clients' death led to their feelings of fear and apprehension. For example, Liz expressed her changed response thus:

> *"I get quite anxious, you know, if someone has a history of suicide. This is coming up for (...) years since and I still get anxious, I still get anxious for someone that is a suicide risk"*

Liz refers to her fear, reiterating that the event still has an adverse affect, although it took place some ago. Her feelings may impact on her existing client relationships, as individual behaviour, thought and emotion are strongly influenced by their expected consequences (Markus & Nurius, 1984). Anxiety in clinicians with other suicidal clients is reported by clinicians following a client suicide (Aldridge, 1998; Hendlin, et al., 2004; Reeves & Mintz, 2001) and heightened anxiety when evaluating suicidal clients can remain for years afterwards in some clinicians (Kleespies & Dettm, 2000). Similarly, Jenny said:

> *"It left me with a lot of anxiety with suicidal people"*

Jenny specifically described her residual concerns and fear. Pam simply said:

> *"It's always there, and it makes me worried"*

This comment appears to indicate Pam's awareness of the potential danger. It may be that the integration of the event into her existing schemas has left a resultant anxiety, which she refers to as being constantly with her. Unsurprisingly, individuals who experience negative life events tend to report an increased sense of vulnerability, congruent with the fact that they have suffered in ways that they may not have been able to control or prevent (Janoff-Bulman, 1992).

Five of the participants indicated that the possibility of another client dying by suicide was to be expected as an integral aspect of their role, and did not cause undue distress or concern. For example, Peter commented:

"For my responsibility, I feel quite clear about it and so I don't angst about it- if I put everything in place, then I don't get anxious about it"

Peter appears to perceive that if he has done all he can to keep the client as safe as possible, he accepts the situation. In a similar vein, Sally said:

"Well, I always take it seriously (...) I do not feel anxious, as I usually see it coming. It's become part of the territory now. It's not a surprise"

It appears that Sally indicates that she has learnt to anticipate that client suicide may take place. This quotation also illustrates that she views this as being part of her clinical role. Following a stressful or traumatic event, the adaptation process includes making sense of the event. It appears that in some, this led to the acceptance of the reality of client suicide. This process may indicate Horowitz's (1986) completion tendency, in matching new information to the old.

Three participants indicated how they accepted their feelings of anxiety, as, for example, Jane said:

"In the sense that if I didn't have some anxiety, I think I would be- how can I put it- almost negligent and it is a normal level of anxiety, as it keeps me on the ball, and keeps me aware. I would like to have a certain amount, with somebody who is suicidal"

Some concern was conceptualised as being a 'spur' or a motivating factor for Jane, as it helped to raise her awareness of the possibility that a client might act on their thoughts. The helpful aspect to her appears to be her vigilance. Jim commented on his exposure to suicidal clients on a regular basis within his clinical field:

"Erm, it does challenge your practice, it really does. I mean, it's the sharp end, of course, umm. But you kind of, you try to put it in perspective, if you can"

The ability to manage the anxiety generated by the risks involved in managing suicidal clients appears to be indicated by Jim. Similarly, Pam said:

"I know it's easy said, and fortunately, I've only had one client actually top themselves, but- and I was upset at the time, but we have to live with that. You know,

if clients don't turn up sometimes, we feel upset, and if things don't go right with the client (...) And, I can imagine some (...) being much more upset than I would be"

Pam stresses her capacity to cope with situations where her expectations change. She appears to be implying that her role includes unpredictable situations, and she specifically mentions that she has the capacity to deal with her response, if one of her clients died by suicide. These extracts suggest that the management of the risk of client suicide was considered to be integral to the clinical role. As part of the sense-making process a re-evaluation of their view of themselves, as mental health clinicians and Counselling Psychologists was, perhaps, evolving.

In practical terms, changes to clinical practice included the development of more thorough risk assessments. Two participants commented on this. One, Sally, indicated:

"...my risk profiles are immaculate, purely because I now understand that people do kill themselves"

There are two strands to this extract. Firstly, Sally illustrates her acceptance of the reality of client suicide. Secondly, she attributes the positive changes to her documentation to her experience. Several researchers have found similar outcomes (Alexander, et al., 2000; Midence, et al., 1996; Courtenay & Stephens, 2001) with positive changes to documentation being reported. Ben refers to developing clearer emotional boundaries and changes in his perception of his role led him to revise and accept the fact of client suicide:

"I now have very clear boundaries with people who are suicidal and I am no longer anxious about it. It's part of the job, and something I have to do"

Ben and Sally describe their acceptance that client suicides may occur. The embracing of certain facts and philosophical viewpoints can help one to cope, including the recognition that suicide is a predictable outcome of major psychiatric disorders, and that suicide is inevitable when an individual is not ambivalent about it (Gitlin, 1999). Other investigators report that clinicians have subsequently become more aware of the possibility of suicide after their experience (Hendlin, et al., 2000, 2004; Kolodony, et al., 1979).

Thus, a range of changes include differences in therapeutic practice, as clearer boundaries developed and improvements occurred in documentation. For some participants, the possibility of client suicide was contextualised as an integral aspect of their role. It was

indicated that provided all measures were taken to protect the client, some participants accepted that they ultimately lacked control over the outcome, and seemed able to deal with the additional stress presented by the heightened vigilance that suicidal clients require.

3.6.2 Emotional needs

The second subtheme shows the various, sometimes contradictory reflections of the ways that were suggested to meet their future emotional needs. These included receiving and giving support within groups, with differing views on de-briefing, and a desire for some professional intervention. A focus within these accounts was the importance of a person to respond immediately and to provide a non-judgemental safe space in which participants could talk about their feelings.

As a form of emotional support, being part of a group was desired by two participants, including Sally:

> *"A group is what is needed, so that each person can offer the other support"*

And also Jim:

> *"We need adequate follow-through (...) more support- a group who could share these issues"*

The emphasis on sharing concerns with others by both Sally and Jim may function to reduce their negative distinctiveness. Supportive relationships with others can be instrumental in enabling the person to feel more confident. Coping strategies to reduce threatened identity may operate at the interpersonal and group/interpersonal group levels (Breakwell, 1986). In providing a social and information network or a context for self-help, being a member of a group is especially powerful as the members of a group may benefit from the feedback and insights of other group members.

Within the accounts of the emotional support that was identified, two participants expressed their desire for de-briefing, two others indicated that they would like groups to be set up, and two requested that an immediate response by a psychologist be made available. There were contradictory views regarding offering staff de-briefing. Peter expressed his concerns thus:

"I've always had my doubts about the value of de-briefing. I've no doubt it ***can*** *help, in some cases, but in others, it can be actively harmful. I'm very relieved that recent research suggests that de-briefing does not do everyone good..."*

Ben took the opposing view and also perceived that taking part in the research interview was in itself a form of de-briefing:

"De-briefing, I see this as a part of my de-briefing. I mean, I think that de-briefing is absolutely crucial for everyone"

Talking with others about the experience was highly valued by Ben. Perhaps the research interview was viewed as a safe place to confide, because the researcher was perceived as being neutral and supportive. Experts disagree on the best form of support to offer healthcare workers. Psychological de-briefing, a relatively recent strategy, developed as a result of the experiences of emergency service personnel. The value of psychological de-briefing has been questioned (Rose, Bisson & Churchill, 2006) and it may not be suitable for healthcare workers, as it may increase the risk of post-traumatic stress disorder. Individuals appear to see de-briefing in different ways; it can be a process taking place within a group, or it may be considered as being a discussion between two people.

In the identification of the importance of some form of immediate emotional support following a client suicide, it was suggested that there was a role for the Psychology Services, a point made by Liz:

"The support you need afterwards, it gets lost (...) I think what we need is what we call an 'Out-patient Psychologist', to tackle these very sensitive human issues. We must have access to someone who's going to be there without asking questions. We need someone neutral, and more objective, impartial, the personal touch. It needs to be delivered by a skilful person, a working person, in order to be credible. I think that's where Psychology will come in"

This illustrates the urgency that Liz felt for the need for immediate comfort and affirmation, as when she uses the phrase: '*the support you need gets lost,*' she seems to be saying that metaphorically, her emotional needs were invisible. In indicating that she does not wish to be questioned, perhaps she is illustrating that she wants to feel accepted. The accessibility of emotional support was emphasised. Through the request for impartiality and a non-

judgemental stance, it appears that she does not feel that there is anyone around her to whom she can confide confidentially. Liz's request for a Psychologist mirrors the findings of Midence et al. (1996), as a Psychologist was also desired, in order to facilitate the nurse participants' discussions. Jim also requested that a person to be available to him:

> *"I think- if the culture could be... I think it's better, it's certainly better than in my time, but there needs to be lots of de-briefing, lots of communication, lots of effective communication. Umm... lots of time. You know, you could almost employ somebody on a full-time basis. There is scope for a full-time job for somebody"*

Jim also indicates his need to explore and he refers to the wider issue of improving further the culture within the National Health Service. He reiterates the accessibility of the person, as did Liz, implying that this does not generally occur. Following bereavement by means other than suicide, there is an expectation of discussion (Lucas & Seiden, 2007). Liz and Jim both indicate that they feel this to be important to them. When emotions are in conflict, there is more distress, and a powerful way of making connections and pulling threads together is by allowing people to tell their story (Howe, 1993). In conclusion, this section highlights the need indicated for participants to confide in others. Meeting the emotional needs of participants seemed to mean, primarily, as having the time to talk and having someone to listen. In addition, the objectivity of the helper was reiterated. While peer support was highly valued, professionally led intervention was seen as being necessary by some.

3.6.3 Self perception

Finally, changes in self understanding within the participants developed over a period of time. Different insights of the self and conceptions of client suicide evolved. In addition, the self-understanding of an individual within their role as a therapist altered, leading to a new recognition of the limitations of this. Some participants accepted and integrated the event into their sense of identity. Some reported feeling that they were vulnerable. One became perceived as being an 'expert'. Learning and gradual growth emerged within eight of the participants. This theme intends to describe the evolution of change and of integration. One participant, Sally, indicated how her overall perception of being a therapist had changed:

> *"Regarding my own role, I have become more fatalistic. I think this is to protect myself. I can see that the circumstances of the suicide, I can see, were not my doing. There is a long waiting list, and no one is indispensable. We are irrelevant, in many ways. If people do cross my orbit, I can hold up a road sign for them. I had high*

hopes at the start. I suppose I was a bit of the 'wounded healer'. I have become overwhelmed by the job, there has been a decline, a compromise, in my head; I can only do my little bit. That has taken experience to realise"

This appears to indicate a carefully considered shift in her thinking. Sally describes a new recognition of the limits of what she can achieve within her therapeutic relationships. She indicates how her expectations have taken on a new realism. The reflexive practitioner position is reflected in Sally's account as over time, new meanings developed. Lewis (2008) proposes that the ability to generate personal meaning out of experiences or memories rests upon the ability to integrate them into a sufficiently generalised form to be able to extract coherent outcomes for the self, and to derive insights (Singer, 2004). Difficult experiences, such as client suicide, may lead to greater efforts at personal meaning-making and ultimately to gaining wider meaning-making resources. It is suggested that this happens because stories of conflict help to construct an enhanced sense of self, or 'self-wisdom' (Lewis, 2008). In contrast, concerns were expressed by two participants regarding their capacity to emotionally manage the impact of a further client suicide. Peter said:

"I've been aware of suicides, but it's the first real suicide I've been involved in. I've been one of the key players, if you like. So, it will probably happen again. Will I be, you know, very much involved? I don't know how I would react. I don't know how it would challenge me"

Peter anticipates that he may struggle to cope if he encounters a similar situation, which may link to appraisal (Beck, 1976). His increased sense of vulnerability may be a result of the uncontrollable nature of this event (Janoff-Bulman, 1992). Another participant, Jenny, also indicated her concern about her ability to cope with the potential effects of another similar experience:

"It kind of, rears its ugly head now and again. When you've been through suicide the way I've been through, and am still going through, you know, you put it to bed for a period (...) if I see (...), and she's- I don't know, unconscious, or something, saying she's taken a whole load of tablets or whatever. How would I feel? I-I would ***hope I*** *would be okay. That would affect me greatly, I think"*

Jenny's account seems similar to Peter's, but includes his image of a current client which appears to serve strengthen his fear. These comments further reinforce the challenges and complexity of the emotional responses that some may experience. The anxiety may be

caused by negative perceptions, which can result in slower integration of the event into the existing identity of the individual (Breakwell, 1986). A wide-reaching impact on overall professional image was articulated by another participant, Liz:

> *"I was left with an effect on my confidence as a practitioner"*

Liz describes the adverse effect on her self-efficacy and competency, which seems particularly profound, encompassing her overall role. These accounts resonate with several studies illustrating how clinicians may become more cautious and lose confidence in their clinical work following client suicide (Menninger, 1991; Gralnick, 1993; Kaye & Soreft, 1991; O'Reilly, et al., 1990; Little, 1992; Hendlin, et al., 2000). A sense of diminished self confidence and self-efficacy may lead to the clinician approaching similar situations with apprehension, thereby possibly reducing the probability that individuals will perform effectively (Maddux, 2005). Increased anxiety may disrupt performance, further lowering self-efficacy, and so on. The self-efficacy beliefs of Counselling Psychologists are important, as self-efficacy beliefs may influence efficacy and effectiveness in many areas, including problem solving. Low self-efficacy may lead to individual reflections on inadequacies, which detract from efforts to assess and solve problems, according to Bandura, (1997).

Jason described some changes within himself:

> *"You try to make yourself tough over the years, not to make yourself over compassionate"*

This seems to illustrate the development of defences against painful feelings. He refers to making himself *'tough'*, seemingly linked to a desire for more objectivity within his therapeutic relationships. Defence mechanisms are well known responses to stress (Lazarus & Folkman, 1984) and they may be employed as a way of coping following a threat to identity (Breakwell, 1986, 1996). Clinical interactions may always involve some degree of emotional arousal. It is claimed that a recurring irony of clinical work is that empathy with the clients' distress may serve to deepen the therapists' pain (Norcross & Guy, 2007). Remaining open to anguished feelings and keeping a self-preserving distance can be a delicate balancing act. Constant exposure to conflict is traumatic and may reactivate clinicians' own personal conflicts, or pose the fear of this. Thus, identification with the client's pathology and striving to maintain our own psychological mindedness can pose a significant challenge (Norcross & Guy, 2007).

In contrast to loss of confidence and increased feelings of vulnerability, two participants referred to valuing and embracing their therapeutic role. One of these, Alistair, commented:

> *"I feel that it's a privilege- I have no problem at all, it is real work, life and death. Some people, of course, play games- but it is worthwhile (...) it's a privilege; it's rewarding and very stressful"*

It appears that Alistair indicates both the inherent strains of therapeutic work, and also that he gains a sense of deep satisfaction from it. Early research indicates how the economic function is only one of the many meanings of work (Morse & Weiss, 1955). For example, individuals may find a certain specific meaning in their current job (Kanungo, 1982). Meaningful work has been conceptualised as resulting from a job that is high in task significance, task identity and skill variety, with a purpose that transcends the financial one (Calhoun & Tedeschi, 2001) which seems to resonate with Alistair's appreciation of his work role.

In terms building inner strength and new strategies in order to cope more effectively in the future, Peter commented:

> *"You know, (...) will enable me to- enable me to deal with suicide even more pragmatically. I've come a long way, but there's more. I mean, maybe I'm doing a marathon"*

Peters' experience is perceived as an opportunity for growth, yet he also alludes, metaphorically, to his endurance, when he feels involved in '*a marathon*', graphically illustrating the challenge of his long test of endurance. His reference to *'being more'* implies that he views the challenge as being on-going. It seems that his meaning is that he is still affected. It seems to him that it will never end, and is a real challenge.

Three participants commented that they were aware that a client may die by suicide. Jim, an experienced clinician, simply said:

> *"I suppose I've got more used to it, as time has gone by"*

Jim seems to indicate a gradual acceptance of the reality of the possibility of a client suicide, which may be connected to the high incidences of client suicide within his field of practice. Whether an increased acceptance emerges from longer clinical experience is unknown,

although it has been claimed that a 'relative immunity' to client suicide may develop over time. Chemtob et al. (1988) found a negative correlation between the effect on clinicians of client suicide in terms of both age and years in practice.

For some participants, challenging experiences were viewed as a learning opportunity. Seven of the participants described how the impact of their experiences of practice with suicidal clients or the event of client suicide impacted on their view of themselves. Vaillant (2000) describes how positive aspects of internalization may occur in the adjustment of the bereaved, building new aspects into the nature of the bereavement process. Ultimately, grief and bereavement are a testimony to human love and attachment, as the former only occurs because of the latter (Raphel & Dobson, 2000). Bonds to others and the pain of separation are seen to be essential to the nature of society (Averill, 1968), and without them there would be little human growth or social development. Changes following a client suicide may sometimes be positive, yet the possible gains of enhanced self-understanding or personal growth are infrequently addressed within the existing literature. One participant, Jason, described how he had changed:

> *"I'll- I mean, somebody said to me, 'treat it as a learning experience', and I think that's quite a profound way of seeing it- I will treat it as a learning experience, I am going to be anxious and concerned about it, but I'm not-umm, I'm not overwhelmed with it, like I was (...) I'm alright with it now, I can talk about it.."*

Jason describes his sense of progression, and the passing of time is seen as being important in this. Loss is an inevitable aspect of human existence and loss and grief are important for development. A client death suicide has been described as a 'rite of passage' and a 'formative experience' (Courtenay & Stephens, 2001, p.3). Sally illustrated how for her, an eventual resolution occurred:

> *"It was much, much later, when I had a very supportive supervisor; we worked very closely together, and went through the issue of suicide (...) that helped me come to terms with it. Gosh, that was about (...) years later"*

The passage of time is also important to Sally's integration of the changes. Within identity process theory (Breakwell, 1986, 1996), achieving an eventual resolution is part of the individuals' drive to reconstruct their identity. The extent and speed of identity change depends on the degree of personal relevance of the change, the immediacy of involvement, the revision of identity content and value created and any negative perception of the

changes. In another participant, Jim, his changed self-perception involved his noticing others' responses to him. He indicates that a positive effect on his status took place, appearing to highlight how negative distinction has been replaced by a positive view of the person, in terms of identity process theory (Breakwell, 1996). Jim commented:

> *"I mean, there have been other suicides, and everyone now comes to me. It's as if, you've been there, you've done it"*

As Jim adjusts, others around him see him with renewed appreciation and value him for what he knows. This extract appears to reflect the change in status of the individual, in terms of others' perceptions. In conclusion, the final section showed how participants described the inner changes they perceived, including their awareness of the reality of client suicide. The differences that some participants described were profound. New understandings of their original expectations and motivation to be a therapist were generated. In addition, awareness of the limitations of their clinical role emerged. Some participants became aware of the need to protect themselves from the potential pain of developing close attachments to their clients.

Summary

The first subtheme, **Changed responses** indicated how the anxiety that was experienced when seeing suicidal clients was perceived to be necessary by some. Others reported uncomfortable feelings of apprehension. It was indicated that the possibility of client suicide was considered to be a reality, resonating with Swartz and Rogers (2004), who noted how the possibility of client suicide is ever present.

The second section, **Emotional needs** presented the consideration given by the participants to the support that was desired to meet their emotional needs in the future. Highlighted within the analysis was the importance of a person to respond to them, to provide an objective, safe space in which they could explore and who would listen objectively. It was thought that this might be provided by a Psychologist, which may have implications for the Psychology Services. Differing views were presented by two participants regarding de-briefing. The provision of groups was suggested as a method of providing peer support, and finally, the idea of changing the general culture within the NHS organisation was introduced, suggesting that support be generally more accessible.

The third subtheme, entitled **Self perception,** illustrated how self-knowledge and positive changes developed within some participants, including being seen as an expert. An interesting area to emerge was how the process of evolving involved recognition of different responses by others. The analysis suggests that the way that others related positively to the participant helped the individual to move to a 'positively distinctive' position (Breakwell, 1996). The analysis also included ways that new meaning may evolve from difficult experiences. The processes of learning and gradual growth are illustrated within this theme. A new awareness of individual vulnerability was also indicated, as it was perceived that an individual might struggle to cope with the repetition of another, similar event. Within the analysis, it was considered that the development of inner defences may act as a protective mechanism from further emotional pain. One participant felt that the experience had adversely affected her self confidence, which was analysed in relation to self-efficacy beliefs. An interesting notion to emerge was the value of the work of a therapist, as therapy was valued for its intrinsic rewards, and the purpose of the work was seen to transcend the financial one (Calhoun & Tedeschi, 2001).

In conclusion, the death of one's client appears to hold a high degree of personal relevance to the participants. It is suggested that high personal relevance creates greater identity change (Breakwell, 1986). The analysis suggests that the renewal process may reflect the workings of the completion tendency (Horowitz, 1986; Janoff-Bulman, 1992). This theme reflects the efforts made to accommodate changes into the participants' identities. Particular insights, including views on their overall role as mental health clinicians appear to be evolving. The aspect of transformation suggests that the on-going process of making sense of the experience, running throughout all the themes, is without a defined endpoint. This was the final theme to be presented.

Chapter 4. Synthesis

4.1 Overview of the research findings

The overall aim of this study was to explore the experiences of a group of mental health care clinicians, including Counselling Psychologists, of clinical practice with suicidal clients and their psychological responses to the death of a client by suicide. The findings present an initial picture of the ways in which the participants view their role with clients who are suicidal and their responses to a client death. It emerges that a client suicide can be perceived as a personal bereavement and also impacts on the professional identity of the individual.

The accounts indicate that clinical practice with suicidal clients presented a challenge for some participants, resulting in intense anxiety affecting individuals both at work and at home. It is shown that others, however, perceived that they had a degree of confidence in their clinical practice with high risk clients, illustrating the differences in the views of clinicians within this study. The impact of the death of a client by suicide had an intense psychological effect and emerged as an important part of this study. Initial responses included disbelief, shock, and fear concerning any professional adverse effect on the individual. Subsequent interpretations appeared to be influenced by the nature of the therapeutic relationship with their client, with grief and anger. Subsequent evaluations included having failed as being a competent professional. Throughout the findings of the study, the process of developing an understanding of the event of client suicide was seen to run as a continual thread. Support was indicated as protective factor in the ultimate recovery from the personal and professional impact and was influential in the experience of the individual.

Many outcomes for the clinician involved with suicidal clients and following client suicide are unknown, and may involve the future of the professional as mistakes may have occurred in their care of the client. Therefore, this area of practice may present a real challenge to clinicians, including Counselling Psychologists. The study shows the effects of being part of an investigation and the manner in which an investigation is conducted appears to be influential, highlighting the importance of a non-judgemental approach by the interviewer. Finally, it emerged that being given information and being informed about subsequent procedures was viewed as being highly valued.

The study's findings have been discussed in relation to existing research literature and to some theoretical frameworks of loss. What is particularly useful within this study is that some

of the outcomes can be applied to the education and clinical practice of mental health care clinicians. For example, the importance of clinical supervision and receiving affirmation from others is emphasised. The provision of adequate information may function to empower those who are involved in the future. An additional unexpected finding of the current study, not reported within existing literature, was the relevance of personal experiences and their impact on their clinical practice with suicidal clients and client death. Self-awareness and reflexivity are shown as being important factors to those who were affected.

The overall processes following a client suicide are portrayed as involving a lengthy adjustment and a challenge for some. Significant elements may assist in the transition, including helpful experiences of clinical supervision, supportive relationships with others, and full explanations. It appears important to those involved that they perceive that they are worthy clinicians. The findings also suggest that an integration of the experiences may occur after many years. It appears that this is an on-going process. The current study also suggests that the reflexive practitioner position is integral to the roles of these clinicians, as shifts in the views of those involved emerged, in terms of being a therapist, and the development of defensive mechanisms to protect the individual from future pain. As reflection implies re-framing, the reflexive-practitioner position can be put to the service of settling past tensions or conflicts or resolving contradictions. The events that surrounded the experiences were contextualised, by some participants, as being part of an overall learning experience. Thus, they provided a means of assisting in re-framing the professional self.

The qualitative methodology employed in the study helped the research to stay alive, by showing 'real' accounts. Interpretative phenomenological analysis provided for a deeper appreciation of the particular issues facing clinicians as the respondents examined areas that were meaningful to them. Some of the issues included their personal experiences of bereavement by suicide and their influence on the participants' clinical practice. Not all of the participants articulated all of the themes, and within the themes, the nuances have been preserved. This discussion has focused on the overall findings of this study. The use of frameworks within the analysis in order to further understanding of the emergent findings will be examined below.

4.2 Review of the application of theoretical frameworks

The analysis and interpretation suggested a range of perspectives from different theoretical positions. These included Janoff-Bulman's (1989, 1992) social contextual assumptive world's theory, Breakwell's (1992, 1996) identity process theory and to a lesser extent, the

work of Brown et al. (1995) on the effect of loss and humiliation. These theoretical frameworks were tentatively applied to the data in order assist in understanding the processing of some participants. No one theoretical framework applied to all of the emergent extracts and themes. Instead, certain aspects of different frameworks proved to be useful in illustrating different areas of psychological processing of the participants. For example, in the shock and fear at hearing of their client's death, Janoff-Bulman's (1992) assumptive worlds' theory seemed to resonate with the shattering of their assumptive worlds. Additionally, Janoff-Bulman's (1992) theory also helped to illustrate participants' self-doubt, and the questions asked in attempts to make sense of the event and derive some meaning from this. Other theories were applied to the data in order to help understand the losses experienced, including attachment theory (Bowlby, 1969; 1973; 1980) and the work of Wortman and Silver, (1989) and Epstein, Kalus and Berger, (2006) emphasising the continuing bond with the deceased.

Supportive relationships with others helped to maintain the self-esteem of some individuals in the aftermath of client suicide. Some participants felt that had failed their client, and Breakwell's (1996) identity process theory served to illuminate the adverse effect on some participants' self-efficacy beliefs. Receiving support appeared to function to reduce the perceptions of a threat to the professional identity. Self-efficacy is largely dependent on the individuals' social context, as the context determines their capacity to gain support (Gecas & Schwalbe, 1983). Within the findings of this study, the desire for comfort from others emerged after the client death, as both a loss and a threat to identity emerged. Janoff-Bulman's (1992) theory proved to be useful in understanding the processing of some participants in their search for affirmation from others following the shattering of their assumptive worlds. In addition, Brown et al.'s (1995) seminal work was tentatively connected with perceptions of humiliation during the investigation of the clients' death.
In conclusion, the impact of bereavement and the perceptions in some participants of failing as a competent professional added some support to the notion of threatened professional identity (Breakwell, 1996). This may be due to the rupture of the 'continuity' of their professional identity as clinicians.

Considering the transitions and personal evolvement of participants, these processes resonated with the work of both Breakwell, (1992, 1996) and Janoff-Bulman (1992). For example, according to Breakwell (1986, 1996), recovery from identity threat involves the processes of assimilation and evaluation. Integration of an adverse event is said to be more likely when the person takes 'a definite step into a new social position, which is expected to improve distinctiveness and self esteem' (Breakwell, 1996, p. 120). This appeared to occur

when individuals were subsequently perceived as being an 'expert' in the area of client suicide. The positive difference in others' responses towards them was noticed, as well as differences within themselves. The completion tendency may have been driving the individual towards recovery (Janoff-Bulman, 1989, 1992). Part of interpreting a traumatic experience can include seeing some benefit and adaption may also lead to growth, as individuals are said to be motivated to live meaningful lives (Janoff-Bulman, 1989, 1992). Positive aspects may occur in the adjustment processes of the bereaved, which was apparent when some participants reflected on the ways they had changed, professionally and personally. Thus, while identity process theory (Breakwell, 1986, 1996) shed light on the effect on some clinician's self-efficacy, confidence and identity, Janoff-Bulman's (1992) theory was effective in highlighting the individual drive towards recovery.

There appears to be some similarity between the IPA methodology that was employed and some of the theoretical frameworks that were used. IPA research and Breakwell's (1986, 1996) identity process theory both situate the person within their social and cultural context. In this aspect, both theories are, therefore, complimentary. Attempting to understand meaning was central to this study, illustrating the value of taking a qualitative approach to explore individuals' experiences. The hermeneutic aspect of IPA research emphasises individuals within a social context and the context is said to affect their world-view. Thus, the meanings of the texts were interpreted within the participants' culture. Their experiences were embedded within their role as clinicians. The influence of the context of the research was apparent throughout, including the perceptions that their experience had challenged their role competence and self-esteem. The influence of context was also apparent in participants' relationships with others. An example of this is the value placed by some clinicians on their relationships with their managers, which seemed to be illustrated in their desire to receive affirmation. Therefore, it appears that in locating the individual within their social and cultural context, Breakwell's (1986, 1996) identity process theory is complimentary to IPA research.

In conclusion, the application of theories in order to aid understanding of the dialogue is made tentatively. No single theoretical framework was applicable to all the extracts and themes. Instead, some frameworks were useful to illuminate certain aspects of participants' psychological processing. Finally, the literature comparison also served to highlight the accounts, in terms of existing research findings.

4.3 Limitations and future areas of research

While the study findings highlight several important areas for changes and development, there were several ways in which this study might have been strengthened. For example, the clinicians had all been qualified within their fields for different lengths of time. Thus, connections might have been made between their years of experience and the response to client suicidal intent and to client death by suicide, providing a fuller picture, but this was precluded by the need to protect the identity of the participants. In addition, as the participants were of different professions, their views of clients and of clinical practice appeared to be influenced by their backgrounds, although this could not be explored within the analysis as this might also have revealed the participants' identity.

All efforts were made to minimise any potential difficulties arising from conducting research in the same location as the researcher. However, had the study been conducted within a different NHS Trust, any potential problems may have been reduced further. This study is affected by methodological limitations. Some of those who volunteered to take part may have had some unresolved issues, such as their responses to an investigation, which may suggest certain biases. Additionally, as the sample consisted of those with clinical experience, as the views of these clinicians may differ to those of clinicians still in training, future studies may help to shed further light on this.

Within IPA research, the aim is to examine divergence and convergence within small samples. There are limits to the representational nature of the data. The aim of this inquiry was to understand a small number of participants' own frames of references or views of the world, rather than trying to test a pre-conceived hypothesis on a large sample (Smith, 1996). As those participants in this study were not a homogenous group, the limitations of generalisability may extend further. However, the participants shared the common factor of being from a mental health care background and there may be implications for clinical or within-service developments for other similar groups of clinicians. In addition, it may be that whilst the participants viewed their experience of practice with suicidal clients and the death of their client differently due to their professional background, some of the essential responses of shock, grief and fears for their professional identity are common to many mental health care professionals. Thus, similar reactions may well be experienced by other populations engaged within mental health care.

In the future, it may be useful to develop a deeper appreciation of some of the contributory factors to personal development and transformation in clinicians, as several of the

participants reported personal growth and enhanced self-awareness resulting from their struggle to adapt to their experiences. Lewis (2008) notes how stories or memories of ordeal may be powerful vehicles around which a sense of self can be built, since they suggest transformation (Thorne, McLean & Lawrence, 2004). Experiences of conflict and struggle may have important functions for Counselling Psychologists, as difficult experiences may be a source of insight and wisdom (Lewis, 2008). Thus, a longitudinal examination of the factors that are perceived as contributing to growth or transformation, over several years, might be of interest. This type of exploration may provide further insights into the integration of such loss experiences. Additionally, as personal self-knowledge and reflexivity are important within Counselling Psychologists, it may ultimately serve to enhance individual functioning and clinical practice.

Some of the participants commented that they found the research interview to be a supportive experience, and it might be useful to assess whether these feelings endure in the future. In addition, some clinicians feel that they are unsupported after a client suicide (Midence, et al., 1996), although many do not utilise the existing support services (Alexander, et al., 2000; Courtenay & Stephens, 2000). Future studies might usefully explore the uptake of counselling services and the barriers to this from the perspective of the clinician.

Finally, there is bias within the interpretation, as the perspective of the researcher represents only one view of these accounts. As the results are a co-construction between the participants and the researcher (Osborne & Smith, 1998), another researcher may have provided a different experience for the participants and subsequently interpreted the findings differently, such as using different frameworks to assist in understanding the data, and in the presentation and the ordering of the themes.

4.4 Applications to Counselling Psychology and recommendations

This study has explored the perspectives of twelve mental health care clinicians including Counselling Psychologists. It has contributed to understanding the effect of practice with suicidal clients and has provided insight into some of the processes that may be experienced in the aftermath of client suicide. The findings suggest the need for some revision of the current preparation provided for a client suicide, including heightened awareness of the real possibility of client death. The information that is currently supplied regarding investigations of such incidents may need to be revised, along with the availability of emotional support.

The findings of this study have implications for Counselling Psychologists and other clinicians, including those providing clinical supervision. The high levels of anxiety in some clinicians with high risk, suicidal clients have implications for the profession of Counselling Psychology and for the colleagues of those seeing suicidal clients, as well as for Clinical Supervisors. Increased levels of support and a culture of open discussions may be useful. The need for supportive relationships may need wider promotion and recognition in all the disciplines. Those who receive less frequent supervision than therapists and Counselling Psychologists may require an additional form of support. As providers of emotional support to others within the essence of our therapeutic work, the support of staff seems particularly pertinent to the profession of Counselling Psychology. Counselling Psychologists currently providing clinical supervision may consider the findings of this study regarding the desire of clinicians to explore their responses, both in practice with suicidal clients and following a client suicide. More flexible supervisee contact could be offered when the supervisee is seeing suicidal clients and following a client death. The resultant effect of reducing the clinicians' anxiety may have a positive effect on morale and clinical practice.

One of the key issues arising from this study was of the clinicians' desire for some form of support following their clients' death, so the profession of Counselling Psychology may need encourage the development of support systems and become more open regarding our needs. Counselling Psychologists may have a key role in sharing and promoting such insights. It seems important that clinicians be offered different forms of support, and given information, both immediately after their experience and over a longer period of time. The provision of support might include individual or group time to process the effects of the event which might be provided by several Counselling Psychologists. Therefore, there may be significant implications for existing Psychology Services and for Counselling Psychologists to provide consultation on an individual basis, within teams, or in groups. Counselling Psychologists could develop supportive groups of clinicians, which would give individuals the

opportunity to meet others and assist those who have experienced different parts of the process to learn from others, equipping them with knowledge and coping skills and strategies. The availability of the counselling services that are currently provided could be promoted at regular intervals, to assist in their uptake for those who require professional intervention. Finally, as when managing suicidal clients, the stress that was experienced by some was high, individuals may consider finding other effective ways of reducing work stress, with clinicians being aware of their needs and being proactive agents in shaping the choices they make. For Counselling Psychologists who are involved in carrying out formal procedures following a client suicide, the manner in which interviews are conducted appears to hold a great deal of influence, and the sensitivity of the approach that is taken may assist in reducing the anxiety of the clinician.

The profession of Counselling Psychology can be at the forefront to address stigma surrounding clinicians' experiences of client suicide. The development of 'experts' in client suicide may help to achieve this. If all clinicians were encouraged to discuss their experiences openly with others, a two-fold advantage may occur. The clinician could be seen as an expert, becoming more 'positively distinctive', and this could also facilitate learning in others. From the learning viewpoint, Misch (2003) argues that the death of one's client can offer invaluable opportunities for self-observation, psychological introspection and personal growth, if those involved have sufficient courage and supportive mechanisms for processing the death and its aftermath.

Counselling Psychologists may become involved in research and service evaluation, to use their knowledge to benefit others and to improve the provision of supportive services. In addition, Counselling Psychologists might also evaluate any new initiatives, such as teaching and group work that may be developed. Finally, providing training and raising awareness of the procedures which may take place following client suicide might be enhanced by developing the available information. Therefore, an information sheet (Appendix 11) has been drafted as a result of the study outcomes, which could be developed and widely distributed. Counselling Psychologists may have a role in the provision of educational sessions and facilitating experiential learning of the aftermath of client suicide, including any internal investigation. The recommendations are as follows:

1. Raising awareness of the need for additional support to those who may require this during therapeutic practice with suicidal clients and following a client death by suicide.

2. Developing the profiles of those involved in a client suicide. They could be offered an opportunity to discuss this event in small groups with colleagues.
3. If possible, a choice of support to be offered to those involved in client suicide.
4. Developing the training of all those in mental health care who are involved in procedures after a suicide death, including what may happen to the clinician, in terms of the Serious Untoward Incident procedures, media involvement and the expectations of those who may attend a Coroners Court.

Conclusion

It can be seen that the 'survivors' of suicide may also be the victims (Shneidman, 2001). A death by suicide can be similar to a stone thrown into a lake, causing many ripples, and affecting clinicians as well as loved ones. This study shows how current practices can be developed, along with new initiatives within Counselling Psychology involving more preparation and training and raising awareness of the unfortunate reality of client suicide. Both developing and continuing to provide supportive relationships within the profession of Counselling Psychology may lead to enhanced self-efficacy and confidence in clinicians and to improved client care.

4.5 Personal reflexivity

The ability to be a reflexive practitioner is one of the key issues within the profession of Counselling Psychology. The focus of this account is to give some idea of what my research meant to me, the impact it has had, and how it has played a significant part in my development, both personally and as a Chartered Counselling Psychologist. The reflexive aspect of the research process is the focus here, and to demonstrate the reciprocal element of reflexive research, that is, how it feeds back into life experience.

Conducting the research has enabled me to reflect on myself as a researcher, as well as a clinician. It has enabled me to reconsider my values about therapy, the courage and realism of my colleagues and the potential experience of the death of one of my clients through suicide. Many participants seemed to find the interview cathartic and useful. Finch (1984), warns of the dangers of creating, however inadvertently, a pseudo-rapport in which participants disclose more than they intended. Although several participants disclosed more than I expected, I believe this was due to the nature of the material and their desire to confide rather than an unintentional intimacy developed in the research interviews. I tried to be aware of power differences throughout, and the perceptions by others of myself, both as a researcher and a psychologist, especially when interviewing those of different disciplines, which might mean that they expected something more 'therapeutic' during a research interview than they might of a full-time researcher.

Regarding my learning through this process, Mezirow (1981) identified the concept of 'perspective transformation', a process of transformations of meaning and cultural assumptions through the assimilation of new experiences, taking account of our past experiences. There are said to be two ways that this is achieved. One of these takes place with a sudden insight into our assumptions; the other is more gradual, occurring through a series of transitions, with changes to previously held assumptions. My insights seem to have occurred gradually; this is similar to the concept of reflexivity. During the process of conducting the research, by keeping a record of the events, I became more aware of aspects of critical reflexivity (Appendix 11). Kolb and Fry (1975) identify the need for reflection, as part of their experiential learning cycle. This is illustrated in the reflexive document following the interviews. The reflections included my reactions to some of the participants, at times with identification and also with surprise, such as the experiences of some of the participants following unwanted media attention. Recording my impressions and focusing on my reactions helped me to identify my emotions and heightened my awareness of my biases. I began to see myself differently, as a researcher as well as a practising

psychologist. Reflexive activity has a central position in practice for a Counselling Psychologist, as part of the process of continual learning (Strawbridge & Woolfe, 2003). I realise now how the research process has tested me, in terms of being determined to see it through. What has been encouraging is that when I have presented it, it drew a lot of enthusiasm. It seems that most clinicians in the field of mental health can relate to this topic and it feels very alive and relevant.

In the analysis and discussion, I had to be careful not to over-identify with some participants. In addition, I felt responsible for ensuring that their views were adequately presented. My learning from the participants has been enormous, including the optimism and 'groundedness' that many clinicians take to their therapeutic work. The process of listening intently to others has helped me to learn in a similar way to my learning from my clients. My recognition that loss and gaining insights are related has helped me to become more aware of the immense value of building my client's strengths. This will drive me to focus more on their resilience and to reflect on their endurance. Perhaps one of my initial drives was to learn from others, in order to be better prepared for this experience. In conclusion, as I am a clinical supervisor of qualified practitioners and trainee psychologists, my role includes explorations of the emotional effects of working with suicidal clients. I see my role in this context to support those seeing suicidal clients, providing a place that feels safe, and being ready to respond with care to those who may have the experience of client suicide. This research has spurred me on to develop this area further and to possibly become involved in training.

Section C: Critical literature review: 'The challenges of traumatic loss: the phenomenon of post-traumatic growth'

Chapter 5. Section C: Critical literature review: 'The challenges of traumatic loss: the phenomenon of post-traumatic growth'

5.1 Introduction

This literature review sets out to examine a range of differing theoretical explanations and research evidence for the phenomenon of post-traumatic growth, which is claimed to occur in some individuals following the experience of a major loss or traumatic life event. Post-traumatic growth is of particular interest to Counselling Psychologists, as it is argued that the current focus within mainstream psychology is on the deficiencies of the person, instead of giving serious consideration to the difficulties and strengths of both the person and their environment (Wright & Lopez, 2005). This review of post-traumatic growth will firstly consider the field of positive psychology, where the distinct concept can be located. Some of the theories that propose an explanation of the mechanisms of growth will be examined. The pertinent literature is to be explored. Finally, the application of clinical skills to enhance individual post-traumatic growth will be considered

Despite the rich research tradition of positive psychology which has evolved over many decades, many topics within the scope of positive psychology have remained isolated, lacking any shared language or common identity. Positive psychology has highlighted the common traditions of those working within the field and provided a conceptual home for researchers and practitioners interested in all aspects of optimal human functioning. In viewing the many strands of research from which positive psychology is drawn, and seeing them as sharing a common core identity, psychologists have taken a sustained interest in the study of human nature as a whole. This rich tradition provides the foundation of applied positive psychology (Linley & Joseph, 2004).

It has been suggested that the foremost advocate for positive psychology was Seligman (2002). Building on the pioneering work of Rogers, (1959), Maslow, (1954; 1968) and others, the field emerged in response to the orientation of mainstream psychology to the medical model and to dysfunction. Thus, the many approaches to positive psychology offer an overall attempt to revitalise the positive aspects of human nature (Seligman & Csikszentmihalyi, 2000). Carl Rogers (1959) proposed that human beings strive to become all they can be. Rogers (1959) referred to the directional force of 'becoming' as the actualising tendency. The organismic valuing process (Rogers, 1957) accounts for both disorder and well being, through its premise that disorder exists if people do not act in accord with their organismic

valuing process, as well being is said to arise when people intrinsically value their choices and behaviours. A continuum of the human experience of disorder and well being is said to encompass both parts of the same view of human experience. Thus, positive psychology has, over recent years, moved towards an integrative approach including both the positive and negative aspects of human functioning (Sternberg & Grigorenko, 2001).

The specific concept of post-traumatic growth claims to underpin the central tenets of the field of positive psychology (Joseph & Linley, 2005; Calhoun & Tedeschi, 1998; Cohen, Hettler & Pane, 1998; Linley, 2003). The perception of the emergence of value following an experience of loss or trauma may co-exist with symptoms of disorder. Tedeschi and Calhoun (1999), based on interviews with many trauma survivors, proposed that a basic paradox of post-traumatic growth is that individuals report that their losses have produced something of value. Those who experience negative life events may feel more vulnerable, being unable to prevent or control their suffering. However, a common theme is the increased sense of individual capacities to survive and prevail (Calhoun & Tedsechi, 1999). Post-traumatic growth can lead to the commonly reported change of an increased appreciation of the small daily pleasures in life such as family and friends, with less focus on previously valued activities. Although firm answers to the questions raised by trauma are not necessarily discovered, grappling with these issues is considered to produce a sense of satisfaction that life can be experienced with a deeper level of awareness. This may be part of developing life wisdom (Linley, 2003), and, in particular, developing the individual's life narrative (McAdams, 1993; Tedeschi & Calhoun, 1995). Reflections on a trauma may be unpleasant, although necessary to gain a wider perspective of life. A subsequent change of priorities may lead to a sense of positive transformation. High levels of post-traumatic growth have been reported following a wide range of traumas (Calhoun & Tedeschi, 2004). Individuals may have greater empathy towards others, greater self-understanding, wisdom and meaning in life (O'Leary, Alday & Ickovics, 1995; Tedeschi & Calhoun, 1995). It is proposed that it is not the trauma itself, but the struggle during the aftermath that may result in post-traumatic growth. Thus, it can be seen that post-traumatic growth, as a distinct concept, appears to endorse the central principles of positive psychology.

Some of the terms used to describe post-traumatic growth include 'thriving' (O'Leary, et al., 1995) and 'benefit finding' (Tennen & Affleck, 1998). However, as growth represents a shattering of basic assumptions that 'thriving' does not imply (Tedeschi & Calhoun, 2004, p. 406), the terms 'post-traumatic growth' or 'growth' (Linley, 2003; Tedeschi, Park & Calhoun, 1998) are to be used within this review. As the distinct concept of post-traumatic growth has been introduced, some of the proposed theories of growth will now be examined.

Models of change tend to address how the usual homeostatic mechanisms of self-regulation may be altered (O'Leary, et al., 1998). Considering the continuum of the development of growth and distressing symptoms, some theorists propose that the incomplete processing of a traumatic event may lead to Post Traumatic Stress Disorder (PTSD). For example, Horowitz's (1982, 1986) psycho-dynamically informed theory asserts that individuals have 'mental models' of the world, in order to interpret incoming information. The intrinsic drive to make these coherent with current information is termed the 'completion tendency'. There are said to be two types of stress responses following trauma, firstly involving intrusive, cognitive repetitions of the event. Reappraisal, in the second response, requires massive schematic changes, and the disturbing memory is avoided. Eventually, a state of equilibrium is said to be reached (Horowitz, 1982, 1986). Symptoms of PTSD are regarded as a result of incomplete processing.

Alternatively, Janoff-Bulman's (1989, 1992) social contextual theory proposes that individual functioning is guided by deeply held assumptions. Experiences are adapted to fit into existing cognitive schemas. Extensive rumination occurs when the person's worldview is revised, with the development of some meaning from the event, as people are claimed to be intrinsically motivated to find meaning in life (Janoff-Bulman & Frantz, 1997). Drawing on the work of Horowitz (1986), the completion tendency is said to guide individual recovery. If individual schemas are shattered, this could lead to post traumatic distress, yet successful adaption may also lead to growth. Thus, Janoff-Bulman's (1989, 1992) theory offers an account of the variability in responses to trauma.

Psychosocial theories emphasise the importance of interaction between individual personality, cognitive appraisal and social support (O'Leary, et al., 1995; Park, 1998; Schaefer & Moos, 1992; Tedeschi & Calhoun, 1995; Waysman, Schwarzwald & Soloman, 2001). During the grieving process, for example, Nerken (1993) proposed that active grieving and efforts to acquire some meaning from the event are essential for growth. Tedeschi and Calhoun's (1995, 2004) functional, descriptive theory, derived from psychosocial theories, claims that the event needs to be challenging enough to instigate the processing necessary for growth. Initially, automatic cognitive rumination helps to create a cohesive description of the event. Growth is claimed to occur along with potential wisdom (Linley, 2003) and the search for meaning. It is proposed that with support from the environment, individuals may develop new schemas, and self-disclosure is considered to be important. In conclusion, Tedeschi and Calhoun (1995, 2004) offer an explanation for the mechanisms of growth, yet fail to address the reason why individuals are motivated towards growth, suggesting that individuals tend towards maintaining to a state of equilibrium. An

integrated theory, aiming to account for both how and why individuals tend towards moving in a positive direction will now be examined.

5.2 An integrated theory of post-traumatic growth and existing concepts of humanistic psychology

An integrated theory of post-traumatic growth proposed by Joseph and Linley, (2005) suggests that people will tend towards rebuilding their assumptive worlds in a positive direction. Based on self-determination theory (SDT; Deci & Ryan, 1985, 1991, 2000; Ryan & Deci, 2000), Joseph and Linley (2005) embraced the organismic valuing process, derived from the humanistic psychology tradition, in which individuals know their own directions in life and what leads to their greater well-being. The accommodation of new information in a negative or positive direction is said to depend on individual differences, the social environment and pre-trauma or early experiences. In an unsupportive social environment, it is claimed that the person will tend towards negative assimilation of the trauma material. Ryan (1995) emphasised that if the 'nutrients' needed for autonomy, competence and relatedness are provided, this facilitates the search for 'meaning as significance,' leading to greater growth.

As humanistic psychology, on which Joseph and Linley's (2005) growth theory is based, covers a huge diversity of different approaches, a review of Joseph and Linley's (2005) theory will focus on the work of Rogers (1959, 1957). Rogers (1959) viewed the basic direction of the actualising tendency as being towards autonomous determination, expansion, effectiveness, constructive social behaviour. It was argued that individuals have the inner resources needed for personal change. Cognitive evaluation theory, a sub-theory within self-determination theory, however, accounts for the ways that people are motivated to carry out autonomous behaviour that can result in well-being, or behaviour may be fuelled by restrictions, such as the avoidance of guilt. Self-determination theory posits that as children grow older, they regulate their behaviour. Behaviour can be disrupted, shifting from intrinsic, self-motivated to extrinsic activities. Extrinsically motivated activity is said to identify the goals and responsibilities that the social world obliges us to perform (Ryan, 1995). Within cognitive evaluation theory, the social environment influences change. While there appear to be many similarities in Rogers' (1959) humanistic psychological theory and self-determination theory, there may be differences, regarding the process of change and the effect of the environment.

A key issue within self-determination theory is how the development of extrinsic motivation and autonomous functioning can be assisted by socialising influences, such as managers and teachers. This internalises the values and regulation of individual extrinsically motivated behaviour, so that it feels self-endorsed by the person. For example, if children do not have the motivation to complete homework, this behaviour may be encouraged if the child feels that it to be valued by others, and is more likely to occur when the individual feels connected with others. This can lead to pursuing goals for intrinsic, rather than external reasons. More effort is used and goals are more likely to be attained, which leads to stronger feelings of autonomy, competence, and relatedness, and thus to a greater sense of well-being (Sheldon & Elliot, 1999).

Explanations that are given for the integration of extrinsic motivation and developing autonomous behaviour seem similar to 'conditions of worth' (Rogers, 1957, 1959). However, Rogers' (1957, 1959) offers an explanation for the process of individual change during therapy, with therapeutic movement within a climate of unconditional positive regard leading to greater individual acceptance and self-actualisation. The climate of unconditional positive regard may exist in a group, classroom or community setting, which seems similar to the socialising influences of managers and teachers, said to guide extrinsic motivation within self-determination theory, although there appears to be more emphasis on the social environment within self-determination theory.

Within Rogers' (1957, 1959) humanistic psychological theory, problems are said to develop in the individual in early life, when disapproval is encountered. Similarly, self-determination theory shows a close relationship between secure attachments, as pre-trauma or early experiences are said to be important in the positive integration of trauma material. Change can occur through the influence of social contexts. For example, health carers can facilitate guiding individuals towards compliance and adherence to treatments. Research shows that when patients felt listened to, better adherence to medication occurred (Williams, Rodin, Ryan, Grolnick & Deci, 1998). While this study indicates that if people are guided by others, positive changes can occur, Rogers' (1959) is more specific regarding the process of individual change and the gaining of new insights may take place.

The basic human needs for autonomy, competence and relatedness are said to be essential for growth (Deci & Ryan, 1985; 1991; 2000). Thus, self-determination theory appears to complement Rogers' (1957, 1959) humanistic psychological theory, but in self-determination theory, receiving environmental support may, arguably, be problematic. For example, support may be hindered following historically stigmatising events, such as bereavement by

suicide (Dunn & Morrish-Vidners, 1988). If support is impeded, this leads to the question of how individuals recover and grow. Those who are affected by stigmatising events may find it difficult to talk with others, as the relationships of cancer patients focused on their experiences of 'victimisation,' rejection and avoidance from friends and even intimates (Wortman & Dunkel-Schetter, 1979). Additionally, individual perceptions of support and actual support may differ as perceptions of support are more strongly linked to well-being than the actual support that is received (Cohen & Wills, 1985). Self determination theory indicates that if people do not feel supported, negative assimilation of the trauma will occur, and no explanation is offered for the growth of individuals who do not perceive that they received support following a traumatic experience.

Self-determination theory (Deci & Ryan, 1985; 1991; 2000; Ryan & Deci, 2000) shares a common ground with existing humanistic psychological theories, although there may be some subtle differences. For example, there is some empirical research into Deci and Ryan's (1985; 1991; 2000) concept of 'needs satisfactions' which could be interpreted as evidence for the role of unconditional positive regard. Items (La Guardia, Ryan, Couchman & Deci, 2000) used to measure autonomy (e.g., My mother allows me to decide some things myself), competence (e.g., My mother puts time and energy into helping me), and relatedness (e.g., My mother accepts and likes me as I am) could be considered to measure the broader concept of positive regard (Joseph & Linley, 2004). Therefore, the difference between 'unconditional positive regard' and 'need satisfaction' may be the terminology. In addition, positive change is considered to be driven by the completion tendency within Joseph and Linley's (2005) theory, which appears to be similar to the humanistic tendency towards self-actualisation. Therefore, it may be that the terms originally used within humanistic psychology were adopted by Deci and Ryan (1985; 1991; 2000).

In conclusion, a positivist approach based on the concept of the actualising tendency makes assumptions about human nature having an inherent inclination to move in positive direction. However whether an unconditionally positively regarding social environment (Rogers, 1957, 1959), can provide the person with the 'nutrients' needed to develop autonomy, competence and relatedness (Joseph & Linley, 2004) is not clear. These 'nutrients' are considered to be necessary for growth. Therefore, while self-determination theory, underpinning Joseph and Linley's (2004) theory of growth, offers an explanation of individual developmental processes and of socialising influences, greater clarity of how change occurs is perhaps provided by Rogers (1957, 1959).

5.3 Validity of the concept of post-traumatic growth

Several aspects may be integral to the validity of the concept of post-traumatic growth, including whether it represents a process or an outcome, how it arises and when and how it should be assessed. Consideration is required regarding the type of event necessary for growth, whether it is influenced by personality characteristics, and if it is best conceptualised as being an outcome or a process, as researchers have typically failed to distinguish between the two (Park & Helgeson, 2006). Most researchers conceptualise it as an outcome (Tedeschi & Calhoun, 2004) but theories of growth attempt to show the process it takes. Studies examining post-traumatic growth over long periods of time, ranging from very recently to many years may be capable of capturing both the process and outcome (Park & Helgeson, 2006).

Post-traumatic growth has been considered to be illusionary, as, according to cognitive adaption theory people need to make sense of a trauma and restore their beliefs about themselves and the world (Taylor, Wood & Lichtman, 1983, Janoff-Bulman, 1992). Taylor et al. (1983) posit that to restore coherence in the world, people can either identify a concrete cause of the event, or discover benefits to justify it happening. Therefore, according to cognitive adaptation theory, growth is illusionary. Similarly, temporal comparison theory shows how individuals are keen to maintain their generally high self regard (Taylor & Brown, 1994). They may make downward comparisons when experiencing major life threats, comparing themselves with less fortunate others, while affiliating themselves with those who appear to be adapting well (Tennan & Affleck, 1997). If so, individual perceptions of growth may not illustrate actual change. It is claimed that those who score highly in positive emotions and openness to feelings will be more aware of these emotions, therefore producing the schema change reported as growth (Tedeschi & Calhoun, 1996). There is some evidence that positive affect is implicated in growth, although the positive relation between optimism and Post Traumatic Growth Inventory scores is found to be modest, (Aspinwall, Richter & Hoffman, 2001) indicating that optimism and post-traumatic growth may be distinct concepts. A recent retrospective web-based study of 1,739 adults (Peterson, Park, Pole, D' Andrea & Seligman, 2008) shows small but positive associations among the number of potentially traumatic experiences and a number of character strengths. It was concluded that growth may entail the strengthening of character.

The time span for growth to remain and the type of event said to be required for it to occur remains unclear. Affleck, Tennen, Croog and Levine (1987) followed heart attack victims over 8 years, finding that remarkable stability occurred from 8 weeks to 7 years from this

incident. There is conflicting evidence of the severity of the event claimed to be needed for growth. The severity of the crisis may be related to greater risk for depression (Frank, Tu, Anderson & Reynolds, 1996, Kindler, Karkowski & Prescott, 1998), anxiety (Kindler, et al., 1998) and PTSD (Yehuda, Southwick & Giller, 1992). The more disruptive the event, the more potential there may be for positive changes to occur (Updegraffe & Taylor, 2000). However, as Carver and Scheier (1999) suggest that even moderate levels of stress may be disruptive enough to elicit change, further studies tracking change over time would be helpful.

Post-traumatic growth has, fairly recently, become the focus of increasing empirical and theoretical work (Linley & Joseph, 2004a; O'Leary, et, al., 1995; Tedeschi, et al., 1998). Table 6, at the conclusion of this review, summarises some of the literature. The empirical literature suggests that while post-traumatic growth may be common, it is not universal (Tedeschi & Calhoun, 2004). Growth has been reported following a wide range of events, including bereavement (Cadell, Regehr & Hemsworth, 2003, Znoj, 2006), breast cancer (Cordova, Cunningham, Carlson & Andrykowski, 2001), and heart attacks (Affleck, et al., 1987). Some of the studies employing prospective and phenomenological approaches following bereavement will be examined below.

5.4 Post-traumatic growth following bereavement

In their prospective, longitudinal study, Davis, Nolan-Hoeksema and Larson (1998) interviewed individuals whose loved one was in hospice care. At 6 months following their loss, they were asked if they had found anything positive in this experience. Seventy three per cent cited at least one benefit. Their specific responses included personal growth, new life perspectives, strengthening family bonds, and support from others. Whether finding benefit six months following the loss predicted distress later was explored. The analysis controlled for distress prior to the loss, as well as the extent to which the participants made sense of the loss (i.e., found meaning) at the 6 month interview. Surprisingly, it was found that post-traumatic growth predicted distress at 13 months, even after controlling for the extent to which the loss 'made sense'. It was not the number of benefits that held predictive value, but rather whether *any* benefit was endorsed.

A prospective study of 205 bereaved individuals was conducted (Bonnano, Wortman, Lehman, Tweed, Haring & Sonnega, 2002) both several years before the death of their spouse, and at 6 and 18 months post loss. Their grief symptoms revealed five core bereavement patterns including common grief, chronic depression, and improvement during

bereavement and resilience. Chronic grief was associated with pre-loss dependency in the relationship and resilience with pre-loss acceptance of death and belief in a just world, which appears to provide some evidence that pre-morbid adjustment can predict the response to trauma. Many bereavement theorists have speculated about the possible unhealthy, maladaptive nature of mild or absent grief reactions (Bowlby, 1980; Rando, 1992; Worden, 1991). One view, that those who failed to show overt signs of grieving were either 'superficially attached' to their spouse (Fraley & Shaver, 1999), or avoidant and emotionally distant (Rando, 1993), was unsupported by this evidence. Instead, it was found that the resilient group was comprised of well adjusted, resilient individuals with adequate coping resources. As it is difficult to obtain truly prospective data, the vast majority of studies have relied on post loss data, aggregated across participants, but this obscures the full course of grief reactions as changes in perception and functioning brought about by the loss cannot be shown. Methodologically, however, concerns include the mean age of those in this study, of 72 years, as these findings may not be transferable to younger individuals. Although the proportion of participants showing resilience and chronic grief patterns were within the range observed within previous studies (Bonnano & Kaltman, 2001), the pre-loss patterns of findings were less generalisable. The broader implications of this study are that those individuals with chronic grief who may have had a dependant relationship may benefit from the traditional 'working through' of the lost relationship (Rando, 1993, Worden, 1991). The researchers were, therefore, able to link growth and patterns of bereavement with clinical recommendations.

A numerically aided phenomenological approach following bereavement was taken in Davis, Wohl & Verberg's (2007) study of 52 adults. Three clusters were found, one which identified meaning making and personal growth, and another which did not find emergent meaning or growth. One cluster featured modest growth. Those who were most likely to report growth interpreted the bereavement as a threat to the self, with growth coming from development of new self-understanding. This seems to support growth as being an emergence from the struggle of making sense of the event. These studies appear to offer some evidence for post-traumatic growth following bereavement, and they provide a direction for further research in the clinical treatment of bereaved individuals. There are, however, many methods of measuring growth, which will be discussed within the following section.

5.5 Assessing post-traumatic growth

To the extent that post-traumatic growth exists as a valid concept, various methods have been used to assess it, each with their strengths and weaknesses (Park & Lechner, 2006).

Two widely used instruments for measuring growth are the Post Traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) and the Stress-Related Growth Scale (SRGS; Park, Cohen & Murch, 1996). Other rarely used inventories include the Benefit-Finding Scale (Tomich & Helgeson, 2004) and the Perceived Benefits Scale (McMillan & Fisher, 1998). The PTGI allows for the quantification of growth in five domains including greater appreciation for life, a change in priorities, warmer relationships with others and spiritual development (Tedeschi & Calhoun, 1996). However, factor analyses of various types of trauma survivors (Maerckera & Langer, 2001) show that these domains do not represent all the factors. Recently, Linley and Joseph (2007) showed support for the original five factor structure as well as a single higher-order construct, although such factors are usually fairly highly correlated and may be best considered as a single primary factor (Park & Lechner, 2006).

Post-traumatic growth may be multi-dimensional, or a one-dimensional construct. Thus, it is necessary to consider whether there are multiple domains of growth, or one single perception of positive change. Early studies used open ended questions about how people's lives had changed when assessing growth, but ideally, a combination of both open and closed ended questions may be most helpful (Park & Helgeson, 2006). Those who reported both positive *and* negative changes showed more growth, in a study by Taylor, Kemeny, Reed and Aspinwall, (1991). Although some studies find a relationship between measures of distress and measures of growth, others do not. This may be relevant to the clinical context, as those who experience a significant level of post-traumatic growth may not necessarily experience a commensurate decrease in distress. The maintenance of the growth experience may require periodic cognitive reminders of what has been lost, so in a paradoxical way, what has been gained remains in focus as well (Tedeschi & Calhoun, 2004).

Some researchers suggest that a simple examination of any positive change versus no change is the best approach (Nolen-Hoeksema & Davis, 2004), whereas others have developed increasingly sophisticated measurement tools. For example, Sears, Stanton and Danoff-Burg (2003) in a study of women with breast cancer, measured growth in three different ways and found three patterns of results. The PTGI was not related to distress or perceived health, but to positive mood and the number of benefits which were cited, in response to an open ended question were not related to any outcome. Positive re-appraisal was related to a more positive mood and to better health. A recent meta-analysis of benefit finding (Helgeson, Reynolds & Tomich, 2006) revealed that the particular growth measure used moderated the relation of growth to outcomes. The tapping of both positive and

negative changes through items stated as neutral stems is also suggested, so that individuals can report change in either direction (Weinrib, Rothrock, Johnsen & Lutgendorf, 2006) which reduces demand characteristics to report positive change, and can, importantly, be tracked over time. However, methodological and conceptual issues arise with items stated as neutral stems, as it is not clear whether negative scores should be added to positive scores or examined separately (Park & Lechner, 2006). Also, this strategy assumes that these changes are at opposite ends of a continuum, thus promoting the view that perceived growth and perceived deterioration are opposites.

Self ratings of growth may require further investigation in order to assess their validity (Linley & Joseph, 2004, Tomich & Helgeson, 2004), as when completing growth inventories, people may be manufacturing positive change in an attempt to cope with the trauma. In three separate studies, Frazier and Kaler (2006) found little evidence for the validity of self reported growth. This is largely consistent with other findings where trauma groups were compared with matched or unmatched control groups on standard well-being measures (Cordova, et al., 2001, Zemore & Shepal, 1989). In a series of studies, McFarland and Alvaro (2000) suggested that growth reports reflected cognitive distortions in order to relieve distress. Additionally, Smith and Cook (2004) randomly assigned participants to two groups. In one group, they responded to the PTGI in relation to a stressful event. In the other, questions were not linked to specific events. It was concluded that current methods for assessing growth may underestimate it, as linking questions to specific stressors may lead the participants to be cautious about attributing their experiences to a traumatic event. In order to substantiate these findings, prospective, longitudinal studies and corroborating reports of post-traumatic growth are required.

In conclusion, the assessment of growth by self reports appears to have little validity as they cannot be linked to measurable changes in personality, resources or behaviour. Individuals' perceptions of growth may be more important to understand their quality of life than measures of actual post-traumatic growth. Park and Helgeson (2006) highlight the distinction between actual change linked to behaviour, and reports of growth that may represent illusions or cognitive distortions. It appears that a combination of methods to assess growth may be the most useful, depending on the research area under examination. Following the experience of trauma, some aspects may be within the control of the individual and therefore could be employed to help to foster post-traumatic growth.

5.6 Can the individual influence post-traumatic growth?

Individuals may find it helpful to discuss their experiences and think about the traumatic or loss event that they have experienced. Martin and Tesser (1996) propose that cognitive processing involves conscious thinking revolving around a theme. However, cognitive processing may be inhibited by social constraints (Tedeschi & Calhoun, 2004). This raises some fundamental issues about fostering and promoting supportive cultural environments, when individuals may be fearful of 'burdening' others and may be reluctant to seek support, particularly following a stigmatising event. Those who suffer a more devastating life crisis may experience more positive outcomes, as major events may trigger an outpouring of support (Kaniasty & Norris, 1995) which can lead to powerful information about individual worth. The reported benefits of support to both mental and physical health are strongly positive (Thoits, 1994), including the reduction of distress, such as in depression and anxiety (Taylor, Lerner, Sherman, Sage & McDowell, 2003a).

Writing about the experience may also be useful for some individuals. Evidence suggests that written communication can have some health benefits (Pennbaker, 1997). In a study of the effects of journaling, (Ullrich & Lutgendorf, 2002) university students who had been instructed to cognitively process their emotional responses, compared to those instructed to focus on the facts alone, reported higher levels of growth after four weeks. Although these sorts of findings are only suggestive, they may be congruent with the view that significant cognitive engagement aids processing (Ullrich & Lutgendorf, 2002). Meaning-making may lead to perceptions of growth, as intrusive thoughts about a traumatic event seem to be connected to cognitive processing. Strong evidence for the role of cognitive processing comes from Weinrib et al. (2006), as people were asked to write about a traumatic event and then complete a growth inventory. Reports of growth were directly linked to indictors of cognitive processing, as was coded from the essays. Consistent with these findings, McCulloch, Root and Cohen's (2006) essay-writing intervention study found that those who were randomly assigned to write about the benefits of a trauma engaged in greater cognitive processing, as was shown in the content of the essay. Those asked about the trauma showed more cognitive processing than those who were randomly assigned to write about the traumatic features of the event or a neutral topic, suggesting that growth may emerge from a period of inquiry. Therefore, it appears that the process of writing may be useful for some individuals as it may lead to greater cognitive engagement.

The assimilation of adverse events by talking in confiding relationships and in public social interactions was described in an account-making model (Harvey, Carlson, Huff & Green

2000). Individuals are said to weave the experience into the fabric of their life narrative (McAdams, 1993). During reflection, lost goals may be acknowledged, and the character of the 'trauma narrative', before and after the trauma, the 'trauma as turning point,' is said to develop (McAdams, 1993; McAdams, Reynolds, Lewis, Patten & Bowman, 2001; Tedeschi & Calhoun, 1995). Although understanding an event and drawing some significance from it have been described as two separate processes, 'meaning as comprehensibility' and 'meaning as significance' (Janoff-Bulman & Franz, 1997) they may be interwoven. The gaining of meaning from an event (Taylor, 1983; Joseph & Linley, 2005) is considered to have two domains, including sense-making, involving looking for attributions (Park & Folkman, 1997; Davis, Nolan-Hoeksema & Larson, 1998). Later, questions of significance may involve existential questions about the purpose of life. It appears that as cognitive processing, talking to others and writing about the experience may assist in recovery, there may be some initiatives which the individual may employ in accentuating the possibility of growth.

5.7 Summary and future directions for research

Several pertinent questions still remain concerning how growth may best be assessed, the type of event required to instigate growth, whether growth can be defined as a process or an outcome and to what extent it may be influenced by individual personality characteristics. Therefore, future studies employing phenomenological methodologies may provide deeper levels of data than longitudinal methods unless these methodologies are combined. As the focus in studies of growth need to include the time span since the event, prospective studies may be particularly useful.

Whether there is interest in perceived or actual growth will depend on the research question under investigation. If, for example, researchers want to know about the experiences of bereaved individuals, the participants' subjective sense of appreciation may override their observable change in appreciation. If, however, the aim is to explore the processes through which some individuals enhance their resources to help them cope with stressors, then a focus on measurable growth may be needed. Thus, both descriptive, qualitative methods combined with measures of growth over a long period with a prospective design would demonstrate what brought growth about and provide information about the experiences of individuals.

Studies should ideally be grounded in theory and designed to test alternative explanations. Laboratory and experimental studies may help to determine whether growth can be

manipulated and can be designed to elucidate some of the mechanisms by which growth may occur. Field studies with longitudinal, prospective designs may be useful. The majority of existing studies are retrospective, but these may be problematic in identifying the individual resources were present before the event occurred. As it is important to separate authentic from illusionary growth, and as self-reports have doubtful validity, self-reports should be linked with external indicators with corroborative reports by significant others (Park, et al., 1996). Finally, sensitivity and caution when conducting research are essential, as Affleck et al. (1987) noted how their research participants viewed even well-intentioned efforts to encourage benefit finding as being insensitive.

5.8 The principles of post-traumatic growth applied to clinical interventions

Several emerging models of therapy emphasise client strength and resilience and a number of interventions have already shown an influence on levels of reported positive changes and growth in people with serious illnesses (Antoni, Lehman, Kilbourne, Boyers, Culver & Alferi, 2001). To date, interventions have not been explicitly aimed at increasing perceptions of growth with the exception of several writing studies, although these were not designed as clinical interventions. Caution may be needed if endorsing large scale growth interventions with people who have undergone major traumatic life events (Park & Helgeson, 2006). With the caution that any attempt to facilitate growth needs to be made after sufficient time has elapsed for the individual to adapt to the aftermath of trauma, some suggestions for interventions within Counselling Psychology derived from existing theory and research will be offered, as providing that these are timed appropriately and delivered sensitivity, they may be useful to clients.

A comprehensive, collaborative formulation can guide the planning and interventions of the Counselling Psychologist, and if this is seen as an active, evolving structure, which the client perceives to be helpful, the formulation may serve as a vehicle for the perception of potential growth, as client strengths and protective factors may be highlighted together with their difficulties. For example, Cognitive Behavioural Therapy for post-traumatic stress disorder (PTSD) does not typically account for the identification of client strengths (Davis, 1999). Generally speaking, as decreasing symptoms in PTSD may not lead to individual growth (Joseph & Linley, 2004b), integrating symptom reduction with the fostering of growth may be an ideal. Although to date, the CBT literature has only sparsely included strengths in cognitive models, a number of CBT innovators have begun to do so (Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2005).

Theoretical concepts of what is suspected about how post-traumatic growth can occur may serve to underpin clinical interventions. For example, as support is known to be helpful, the client's assumptions, including their perceptions of support and the actual available support may be tested, as it may be that some individuals may avoid others following a stigmatising trauma or loss. As Tedeschi and Calhoun (2004) suggest that the struggle to make some meaning of the event is associated with post-traumatic growth, the words used by the clinician should be connected with the struggle. In the aftermath of trauma, clients may exhibit a high level of cognitive engagement with and cognitive processing of their situation. Thus, effective listening skills, in addition to specific interventions designed to reduce the trauma-related symptoms are essential.

The empathic manner of the Counselling Psychologist may help to provide the acceptance said to be vital in the process of reconstructing an event (Harvey, et al., 2000). Helping clients' to create a coherent structure of their experience can assist in the process of meaning making, and has been shown to play an important role in adaptation to trauma (Davis, Wortman, Lehman & Silver, 2000), as narratives bridge the past with the present. Clients may weave the event into their life narrative (McAdams, 1993) which may lead to the client engaging in reflection of their processing of events. An appreciation of how they have grappled with the event can occur dynamically over time, reinforcing the value of active empathic listening and of noticing the changes that are made.

Some individuals who have been exposed to trauma may feel the need to tell their story repeatedly which can provide a safe exposure function when the difficulty is associated with an identifiable stimulus array and can have therapeutic value (Tedeschi & Calhoun, 2004). Re-telling the story may help the client to engage in cognitive actions that help them to accommodate cognitive structures to the events. The possibility of post-traumatic growth exists through this process. Subtle changes in the clients' perceptions in the telling of their story and shifts in the affect displayed can be highlighted. There may be a need to respect any 'positive illusions', as it may be necessary for those facing major traumatic circumstances to operate with certain 'benign' cognitive distortions (Taylor & Brown, 1988).

The noticing of clients' strengths by the Counselling Psychologist may be a therapeutic cognitive experience for the client. It may be useful to point out the capacity of the individual to struggle to survive psychologically and to adapt to their circumstances, while also demonstrating awareness of the difficulties that are involved. The intention is to respond in ways that reflect the discoveries that the client is making. Being led by the client through the construction of the case formulation can be an effective method of gaining accurate

feedback, and checking of the clinicians' understanding with the client can reduce the possibility of biased interpretations.

The use of the language of the client, particularly the words used to describe the crises, and implementing clinical interventions that work with their belief system (Calhoun & Tedeschi, 1998) may help the client to feel that the clinician is attempting to understand their perspective. Listening for the clients' use of metaphors, or introducing metaphors may make exploration more effective as they may facilitate client expression, allowing trauma survivors to acknowledge areas that may otherwise be difficult for them to articulate. Metaphors can conceptualise the rich interplay of beliefs, emotions, and physical states. If they come from the individual, they may have greater personal meaning and resonance.

The experience of loss or trauma may require an exploration of existential issues such as fears for the clients' own mortality. Meeting others who have experienced similar difficulties and can describe ways their struggle has changed them, possibly in a group setting, may be useful following a stigmatising event. The 'normalising' of their responses by others may help to facilitate growth and Counselling Psychologists may have a prominent role in the development and the facilitation of groups. Tedeschi and Calhoun (1995, 2004) advocate group treatments for many trauma survivors, with the expectation that the mutual support exchanged may also give survivors an opportunity to share empathy and compassion. Finally, Counselling Psychologists may become more aware of the potential for growth through a process of self reflection, consideration of instances of personal growth, and searching for inner strengths within oneself.

In conclusion, interventions to facilitate potential growth may be introduced within a comprehensive case formulation, alongside appropriate treatment strategies for the difficulties that are experienced. This may lead to the Counselling Psychologist looking for themes of potential growth as a general framework, rather than in a prescriptive manner. Counselling Psychologists can aim to increase client expectations, hope about change, general sense of optimism, self-efficacy and coping strategies. In order to integrate theory, research and outcomes successfully into clinical practice, however, interventions to promote growth following trauma need to be framed sensitively, with awareness that growth may occur in some individuals but not in all.

Summary

The research literature indicates some evidence for the development of post-traumatic growth following adversity, although there are several conceptual and empirical questions that remain, which would benefit from further investigation. Post-traumatic growth appears to represent well-being within a context of suffering, a kind of hope. It has long been recognised that positive changes can come about as a result of suffering (Frankl, 1963, Kessler, 1987). The capacity to find meaning emerging from the experience of loss may be vital to our existence.

Table 6: A summary of studies of post-traumatic growth

The following is a summary of some of the research studies reviewed within the critical literature review.

Author	Title	Design/ measure	*N*	Outcome
Polatinsky & Esprey, (2000).	An assessment of gender differences in the perception of benefit resulting from the loss of a child.	PTGI. The impact of variables of nature and length of time since the loss, age and marital status of the bereaved.	67	Bereaved parents were found to perceive benefits, with a greater relation of benefits to those bereaved through illness, and the longer time elapsed since bereavement. Poor evidence to suggest differences in benefits due to gender.
Bonnano, Moskowitz, Papa & Folkman, (2005).	Resilience to loss in bereaved spouses, bereaved parents and bereaved gay men.	Two studies: Structured clinical interviews, self-reports, friend ratings of loss and pre-loss adjustment. Subjective researcher ratings. Measure of positive affect.	Over 1,500 .	Groups of bereaved/non bereaved individuals. Resilience was evidenced in half of each bereaved sample when compared with matched non bereaved and 36% of the caregiver sample. Resilience was rated more positively as being better adjusted by close friends.
Davis, Wohl & Verberg, (2007).	Profiles of post-traumatic growth following an unjust loss.	A numerically aided phenomenological approach.	52	Those most likely to report growth saw the experience of bereavement as a threat to the self. May

				need more refined approach, and make distinction between loss and benefits.
Bonnano et al. (2002).	Resilience to loss and chronic grief.	Prospective. From pre-loss to 18 months post-loss.	205 .	PTG and resilience to loss after the death of a spouse. There was no evidence for delayed grief. Those with elevated depression prior to the loss (11%) showed dramatic improvement and low levels of depression during the bereavement. The follow-up showed that there was no evidence of maladjustment or denial among either the resilient or the improved groups.
Peterson, Park, Pole, D' Andrea & Seligman, (2008).	Strengths of character and post-traumatic growth.	Quantitative, empirical, retrospective. Inventory of strengths and PTGI.	1,739	Web based. Small but positive associations among number of traumatic events and cognitive and interpersonal character strengths.
Linley & Joseph, (2007).	Confirmatory factor analysis of the PTGI.	Factor analysis.	372	Support for the original five factor structure, and indicating a higher-order construct with five first order latent variables.

Davis, Nolan-Hoeksema & Larson, (1998).	Making sense of loss and benefiting from the experience: Two construals of meaning.	Longitudinal, prospective. Open ended	205	To assess benefit-finding in bereavement. 6 months after the loss. It was concluded that it was not the number of benefits that held predictive value but whether any benefit was endorsed.
Affleck, Tennen, Croog & Levine, (1987).	Causal attribution, perceived benefits, and morbidity following a heart attack. An eight-year study.	Open ended.	287	Causal attribution, perceived benefits, and morbidity following a heart attack.
Frazier & Kaler, (2006).	Assessing the validity of self-reported stress related growth.	Self reports.	87	Little evidence for self reported growth was found.
Cordova, Cunningham, Carlson & Andrykowski, (2001).	Post-traumatic growth following breast cancer: a controlled comparison study.	PTGI.	70	Cross sectional study (a) compared breast cancer (BC) survivors self reports of depression & PTG with age and education matched healthy comparison women and (b) identified correlates of PTG amongst BC survivors. Groups did not differ in depression or well-being but group (a) showed greater PTG in

				relation to others and appreciation of life, positively associated with prior talking about breast cancer and with perceived life-threat.
Park, Cohen & Murch, (1996).	Assessment and prediction of stress-related growth.	SRGS	506	Most stressful event in past 12 months.
Sears, Stanton & Danoff-Burg, (2003)	The yellow brick road and the emerald city: Benefit finding, positive reappraisal coping, and post-traumatic growth in women with early- stage breast cancer.	PTGI.	60	Explored growth in three different ways and found three patterns of results. In their study of women with breast cancer, a commonly used growth inventory was not related to distress, but to positive mood. The number of benefits to an open ended question was not related to any outcome, and positive re-appraisal was related to a more positive mood and better health.
Smith & Cook (2004).	Are reports of post-traumatic growth positively biased?	PBS	276	University-2 groups. One not linked to event. Found that linking questions re growth to a stressor may lead to caution reporting growth, creating a positivity bias.

McMillen & Fischer, (1998).	The Perceived Benefits Scales: Measuring perceived positive life changes after negative events.	PBS	289	Over 5 years, the most distressing event in the past 5 years included mass killing and plane crash. Using the PBS, some positive associations were found.

Note- PTGI: Post-traumatic growth inventory.

SRGS: Stress related growth scale.

PBS: Perceived benefits scale.

Section D. Client Study

'The use of 'reliving' interventions and optimising psychological strengths in a client suffering with Post Traumatic Stress Disorder'

Chapter 6. Section D: Client study: 'The use of 'reliving' interventions and optimising psychological strengths in a client suffering with Post Traumatic Stress Disorder'

6.1 Part A: Introduction

This client study provides an account of therapeutic interventions, including 'reliving' a trauma, following the clients' traumatic experience. It also demonstrates how the clients' strengths were promoted, within a Cognitive Behavioural Therapy (CBT) case formulation. This study addresses the ways in which the case formulation informed the treatment, and illustrates the cognitive model that was applied. The key interventions and the progress that was made by the client are identified. Finally, a reflective account of my learning from the case is included.

6.1.1 Rationale for the choice of case

This client study relates to my areas of research and clinical interest. It aims to provide an example of individuals' adjustment to a traumatic event. My research study explored a range of responses to the stressful, sometimes traumatic event of client suicide, and the literature was reviewed regarding post-traumatic growth. Within the broad continuum of possible responses to trauma, this case presents a client affected by Post Traumatic Stress Disorder (PTSD). Using Cognitive Behavioural Therapy as a treatment for PTSD demonstrates the value placed of obtaining empirical support for the efficacy of interventions and for adapting the treatment to the client's problems. This case further demonstrates the importance of developing an effective, collaborative working alliance with the client, and how it can assist in promoting change. Focusing on the clients' strengths and qualities as well as the difficulties served to accentuate protective factors which may encourage goal achievement and improve the quality of life. This case illustrates how distressing difficulties may emerge following trauma and how they may co-exist alongside the existing strengths of the individual.

6.1.2 Summary of theoretical frameworks

Cognitive Behavioural Therapy (CBT) is frequently used in the treatment of several mental health problems including PTSD (Ehlers & Clark, 2000). The most characteristic symptoms of PTSD are repeated, unwanted re-experiencing of the event, nightmares and sensory impressions of the event. Avoidance of reminders of the trauma may include avoiding

people, places, or circumstances. Clients may be affected by hyperarousal, which may include hypervigilance for threat, exaggerated startle response, irritability and difficulty concentrating and sleep problems. There may be emotional numbing, feeling detached from emotions and other people, and reduced significant activities. Although many recover, in a significant group, these problems persist, often for years (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995).

While the relief of distress was addressed first, another aspect of my work was to notice client strengths and incorporate these within the case formulation. A strengths-focused approach has been advocated within CBT case conceptualisation (Mooney & Padesky, 2002; Padesky, 2005; Padesky & Mooney, 2006; Kuyken, et al., 2009). Kuyken et al. (2009) recently introduced fresh ideas for suggesting how case formulations in Cognitive Behavioural Therapy may incorporate the principles of collaborative empiricism, client strengths and evolving levels of conceptualisation. A large survey of people who were receiving mental health services showed that the most important outcome for clients are attaining positive mental health qualities, such as optimism and self-confidence, a return to ones' usual, normal self, a return to usual levels of functioning, and relief from symptoms (Zimmerman, McGlinchey, Posternak, Friedman, Attiullah & Boeresu, 2006).

6.1.3 A cognitive model of PTSD

Within cognitive models, anxiety is the result of appraisals relating to impending threat. In conceptualising PTDS from a cognitive model, this may initially appear puzzling, as PTSD results from an experience which has already taken place. Ehlers and Clark (2000) propose that PTSD occurs in the appraisal of a traumatic event and/or its sequel, which produces the common effect of creating the sense of a serious *current* threat. Those individuals with PTSD are unable to see the trauma as being a time-limited event that does not have negative global implications for their future. This threat can be external, e.g., 'the world is a dangerous place', or commonly, internal, such as a threat to ones view of oneself as a capable/acceptable person, who can achieve important life goals, (Foa & Riggs, 1993; Janoff-Bulman, 1992; Joseph, Williams & Yule, 1997; Meichenbaum, 1997; Resick & Schnicke, 1993). The emotional response to events will depend on particular individual appraisals (Beck, 1976).

Ehlers and Clark's (2000) model of CBT for PTSD includes background factors such as the cognitive processing which took place during the event, the nature of the trauma memory, the individuals' appraisal of the trauma and its aftermath, and the strategies used by the

person in order to control the perceived threat. Two key processes are proposed. First, that there are individual differences in appraisal of the trauma and in subsequent events, and also in the nature of the memory for the event, and its link to other autobiographical memories. Maladaptive behaviours are, to some extent, learned, and learning principles can be effective in modifying these behaviours.

In normal memory, the hippocampus stores autobiographical memories with a verbal, story-like element, which are updated over time to include new information, which were termed by Brewin (2001) as VAMS (Verbally Accessible Memories). During extreme stress, however, the danger triggers a flight/fight response and cortisol is released, causing decreased hippocampus function so that fewer VAMS are made. The memories made in trauma tend to have different quality, as the blood supply to the brain is increased, causing non-verbal (not 'story-like') memories to be created, termed SAMS (Situationally Accessible Memories). SAMS are subject to involuntary recall, requiring a 'trigger', and they cannot be updated over time. The person affected by these memories may hear noises, discern smells, and feel physical sensations; the trigger might, for example, be the sound of a bus. Both of these types of memory remain after a trauma, but as SAM's cannot be updated, they can be developed by thinking or talking about the trauma event when the person is not extremely anxious. Slowly, as the memory is processed, increasing features of the trauma will be covered by a VAM, but if thinking or talking is avoided, the opportunity to process the memory and to develop VAM's can lead to recurring PTSD symptoms. (A diagrammatic representation of Ehlers and Clark's (2000) model can be seen in Appendix 13). In conclusion, Ehlers and Clark (2000) propose that the intrusion characteristics and the pattern of retrieval characterises PTSD, which is affected by the way that the trauma is encoded in memory. As a maladaptive coping strategy, the suppression of thoughts connected to the trauma memory is said to increase unwanted trauma recollection. This is the theoretical underpinning for my interventions.

6.1.4 Context of the referral

Mary[1] was referred to the service by a Consultant Psychiatrist. The referral letter stated that she was a 56 year old woman with PTSD following exposure to a trauma at her workplace. The letter detailed the incident when she witnessed the remains of a body following a person being run over by a train. The letter outlined that she had two previous unsuccessful therapeutic interventions over the nine months since this incident which were arranged by

[1] Real names are replaced by pseudonyms throughout this study, in order to protect confidentiality.

her employer. She was taking anti-depressant medication on a regular basis. Mary was affected by high levels of anxiety, a heightened startle response, disturbed sleep, nightmares and flashbacks to the incident. She had been unable to resume her employment for the previous 10 months. The consultant recommended CBT to address these symptoms and confirmed that she would continue to be reviewed on a regular basis within her outpatient clinic.

6.2 Part B: The initial assessment

6.2.1 Convening the first session

I first met Mary in the waiting area where I greeted her and introduced myself. I noticed anxiety and distress in her face immediately. Within minutes of our sitting down together, she was the verge of tears. She looked at me in a bewildered way and her hands shook. She was of heavy build and dressed in casual clothes. As Mary had not met a psychologist before, I began by clarification of her understanding and expectations. Mary spoke openly, in an anxious but trusting manner, explaining that her consultant had referred her. She wasn't getting any better. I explained that although I knew some of her problems from the referral, the purpose of the session was to gather an understanding of her current difficulties from her perspective. This was the beginning stage of deciding how she might best be helped. This session would last about 50 minutes, I explained, and afterwards, with her permission, I would write to her referrer, and her General Practitioner would receive a copy of this correspondence. Mary had a choice to receive copies of correspondence, which she requested.

6.2.2 The presenting problem

Mary explained that she held a senior position with her company and that part of her role involved assisting in serious incidents. She had worked there for over 20 years. This was the first time that she had taken time off, other than for colds. She had witnessed a similar incident in the past, but she had been prepared for that beforehand, and she could not see why she had not been able to carry on as usual following the more recent incident. She spoke anxiously and very rapidly. Therefore, I tried to focus on responding to her with empathy, simultaneously categorising the information of her previous trauma experiences, this recent one, and, importantly, her current appraisal of the situation. I quickly saw that her perception of needing to be able to cope had affected her, and this might lead to avoidance, or safety behaviours.

At an early point, I reassured Mary that we had plenty of time, hoping this would allay some of her anxiety. I assured her that we did not need to talk about everything today, as we would be meeting regularly. I explored any previous therapeutic intervention, as expectations of therapy are known to influence the outcomes (Woolfe, 1996). Mary explained that her counsellors had not really helped, as they had 'just listened'. I was interested in her prior knowledge of CBT. However, according to Mary, the counsellors had 'said very little'. She

was confident that this therapeutic intervention would be effective, as it was to occur within the National Health Service.

Mary reported that her sleep was adversely affected, which worried her. She was afraid that she was 'going mad'. She would wake in the night, feeling terrified after having nightmares. She had stopped going out with friends and to her dance classes. As she had not returned to work, she did housework and watched television throughout the day. She described gaining weight, which she attributed to 'comfort eating.' This contributed to her low mood. Compounding these problems were financial concerns. She spoke a little about the trauma incident, but became distressed and tearful. I assured her that we would not need to discuss it until she felt more able.

6.2.3 Background and family history

Mary had divorced her husband some years before, and had lived alone for about ten years. Until recently, she felt that she had a strong connection with her daughters. She used to speak with her elder daughter daily, although presently they spoke around once a week. She had four grandchildren. Both her parents were now dead. Before the event, she had reached a senior position at work. She had never expected to have done so well. She described herself as being a 'strong person', and explained how others had relied on her to do the jobs that they disliked. Her long hours at work had led to her feeling that this was all she had existed for. If anyone within her company was unwell, she would offer to cover their work. She was angry that no one had been in touch with her, or sent a card, which was usually what she did. This illustrated to me the central importance of her being a 'tower of strength,' and highly conscientious, and it also indicated that she was capable of high levels of functioning. It seemed to show how being needed by others may be important to her and possibly be part of her core beliefs.

6.2.4 The assessment process

Assessment was complicated by the presence of multiple difficulties. A functional analysis included gathering data from various sources, including Mary's psychiatric records and her own verbal accounts. The information was recorded in an initial screening session and data was continually gathered over several subsequent sessions, including details of any physical problems, alcohol use, social interactions and support. Mary did not express suicidal ideation or intentions, and had not previously done so. She did not use alcohol or illicit drugs. CORE (Clinical Outcomes in Routine Evaluation) scores were taken and before and during therapy

at several different points in order to assess various factors, including functioning, suicide risk and any improvement. As Mary was able to partially recall the content of her flashbacks, descriptions of these were ascertained during the assessment sessions.

6.2.5 Choosing an appropriate treatment approach

1. As Mary's symptoms were of over 9 month's duration, this was considered to be chronic as opposed to acute PTSD. The treatment choice in chronic PTSD is trauma-focussed CBT, according to the National Institute of Clinical Excellence (NICE: Clinical Guideline 26, 2005).

2. My client fitted the suitability criteria for CBT (Curwen, Palmer & Ruddell, 2000).

When deciding on the treatment approach, I explained the fundamental assumptions of the cognitive-behavioural model to Mary, the nature of PTSD and how they worked together, so that the choice of treatment became a joint decision. These concepts were subsequently referred to throughout the therapy process, in order to reinforce the help to develop her understanding of the therapy.

6.2.6 Case formulation

Each session explored Mary's difficulties in further detail. Throughout the process of therapy, the case formulation was developed and monitoring of her progress was continual. Initially, Mary was clearly struggling with the impact of her experience. When developing the formulation, my thinking was tuned to both her initial difficulties, and to searching for her underlying assumptions which might lead to an understanding of her core beliefs. It appeared that her experience had activated beliefs and assumptions laid down earlier in her life regarding the need to cope, in fact, to be a 'key' person amongst others who did not do this. Thus, her absence from work led to her perception of now being a different person.

Mary's problems included flashbacks, which did not appear to have any particular trigger and were associated with a sense of terror. Her prolonged absence from work had led to both guilt and financial concerns. It created the lack of a regular routine and previous social contact, as well as the intrinsic rewards that work may bring (Robertson, 1990). Compounding these symptoms were her feelings of anger towards those at work. As she avoided friends and previous regular contact with her daughter, her mood had become low

and she felt increasingly isolated. She reported a lack of ability to concentrate and periods of irritability, feeling that her personality had changed, as she recalled how she had been 'quick witted, out-going, and funny' before. She reported how she sometimes interpreted her problems as a sign that she had permanently changed, although she also held the belief that this intervention would be helpful to her.

When constructing a formulation of her difficulties, a framework for CBT formulation (Dudley & Kuyken, 2006) was used which refers to both the levels and the process in terms of the five 'p's' (presenting issues, precipitating factors, perpetuating factors, predisposing and protective factors). This emphasises what maintains the problem, based on collaborative empiricism (Beck, 1976). From the outset, I was also attuned to noticing her qualities and her strengths. I noticed immediately how receptive and engaging she was, despite her obvious distress. My ideas were discussed with Mary throughout the development of the formulation, and I adapted the terminology so that it was more 'client friendly.' In order to indicate the dynamic nature of the formulation, it is briefly shown below:

Protective Factors:

Amongst Mary's strengths, it emerged fairly early on that she had a good sense of humour and the ability to hold the attention of others. She commented how others had found her to be great company. Her relationships with her sister, her elder daughter and her grandchildren had been rewarding. Mary appeared to have positive expectations of therapy. A sense of hope for a positive outcome and traits of optimism are associated with coping resiliently with adversity (Kuyken, et al., 2009, p. 106). Finally, her job acted as a protective factor, as did her friendships. Over time, her relationships with others were rekindled and further factors emerged, including her energy and religious beliefs.

Predisposing Factors:

These were her appraisals and associated beliefs, which emerged as: *'Others cannot ever understand how bad I feel. I will be seen as weak. Therefore, I will not talk about this'*. The rules and assumptions that Mary held, or her conditional beliefs appeared initially to be connected with the high value placed on being strong and capable. Over a longer period, the rules and conditional beliefs emerged as being connected with one of her core beliefs: *'Only if I work hard will I be safe'*. Subsequently, her core beliefs included her assessment that she did not deserve her position, thus it was associated with the belief*: 'I am unworthy.'*

Perpetuating Factors:

The avoidance of previously enjoyed activities perpetuated Mary's difficulties. Over several sessions, it emerged that Mary thought that her daughter saw her as a person who always coped with life. Another factor that served to maintain her problems was the avoidance of friends and colleagues. Over time, this became less problematic.

Precipitating Factors:

Prior to her commencing therapy, the precipitating factors to her presentation included her experience of an intense sense of threat and fear at night, when she recalled partial memories of the trauma experience. Also, precipitating her mood and presentation were her fears of returning to her previous employment.

6.2.7 Negotiating a contract and the goals of therapy

The following three sessions were arranged. It was agreed that we would meet on a weekly basis for about fourteen sessions of 50 minutes duration. I explained that I could subsequently offer a small number of additional sessions, if it was necessary, and that we would review the therapy in an on-going manner. I explained that I would periodically remind her of the number of sessions remaining. On exploring what Mary wanted to achieve, she explained that she wanted someone to talk to. Subsequently facilitating her to formulate specific goals, over time, her goals included to get to sleep more easily, to feel more at ease with others, and to be able to put the trauma into a different perspective. As she knew that she needed to return to work, this was considered a longer term goal. We discussed confidentiality in relation to sharing information with others, supervision and self-harm.

6.2.8 The approach taken

A CBT approach was adopted from the outset. As might be expected by those experiencing flashbacks, Mary showed a degree of vagueness and confusion (Kennerley, 1996) which protracted the assessment period. The term 'flashbacks', commonly used to describe vivid intrusions of memory, form part of the salient features of identification in the assessment of dissociative disorders (Steinberg, 1995), including post-traumatic flashbacks. They may have a purpose, through the replaying of traumatic scenes, in scanning for ways to protect the individual, thus preparing them for other incidents in the future (Freedy, Shaw, Jarell & Masters, 1992). However they are problematic, distressing, and do not necessarily replicate complete memories (Kennerley, 1996).

The process of intervention had two main stages. The initial stage involved psycho-education. Following a trauma focussed approach to PTSD, it was essential to begin by giving Mary information regarding the development of her symptoms, in order to help her to understand how many people may be similarly affected. I explained the rationale for 'reliving' the trauma event, supplementing my explanations with a client leaflet commonly used within this setting (Appendix 15) which enabled Mary to read more about this at home. She was encouraged to ask questions.

The second stage of intervention involved aiming to give Mary some skills including 'grounding techniques,' in order to help her to feel in control of her symptoms when they were triggered and then work to try and directly address the symptoms to try to stop them being triggered. As this was a chronic trauma, reliving work with cognitive restructuring was planned for the memories specifically linked to the trauma and the worst part of the memory of the traumatic event.

6.3 Part C: The development of therapy

6.3.1 The pattern of therapy

Mary and I met for a total of 17 sessions of individual therapy, on a weekly basis for the first seven sessions. There was a break over a holiday period. We then met weekly for five further sessions. After that, Mary cancelled two sessions and we recommenced therapy in the final phase over several weeks on a weekly and then on a fortnightly basis.

6.3.2 Beginning therapy

The first few sessions involved building a rapport with Mary. Several of the initial sessions, within the context of gathering more information, focussed on developing a sense of trust and rapport, while Mary explored her thoughts and feelings about her situation. I empathised with her overall sense of helplessness, simultaneously gathering information about her symptoms, and building a more complete picture of her as a person. The efficacy of a cognitive and behavioural technique is dependent in part on this relationship, with the need for warmth, accurate empathy and genuineness (Beck, Wright, Newman & Liese, 1993). Building a collaborative relationship was easy as Mary was immediately likable, being open and expressive. However, her confusion and her expression of several issues in a fragmented manner, moving quickly from one topic to another made it difficult for me to follow her. We built up a good rapport during these sessions as I was able to demonstrate my acceptance of her confusion and her difficulties and I attempted to 'normalise' her reactions.

When I explained the model to Mary, technical language was kept to a minimum, so that she was basically aware of what CBT was and the influence of memory and processing of the event. This presented a challenge, especially in explaining the role of memory, but presenting information gradually and referring back to it in subsequent sessions aided the learning process. Mary's confusion, anxiety and distress may have related to her experiencing of flashbacks and to her lack of sleep as well as the distress that she experienced within the sessions.

When identifying her most urgent problem, Mary was most disturbed by her lack of sleep. To assist her in relaxing during the night, we explored a range of strategies including developing a bedtime routine, avoiding caffeine and remaining in bed when she awoke rather than getting up. She also decided to establish a regular time to rise.

6.3.3 Initial difficulties in the work

Managing the session time presented a challenge due to the complexity of issues that arose and the time required to explore these. A tension was the need to build an effective working alliance, combined with the introduction of specific techniques to effectively address some of her difficulties and symptoms. Her sometimes erratic flow of speech made it a struggle for me to identify her specific concerns. Internally, I tried to connect her difficulties to her underlying core beliefs, which, retrospectively, was unnecessary, as these emerged later. The need to give Mary time to talk seemed to me that we could not begin the reliving the trauma or the preparation. However, this was required before reliving the trauma could begin, and, on reflection, seems to have been part of the essential period of preparation.

6.3.4 Key interventions

During subsequent sessions, both to help with addressing her flashbacks, and as a way of grounding herself to the present during the planned reliving work, Mary needed a range of 'grounding techniques'. These were, ideally, to cover as many sensory modalities as possible, to counteract the flashbacks. If possible, they should be tangible, portable, and pleasantly linked with the present. Any image needs to be of a safe and soothing place. Kennerley (1996) offers various suggestions involving imagery, a phrase or an object associated with a sense of self, present and safety, to help the client to 'ground' themselves in the present. Imagery is also useful as relaxation exercise, covering many sensory modalities, and needs to include a 'way in,' such as a doorway or a gate. The phrase: *'I am Mary, a mother and a manager'* was decided on. As her 'flashbacks' were sometimes associated with a sense of worthlessness, this phrase 'reset' the current situation and focused on her achievements. Mary immediately chose her rosary beads for her object, as they were carried in her handbag, and her image was of going through the doorway of her church. These were a source of comfort to her. These techniques were practised several times until they came to her easily.

In the subsequent process of engaging her in 'reliving' the traumatic event, I began with reminders of her ability to use grounding techniques effectively, with her beads at hand. The process included imaginal exposure to activate the fear network (SAMS: Situationally accessible memories) in a controlled manner. I explained that she was to keep her eyes closed, or stare at the wall to avoid making eye contact, as this may provoke feelings of unacceptable intensity. Mary was to describe the events as if they were in the present tense and in the first person. To assist her, I gave her a fictitious example. She was then helped to

talk in as much detail as possible, beginning at about 10 minutes before the incident, up to the point where she felt safe. Mary described being at the incident, holding a torch and what was said. By asking *'what can you see, what can you hear, what are you thinking?'* Mary was able to recall up to seeing certain items. Then she faltered and stopped speaking. At this point, we used the grounding technique of her visualising going through the door of the church and she repeated her phrase. As Mary was frequently distressed, I limited the first and second sessions to this point, and she was reminded to say her key phrase. At fifteen minute intervals I summarised to see if I had understood and to show empathy, also using this as an opportunity to introduce the next steps of the process. As with my other clients, I found it difficult to engage with her when her eyes were closed, as I was so used to seeing her emotions within her eyes; thus, I observed her tone of voice and her capacity to carry on with her story. Mary struggled to keep her eyes closed, so I gently reminded her of the need to keep them shut, smiling as I did so.

The remaining stages were introduced very gradually. By our fifth session of reliving, Mary was able to recount the entire incident. 'Hot spots' or specific memories causing her high levels of distress were identified, including her recollection of specific body parts and her association of these as being part of a person who possibly had a family. Another crucial area was the coldness she perceived had emulated from colleagues, which Mary understood as callousness. We audiotape recorded the session and the tape was given to her to listen to for 'homework'. Step two involved sessions exploring the 'hot spots' and developing 'updates' to be incorporated into our next session of reliving (Grey, Young & Holmes, 2002). This brings in new meanings, to update her SAM's with VAM's, and included her current fear, and feelings of shame and guilt at not being able to carry on as before. This was to prevent continual reactivation of SAM's in the form of flashbacks and nightmares. The aim is to transform the meaning of the trauma recollection as being a past event, not to discover the 'true facts' (Kennerley, 1996). The schematic representations she had may be reconstructed from roots within childhood.

Within the sessions, I focused on Mary's capacity to remain in the present tense, which frequently faltered and resumed when she was describing the events in the past tense. I was responsive to her emotional reactions and empathic to her clearly expressed distress. Later, I allowed myself to reflect on her traumatic experience and I realised how hearing the details of this had affected me. I felt I needed to talk to my colleagues. They subsequently shared similar experiences, a process which I experienced as being very comforting.

Mary's appraisals included the others involved in the incident as being callous. I was empathic to her sense of being isolated in her reaction. I hypothesised, internally, that the responses of colleagues might be their way of coping with their anxiety. In a subsequent search for alternative explanations, we questioned the evidence for her conclusions. Encouraging the development of 'updates' was similar to the usual CBT techniques, as the development of rational evaluations was aided by the use of tools commonly used in CBT, including 'Thought Records', enabling connections to be made between a situation, her thoughts and her emotional and behavioural responses. In searching for a more helpful explanation, Mary was asked to consider an alternative view. Initially, this was: '*They were laughing because they are men'*. I explained how her new explanation was connected to her emotional response of feeling calmer, thus enabling the link between cognitions and emotions to be drawn.

It emerged that Mary worked in a male-dominated environment where difficult issues were frequently made light of. Mary had avoided contacting her colleagues. Gradually, she considered that alternative views might lead to different responses. Her initial thoughts about her colleagues were combined with inferences, such as: '*They should have rung. I would have rung them. Therefore, they don't care about me*', which were elicited through using typical CBT interventions, including the 'downward arrow technique.' In linking these ideas to her core beliefs, the value placed on working hard and caring for others was reiterated. Exploring her beliefs within later sessions led to Mary slowly questioning her beliefs. She also thought that she did not really deserve her position. In this way, the problem formulation developed. Her emerging self-awareness provided another perspective of the origins of her sense of responsibility to continue at work, as her 'global' perception was that she 'should' be able to cope. Thus, it appeared that the trauma event had triggered some underlying schemas and deeply held beliefs about needing to cope with problems at all times.

Helping Mary to construct an alternative trauma related explanation or 'storyline alteration' (Kennerly, 1996) from: *'I am not safe. They do not care, I am alone'*, I asked her: 'What do you know now?' She was able to respond: '*I am OK. I survived*'. Eventually, Mary was able to stay with whole trauma image, and practicing this repeatedly in each session enhanced her capacity to do this. A range of negative emotions and different appraisals were thus activated at the same time, including the view that others did not care about her. The degree of conviction of these varied at different points of time.

Mary listened to her audiotape at home between our sessions. She slowly began to address some of her 'safety behaviours' and her avoidance of anxiety-provoking situations such as

seeing her friends. Managing the session time included reliving the trauma and exploring current problems such as her anger towards others for 'not caring'. Subsequent sessions led to her beginning to question the time and energy she had invested in supporting others.

6.3.5 Liaison with other professionals

Communication with others included copying correspondence to her company's doctor. Mary was asked to authorise the disclosure of this. An initial letter and an interim report indicating her progress were sent. At the end of therapy, a closing report detailed the interventions and the overall outcomes achieved. In addition, discussions with Mary's psychiatrist took place informally, which were useful to share our impressions. This communication enabled the others involved in her care to be aware of my involvement and for us to maintain a cohesive management plan.

6.3.6 Changes to the formulation and plan

After about 8 weeks of therapy, Mary discussed the possibility of a gradual return to work. This became a focus of exploration and a source of anxiety until she was told she did not need to return to her previous role. The formulation changed with her circumstances and goals. Her work gradually emerged as having a protective function, as it was invaluable in helping Mary's mood improve and to resume a routine. As she demonstrated humour and warmth in her interactions with me, this was noted with the factors that appeared to have a protective function. Seligman (2002) describes individual strengths as being personal qualities, including kindness, integrity, wisdom, the capacity to love and be loved, and leadership abilities. Close relationships with others, which were stronger before the traumatic incident appeared to be a powerful source of protection to Mary. I also became aware of the value she placed on her religious beliefs. These factors were incorporated into the case formulation as a dynamic process, across situations and time (Luthar, Cicchetti & Becker, 2000; Masten, 2001, 2007; Rutter, 1987).

Mary's perceptions of her experiences, related to the violation of her personal rules, were under a process of revision. Her relationship with her daughter remained as a 'protective factor' within the case formulation and developed as Mary began resuming contact with her. These changes informed my interventions in terms of reviewing and evaluating the success of the achievement of her goals. When Mary began to feel more positive and stronger, her goals included devoting considerable time and energy to her family. The focus of therapy shifted from symptom reduction to developing her self-observational skills, underlying

assumptions and strategies that enabled her to review her well-being and to respond effectively.

6.3.7 The use of supervision

My supervisors' initial reaction to the case disturbed me slightly, as she queried why Mary was so upset by the trauma, if this was part of her job? It seemed that my supervisor could not understand Mary's reaction. I responded to her doubts by sharing the formulation, explaining that this was the second trauma she had been involved in, and that Mary was unprepared for her response to it. I slowly became aware of my need to defend her as I wanted my supervisor to understand her difficulties. I realised, through my discussing the case, that I had strong feelings of attachment to Mary. My supervisor began to see how the event had triggered her 'core beliefs' and the whole picture gradually emerged. Subsequently, my supervisors' affirmations of the work encouraged me. I do not believe that my attachment to Mary was unhelpful, but I was surprised to only learn of the strength of this within the context of supervision.

The effect of Mary's vivid trauma descriptions also meant my utilising clinical supervision to reflect on my responses to the images that she had described. It also helped me to reflect on ways of caring for myself. My supervision sessions were a source of comfort, as I could express my feelings concerning the details of the trauma incident, which helped to lessen its overall impact.

6.4 Part D: The conclusion of therapy

6.4.1 Outcome of therapy

Over time, it appeared that Mary's 'spirit,' her original character, and her enthusiasm was returning. She asked me if her 'new memory' would be like her memories of a wedding. I explained that whilst her memories could not become happy ones, it was hoped that eventually they would be less connected with fear in the present. Mary slept better, but never had an unbroken night's sleep, although her waking during the night with feelings of terror reduced.

Mary remarked on several occasions that the others in the waiting room looked 'dreadful', and that she hoped that she would 'never be like them'. It seemed to me that this indicated her desire to recover. She was socialising more and although she did not initially enjoy it, eventually she described events with far more enthusiasm. Seeing her daughter more frequently brought her a great deal of joy. Additionally, Mary took extra care with her appearance, showing the employment of some adaptive strategies. Over time, the changes were more marked. I noticed that she had lost some weight. These differences provided another area in which I could point out her strengths, as her appearance seemed to reflect some positive internal changes.

Mary's overall perception of herself was beginning to change. She adapted slowly to her new role, surprising herself as her view of work altered, seeming to illuminate a shift in her core beliefs, with less concern for others' views and with less importance focussed on her work. Mary subsequently perceived that her difficult experience had led to her gaining new priorities. For example, she spent more time and energy with her family, rather than focussing her energy at work for long hours. This resonates with reports of post-traumatic growth, as, following experiences of loss or trauma, some individuals are said to gain new perspectives and to perceive a strengthening of family bonds (O'Leary, et al., 1995; Tedeschi & Calhoun, 1995). These changes also demonstrate how the difficulties that some individuals may experience following trauma can co-exist with the gaining of new understandings and the utilisation of their existing resources.

6.4.2 The therapeutic ending

The ending of therapy was signposted from the outset as Mary was aware that the sessions were time-limited. However, it was useful to her for me to remind her, at intervals, of the number of sessions still remaining, although there was some flexibility in this. Mary was sad during our last session. The ending of therapy also raised feelings of sadness in me, as I liked her so much. Ending with Mary reinforced to me the temporary aspect of the attachments that are made with all of our clients, through the very nature of the work. Although we may become a central figure in their lives, they, too, may be important to us.

6.4.3 Reflections of the therapeutic process and my own learning

Through this case, I learnt more about tailoring CBT to the client's needs. Cognitive behavioural therapy was an effective framework for the interventions with Mary. Being armed with written, easily understood information to back up my explanations, combined with Mary's enthusiasm to recover made explaining the rather complicated CBT model of PTSD easier. The therapeutic relationship was at the centre of our work together. She had engaged with the process of therapy, within and between sessions, and I found her a delight to work with. This may have been influenced by her easy rapport.

Enacting the CBT principles requires that the case formulation is a dynamic, evolving representation that may remain the same for some sessions, but is constantly under revision. Using the problem/goal orientation of the formulation enabled me to work strategically, planning ahead and anticipating the stages of change; for example, by addressing Mary's most distressing difficulties in sleeping first, before moving on to the demanding 'reliving' interventions. My explaining the formulation to Mary in everyday terms had been helpful. The case formulation, as the framework for intervention planning, had provided an understanding of her problems and helped lead to appropriate intervention techniques.

The reflecting of her strengths had seemed to boost Mary's awareness of her resources and appeared to reinforce her plans and goals. Viewing her 'distress through a strengths lens' (Dudley, et al., 2006, p. 117) had reinforced how difficult responses to trauma and the capacity of some individuals to overcome these may co-exist. I came to understand how certain areas of Mary's life were important to her, such as her relationship with her daughter. Through recognising the avoidance behaviours that maintained her difficulties, I also saw

how her capacity for warm, caring relationships could be a protective element for her, improving her well-being.

The therapy had provided Mary with an outlet for difficult, distressing feelings of shame and horror within a safe space. I learnt more of the value of normalising these responses, which helped Mary to feel that there was hope for changing. The main component of the therapeutic process appeared to centre around my being aware of Mary's need to explore current problems, combined with the necessity of introducing specific interventions based on her trauma experience. My anxiety about delivering interventions to begin the reliving work meant that at times, I found it difficult to achieve this balance. However, regular summaries within the sessions helped Mary gain some clarity and also served to help to keep me focused.

I appreciate how the development of our therapeutic alliance helped to facilitate the delivery of interventions specifically for PTSD, as we decided on 'grounding techniques' and identified 'hot spots' in advance. In addition to specific interventions, we identified her 'safety behaviours' and the thoughts she had around others. Her thoughts and behaviours, linked to her deeply held core beliefs emerged over time. Mary ultimately gained a deal of self-understanding concerning her main 'caring' role, subsequently resuming many enjoyable aspects of her life. Thus, conventional CBT strategies and specific interventions to address her problems around the trauma were employed, combined with strategies aimed to improve her functioning and her quality of life.

Whilst I was seeing Mary, I reviewed the literature base of Cognitive Behavioural interventions in PTSD and discussed the case with a colleague, an expert in trauma work. I was also fortunate to attend a seminar on reliving work in PTSD which reinforced many of the principles underpinning this intervention. Some researchers note that misconceptions may affect the widespread use of 'reliving', including reluctance in some therapists to use it as it causes distress (Bryant, 2008; Rothbaum & Schwartz, 2002). However, Foa (2006) argues that avoidance of reminders of the trauma and restricting routines may lead to chronic symptoms of PTSD and that exposure therapy is a safe treatment with benefits that can remain long after therapy finishes. Bryant, Moulds, Guthrie, Dang, Mastrodomenico, Nixon, Felmingham, Hopwood and Creamer, (2008), in a randomised trial of 118 patients, investigated the extent to which cognitive restructuring would augment treatment response when provided with exposure therapy. Their findings suggest that optimal treatment outcome may be achieved by combining both exposure therapy and cognitive restructuring.

Ehlers and Clark (2000) note that while it is unclear exactly why 'reliving' is effective, several aspects may facilitate elaboration of the trauma memory. Reliving the trauma memory claims to link together the previously unconnected parts of the experience, giving them a context. The context given to the memories may reduce triggering isolated parts of the memory, such as images of the trauma, in Mary's case. Reliving may facilitate elements of memory that are difficult to access otherwise. It may facilitate problematic appraisals, such as Mary's perception of 'callousness' in her colleagues. It may also relieve distress, linking information received after the trauma to correct impressions and thoughts during the trauma, so the event poses less current threat. Finally, reliving of a trauma may facilitate client discrimination between 'then' and 'now', with recognition of how the stimulus differs from those during other safe events (Ehlers & Clark, 2000).

While many propositions of Ehlers & Clark's (2000) model remain to be tested, there is support for several central features, particularly negative interpretations of initial PTSD symptoms (Ehlers & Steil, 1995; Dunmore, Clark & Ehlers, 1997; 1998; 1999; Ehlers, Mayou & Bryant, 1998). Negative interpretations of post-trauma responses (Dunmore, et al., 1997; 1998; 1999) have been shown to predict PTSD persistence. In addition, Foa, Molnar and Cashman (1995) found that improvement in PTDS is related to the extent to which the trauma narrative becomes more coherent. Finally, a review of the literature of exposure methods, including focusing on and describing details of the trauma experience, indicates strong support for further well-controlled studies applied across trauma populations (Rothbaum & Schwartz, 2002). As a Counselling Psychologist, I am privileged, through training, to appraise relevant research and apply it to my practice.

In conclusion, through this case I learnt to be more reflexive. Discovering ways of caring for myself during trauma work is an evolving process. It seems to be very important to share feelings about trauma cases when we may be affected by our clients' material. I also leant how my attachment to Mary led to my wanting to 'protect' her. For both of us, it seemed, the ending was difficult, and I learnt more about my capacity to contain my feelings of sadness when ending therapy. Finally, I feel that I did some valuable work with Mary, in finding a balance between the client's need to explore their problems and the application of specific techniques. Hopefully, the gains derived in therapy will remain with Mary. I am left with strong feelings of warmth towards her. This piece of work has empowered me, both the application of CBT for PTSD and in providing therapy at the clients' pace.

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APPENDIX 1

NHS

Local Research Ethics Committee

13 April 2005

Ms Ruth Dallob
Counselling Psychologist

Dear Ms Dallob

Full title of study: ***An Investigation into the Experiences of Psychologists and Mental health practitioners of suicide and managing suicidal clients.***

REC reference number: ***05/Q0302/21***

Protocol number:

Thank you for your letter of 16 March 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 08 April 2005. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully. You should also copy letters of permission received from the relevant managers to the REC before you commence and not wait after 3 months as suggested. This means that as soon as the letters are received you may commence with the relevant team.

APPENDIX 1

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application	On Line Version 4.0	25/01/2005	31/01/2005
Investigator CV			31/01/2005
Protocol	Version 1	25/01/2005	31/01/2005
Covering Letter		25/01/2005	31/01/2005
Copy of Questionnaire Semi Structured Questionnaire	Version 1	25/01/2005	31/01/2005
Letters of Invitation to Participants Letter of invitation	Version 1	25/01/2005	31/01/2005
Participant Information Sheet	Version 2	01/03/2005	30/03/2005
Participant Consent Form	Version 2	01/03/2005	30/03/2005
Response to Request for Further Information		16/03/2005	30/03/2005
Letter to Team Leaders	Version 2	01/03/2005	30/03/2005
Letter of Support from Team Leaders	Version 1	01/03/2005	30/03/2005
Distribution List for Letters to Team Managers			30/03/2005
Debriefing Information	Version 1	25/01/2005	31/01/2005
Applicants Check List NON CTiMP's			31/01/2005
Letter of support - Derick Moore		26/01/2005	31/01/2005
Academic Supervisor CV - Malcom Charles Cross		25/01/2005	31/01/2005

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor and the R&D Department for NHS care organisation(s) that the study has a favourable ethical opinion.

Local Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	05/Q0302/21	**Issue number:**	1	**Date of issue:**	13 April 2005
Chief Investigator:	Ms Ruth Dallob				
Full title of study:	An Investigation into the Experiences of Psychologists and Mental health practitioners of suicide and managing suicidal clients.				

This study was given a favourable ethical opinion by Local Research Ethics Committee on 08 April 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes (1)
Ms Ruth Dallob		PARTNERSHIP TRUST	Local Research Ethics Committee	13/04/2005	

Approved by the Chair on behalf of the REC:

..... (Signature of Administrator)

Ms Carolyn Burden

..... (Name)

An advisory committee to : Strategic Health Authority

APPENDIX 1

APPENDIX 2

NHS

NHS Trust

Ruth Dallop

Tel:

4 January 2004

Dear Ruth

Re: "An Investigation of the experiences of Psychologists of Client Suicide"

Your amended proposal for the above research project has been reviewed by the Trust's Research Governance Steering Committee (RGSC).

The RGSC has considered the research governance requirements including adherence to the data protection issues and I am pleased to confirm that the RGSC has given their approval for you to undertake this project within the Trust.

The Committee also noted that you have now got approval from the Local Research and Ethics Committee and that you are now ready to proceed with your project.

We would like to be notified when the project actually commences and when it is completed we are required to add details of your project to the National Research Register, listing your name as the local contact point.

I hope all goes well with your research.

Yours sincerely,

.....

Joe Lary on behalf of the R&D Steering Group

This letter has been copied to:

Appendix 3: Letter of introduction Letterhead

To: (names deleted)

Re: Research study: An investigation of the experiences of psychologists and mental health practitioners of a suicide and of managing suicidal clients.

I am a chartered Counselling Psychologist conducting a research study for my Doctorate in Psychology with City University, London. I wish to look at how staff cope with working with clients who either express suicidal intentions or who have committed suicide.

I am hoping that you will agree that this is a major worry for all of us working in mental health, and that you will see the value in my research and hence that you may support me to do this work by inviting any members of your team to participate in this research.

The interviews will take no longer than 60 minutes and will take place in a clinical room (which is private and quiet) in the workplace. I wish to interview people who have experience, recent or otherwise, of working with suicidal clients. There is much policy and guidance about how to prevent suicides, given that the Government hopes to reduce deaths by one fifth by 2010. However, there is a paucity of evidence about how we cope when suicides occur, or when we have real concerns that they might.

I wish to focus on:

- How people feel about working with suicidal clients
- How any possible death that may have occurred in their caseload may affect their subsequent work with suicidal clients
- Whether there are implications for support for staff
- Whether there are implications for how investigations are carried out
- How well people are informed about existing policies and whether they feel they are adequate, and if they know who to tell and what to do when managing a suicidal client

The participants do not need to have had the unfortunate experience of the suicide of a client to take part in the study.

The potential risk of participants becoming upset by their recollections is addressed by my carrying out a de briefing at the end of the interviews, and ensuring that they know how to

seek support afterwards, should the need arise. They may find talking to be helpful, providing a space in which they can reflect. The information obtained will be strictly confidential in that no one will later be identified by their name or occupation.

I attach copies of the Invitation letter and Participant Information Sheets. I hope that you will distribute these to members of your team and ask them to approach me. In order that I can demonstrate to the Ethics Committee that I have gained the support of key managers like yourself, I would be grateful if you would sign and return the attached confirmation letter in the envelope provided. If you need to talk to me further about any aspects, please do not hesitate to contact me on (number deleted). Thank you.

Yours sincerely

Ruth Dallob (Chartered Psychologist)

Appendix 4: Letter of invitation Letterhead

Dear Colleague

Title of Project: An investigation of the experiences of psychologists and mental health practitioners of a suicide and of managing suicidal clients.

I am conducting a research study as part of my Doctorate (DPsych) at City University and I would like to invite you to take part. It will involve an interview, which will be completely confidential. No one will identify you or where you work. I have attached the Information Sheet, which gives you all the details.

The study has been approved by my supervisors, Dr Malcolm Cross at City University, Dr Jennifer Newton at the London Metropolitan University, and (NAME DELETED) Head of Psychology Services. It has received approval from the Trust's Research and Development committee and The Local Research Ethics Committee.

Thank you for taking the time to read this.

Yours Sincerely,

Ruth Dallob (Chartered Psychologist).

Appendix 5

Letterhead

May 2005.

Participant Information Sheet

Study: 'THE EXPERIENCES OF PSYCHOLOGISTS, PSYCHIATRISTS AND MENTAL HEALTH PRACTITIONERS OF MANAGING SUICIDAL CLIENTS AND SUICIDE'.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part, but I will be very grateful if you are able to find the time to do this.

Background and Aims

The reason I am carrying this out is to explore the experiences of mental health professionals of managing suicidal clients. Should one of our clients complete a suicide, studies show that there are common factors in our emotional reactions, which can include guilt and anger as well as pain, and I would like to explore these, and compare the outcome with existing studies. Also, our reactions are similar if we have a suicidal client on our caseload, and many people do not feel adequately trained to deal with this.

I would like to ask you about any guidance, training and support that you have received and whether you feel that more and different support is needed. I would also like to look at the investigation process that follows a death through suicide, looking at the effect on the staff member, and eventually feed this back to the Trust.

Why have I been chosen?

You have been asked because of your experience of working with clients who have felt suicidal. You do not need to have had the unfortunate experience of a client committing suicide to take part. You will be one of 12 participants from within the Trust.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to, you will be asked to sign a consent form. It is up to you if you decide to withdraw from the study. If you decide to withdraw at any time, there will not be any effect on you.

What will happen if I take part?

If you agree to take part, I will book a private room for us to meet. I will ask you some questions, which will take about 40-60 minutes. I will record the interview and later the tape can be wiped clean. The notes made from the tapes will not be attributed to any particular

person. Nothing will be traceable back to you. You will never be identified in any way, nor where you work or your occupation. In the unlikely event that you discuss issues that put clients at risk, this would be discussed with your manager.

Once the research is complete, I will feed this back in bullet points to provide an overview to all who take part. Some of it may possibly be published in the future, as a paper in a journal such as Counselling Psychology Review.

Possible Disadvantages to taking part.

It may be upsetting to discuss the difficulties of managing suicidal clients or if a client you knew has committed suicide. However, at the end of the interview, a debriefing takes place, and you will be told about how to seek confidential support in the future if you wish to.

Possible Benefits to taking part.

It is one of our worst nightmares that one of our clients kills themselves, and we can struggle with managing suicidal clients and the anxiety this creates. You may find it useful to talk with someone objective about the level of support you feel you have. The interview will provide a confidential space in which to reflect on any difficulties in this area of your work. It may be useful to look at what you find helpful, in terms of support, and what support you have.

The research study may subsequently affect the way events are managed in the future, as potential suicide is a real issue for those of us in mental health care.

This will hopefully influence Trust policy, perhaps in terms of the levels of support provided and a review of the guidelines that exist. There may also be a benefit in terms of recruitment and retention of staff, and training.

Please can you contact me on (number deleted) to arrange to meet. If I am not there, please leave a message and I will get back to you as soon as possible.

Thank you.

Ruth Dallob
Chartered Psychologist

Appendix 6: Letter of support

Letterhead

Date

Dear Ms Dallob

Re: Study: 'THE EXPERIENCES OF PSYCHOLOGISTS, PSYCHIATRISTS AND MENTAL HEALTH PRACTITIONERS OF MANAGING SUICIDAL CLIENTS AND SUICIDE'.

This is to confirm that I am happy to distribute the Participant Information sheets and letters of invitation to some of my team. I am in support of the research, and aware that there is no 'institutional association' (e.g. the researcher does not share the same office or have any other working contact with the potential participants).

Yours sincerely

SIGNED:
PRINT NAME (BLOCK CAPTITALS):
Date:

Appendix 7: Semi- structured interview schedule

Can you tell me what experience you have had of working with clients who had active plans to commit suicide?

Prompt questions:

How did you feel at the time?
Who did you talk to about it?
How did you feel about telling them?
What do you think of the support that you received?

Has a client you were working with died by suicide? (If no, go to question re support)

If yes: Prompt questions:

How did you feel at the time?
Who did you talk to? (supervisor, colleagues, family?)
How did you get support at the time?

Was there an investigation?
How did you feel about it?
How did you feel afterwards?
Did it affect your work with other clients?
How do you feel about the support you received?

What do you think about the support that you have in managing suicidal clients?

Prompt questions:
Who gives you support?
What else do you need?

What do you think of the training you received in this work?

How do you feel about working with suicidal clients now?

Appendix 8

Letterhead

Title: "An investigation of the experiences of mental health practitioners of managing suicidal clients and suicide."

Consent Form

Researcher: Ruth M. Dallob

1. I confirm that I have read and understand the information sheet dated April 2005 for the above study and have had the opportunity to ask questions.
2. I understand that my participation is entirely voluntary and that I am free to withdraw at any time.
3. I realise that the interview is to be audiotape recorded.
4. I agree to take part in the above study.

Signed ..... (Participant)

Signed..... (Researcher)

Date .....

Appendix 9: De-briefing

The interview is over now. Thank you for speaking with me. I wonder if you are aware of how to get some further support if you feel that you need it at any point in the future?
Do you have anything more that you feel you need to ask about? If you would like a copy of the transcribed interview this can be arranged. At the end of the research project I will let you know the outcomes. You can withdraw from the study at any time. Please contact me if you decide to do this and the tape and records will be destroyed.

I hope that you have had a satisfactory experience of taking part in this research. If you need any support, I can give you some information. You know that you can talk with your supervisor, your manager, and you may know already that there is a telephone counselling helpline that the Trust provide free of charge. It is ICAS NATIONAL SUPPORT –PERSONAL SUPPORT LINE 0800 072 7072. It is available for 24 hours a day, 365 days a year. It is completely confidential. Also, there is face to face counselling available. (Give details if needed. Trust's Workforce Wellbeing Service, it is also confidential). Access is via the free helpline.

Thank you again for participating in the interview.

Appendix 10: Process issues: Reflexive diary

I am a Chartered Psychologist whose practice with clients with mental health problems puts me at the sharp end of this area of work. I have over 10 years experience in the field working with adults in a range of settings. My daily clinical practice has an edge which involves searching for aspects of suicide risk in clients; risk assessments are made with each client see. In a previous setting a client I had seen later went to hospital and died, while in hospital, by suicide, as I heard later. This was a shock to me. I found myself with lots of unanswered questions, about whether if I had seen him again, anything would have made any difference. The death of my grandfather was probably another influencing factor in deciding on this study topic, although it was on the periphery of my thoughts when considering this. It left me with a sense of unease.

Some assumptions I held before carrying out my research were that people might be hurt or angered by the investigative process following a death by suicide in the health service, and that they might feel anxious about working with clients in the future after a death. The following provides a reflexive record of the unfolding experiences I had whilst interviewing, and will help me to bear this in mind when analysing and identifying the themes.

August 2005

I am so relieved, excited and anxious all at the same time. I think this has been in the planning for so long, and it was difficult getting through the Ethics Committee, I secretly doubted it would ever happen. My participant actually articulated my own opinions of suicide and risk, and choice to die, but I have not verbalised it. She described her transition and the way her opinions changed. There is a lot of positive identification here, and I must try to be aware of it when writing up. Also, I see where what she says supports much of what I've read in the literature. It is beginning to look like I will have enough participants.
I was deeply touched by the support shown by one of the team leaders who clearly has tried to help me. He also wrote a supportive letter to the Ethics committee saying that he thought it was a very useful project.

Interview

It was asked for a psychologist to be available to them at all times. This made me think they wanted me to help. I came away slightly flustered and frustrated.

Interview

I felt a little irritated by the interview process when with 'T'. This may have been because I could not hear him properly. The recording was clear and audible for my voice but not for his- this may be a speech difficulty, as it was just partially inaudible. More than that, I had some difficulty connecting with the material, the content of what he brought. I wanted to see it through his eyes and appreciate the differences in our training and background but this process felt difficult.

Interview

During the last interview, the lady seemed self conscious of the audiotape recorder, and I had set it out where she could see it, although I later placed some magazines over it to try and conceal most of it. Noises from outside the room were intrusive, and I felt annoyed by them. I regretted the equipment needed to some extent as I was disappointed by the amount she disclosed and it seemed the presence of the equipment was partly responsible for this.

Interview

I am so pleased she agreed to be taped, to participate- experienced and confident. During the recording I feel we come from the same place, the same understanding of the issues. Yet I am impressed by her ability to really not feel responsible when a client of hers did commit suicide, as I secretly think I would partly through fear of the whole process.

Interview

During the interview with 'X', I felt in awe of him. He knows so much and articulates so clearly it is a privilege to spend time listening to his views. I felt if ever I had a problem- he would be so good to talk to and surely this is how his clients feel. I identified with his desire to probe, to get to the bottom of things, and yet I wondered about his lack of support. He seemed isolated. He had the ability to 'hold' and contain other's anxiety. I was impressed too, that he was confident and seemed to engender support. He spoke of active listening. I was hot, and at times I found it hard to focus, as there was a lot of noise outside. It was a real learning experience in the way he saw the person in the service, and spoke often of individual clients he had treated.

Interview

I was struck by her articulately stated views and great sense of humour, too. I enjoyed being with her- as I usually do. She articulated some of what I feel- that people do have a choice- and that we are not essential to them- although we know we do have an important part to play- that believing we are somehow omnipotent to the client is very dangerous- to them and us too... Her confidence was impressive. I think I feel less confident.

End of the interviews.

It took so long and felt repetitive. I now have the next stage of analysis ahead and it feels lonely and daunting, yet I still so much want to plough on and begin to feel again as I used to that I am making progress and doing something productive towards it. It now feels daunting to begin the analysis so I am still tidying up the transcripts and checking them. It feels daunting to begin the next stage but my supervisor and head of services have both offered to help go through the themes once I have identified them. I also have some anxiety that I have an adequate number of participants. I have looked at some recent articles which very much support the numbers I have used in terms of being overwhelmed by the quantity of data otherwise. That is a relief.

While transcribing I became aware of what seems obvious, but is really striking- that those who are nurses see the process far more punitively- and seem to feel they would be punished more than others. Is this to do with training and expectations? This could well be the case, and yet it is such a small sample this could be purely an individual thing, yet because of my background I do think it is more due to training. I will need to be aware of how my values and beliefs are potentially to shape the way in which I analyse this.

Now several months into the transcribing I never thought it would take so long, offered some help and gratefully accepted. I will need to listen to all the tapes to really re-appreciate the process and context of the written word, or else a great deal may be lost in the discussion and writing up stages. When doing this, I do not really look at responses to questions asked just focus on what has been generated. Heuristic methods of conducting research allow the process to be fluid. Fontana and Frey (2000; 657) present a view of interviewing that matched what I did: 'interviewing and interviewers must necessarily be creative, forget how-to rules, and adapt themselves to the ever-changing situations they face'. In the analysis of themes I will try to present a fair representation, recognising my own bias and including all points of view. This will present a different perspective and must be taken into account. I

think that when I present the rich findings, the quotes used will lack the impact of hearing their voices, the inflections and pauses, yet I have tried to show this in the verbatim transcribing.

A great deal of my learning has been about seeing how others view the work, this intimate work we do- and how they value it what it gives them in terms of satisfaction and reward, feeling that they are digging deep with someone to help them understand themselves better and contain self destructive urges. This has helped me reflect on my motivation too- as I listened to the participants; I began a process of self-examination about what I do and what drives me. This is also to help clients understand themselves better and see other ways forward in that there is hope and often a lot of enlightenment which releases them from self punishing ways of seeing their situation. I tried to be seen as a researcher during this, but also to be seen as myself, and this applies to my practice too. We perhaps need to consider how we can be more authentically ourselves during the therapy process. I am beginning to see the research as a process of learning and reflection and I love the fact that it is there for me- some other part of my whole identity, yet within me all the time. It's almost like a place to go where I'm doing something that's for me, a place or space in my mind that I go to, in order to work on elements of my research. At the moment, there is so much data and so many themes to come from it that I feel confused as to how it will emerge, it is not in shape. I cannot as yet make it take shape and it feels messy and needs so much to be gradually shaped and straightened.

May 2006.

Now in year 2, I have conducted and transcribed all the interviews. My supervisor is encouraging and affirming. I have begun the pulling of data into the first theme. The first theme is the emotional aspects when having experienced a death. It is hard to put into one as so many others run into it, but to have sectioned off each one first is definitely the solution then go through each either adding or disconfirming the first. It feels exciting to be at this point so far ahead yet still with a mountain of work. This part demands a systematic thorough approach.

June 2006

On reflection, I feel satisfied with the amount I have achieved. In just over a year to have actually conducted and transcribed the interviews, as well as getting approval is a fantastic amount of work. I am now writing up the first and second themes, including themes I was

not expecting, really trying to see how the different people drew me to them and my processes of identification. In the actual choosing of quotes to include it seems inevitable there will be bias, it's unavoidable. It reminds me of person-centred work, in my choosing what part of the client's meaning to respond to, there is for me a struggle to be truly person centred. I am trying to show connections between the themes too. I went to a Research meeting held in the department and was enthused. I came away feeling supported and encouraged by the others there.

Year three

At the final stage now. I had at times doubted I could finish this. I have learnt about my own tenacity and learnt to deeply value the support others have given. The methodology allows a degree of flexibility. Importantly, it helps the research to stay alive, by showing real accounts given by real clinicians. I hope this study makes a contribution.

Appendix 11: Draft of Information Sheet for clinicians:

What to do after a client dies by suicide

The Initial Reaction

The death by suicide of a client can happen to anyone, often in spite of the best efforts of all concerned. When a client dies by suicide, you are faced with the emotional impact on yourself and your colleagues, the client's family or friends and other clients. Initially, you may experience a range of emotions, including shock, guilt, anger towards the client and disbelief that this is happening to you. Fear of what will happen to you is a very common feeling. These feelings can persist and you need to know where to turn to for help and support.

To question yourself and your practice, and wonder why the client did this and whether you might have done something differently to prevent it are also common responses. As the loss of a relationship has occurred, it is very 'normal' to feel a range of mixed emotions. The impact on the individual may vary, depending on many factors, including your relationship with the client. Other factors include:

- Whether you work within a team or saw the person alone
- Whether the death occurred whilst you saw them in a ward situation
- Whether you are the Care Co-ordinator
- If you have already experienced a death by suicide; your response to this death may trigger some of those previous feelings
- If you feel you can express your responses openly with colleagues or a supportive manager

Any investigation into the death

To try and discover as much as possible about the next stages may be a relief, as being prepared will reduce anxiety. The inquiry itself may take up a great deal of time, disrupting normal routines. The trust's Clinical Risk Department, who manage serious incidents, will advise on all the steps needed, but the following is offered as guidance.

Communication

The Consultant or head of the clinical team will inform the client's family as soon as possible. They need to know what has happened and may need to vent their feelings. Whether the clinician caring for the client becomes involved in this will vary on the circumstances. A duty of confidentiality to the client still exists. The Trust policies should be followed for guidelines on what else is done regarding reporting and documentation.

Seeking Support

Feelings of being under scrutiny, being potentially blamed and feeling inadequate are common. It may be possible to seek out others who have had this experience. Clinical supervision may be an opportunity to express your personal feelings and response to this event. Your manager may be the first person to whom you turn. Informal support can be very useful. It may be helpful to confide in a member of staff with whom you have a comfortable relationship. For confidential telephone support, ICAS, our employee assistance programme, has a 24 hour helpline which is available to all staff. The Trust also provides individual confidential counselling. You can discuss this with your manager. If you feel the impact is severe, your General Practitioner may be able to offer a referral for more specialised support.

Should there be an inquest, ask for support from the persons responsible for managing Serious Untoward Incidents. The Clinical Risk Department will provide advice. Team support at this time can be invaluable, as many staff have reported feeling that they are 'in the dock' (Hodelet & Hughson, 2001, p 3). '*Therapists in Court- A Legal Resource Guide*' (Bond & Sandu, 2005) addresses many aspects of legal processes and what can be expected. Dr Gavin Newby of the Pennine NHS Trust has also written a guideline for staff. When processing this event, if you question yourself about what might have been done differently, it is important to remember that many suicides cannot be prevented.

Meetings

Attending meetings to discuss the client suicide has been found by some to be helpful in learning the facts about the situation. They may be helpful and can lead to seeing the event differently. The Trust aims to avoid attribution of blame and to see if lessons can be learnt. Others, in the future, will be in your position and you may be able to advise them from your experiences.

Reflection on the events may lead to your being able to see that the organisation may change something as a result, if necessary. Others may come to you for advice, although it may not feel this way at present. If we can aim to make these events as open as possible the stigma attached to this can be reduced and we can hopefully learn from these sad events.

	Appendix 12: Table of superordinate and subordinate themes		
Subordinate themes	**Superordinate themes: examples**	**No of refs:**	**No of prtpts:**
Understanding the client and self	**Superordinate theme 1: Being with suicidal clients**		
	'I think, some level of despair or helplessness' (Bill 3.14)	10	6
	'The vast majority of problems are dynamic issue within communication and need to be understood at that sort of level. That requires a degree of confidence' (Jane 1.16)	12	6
	'Hold that situation and wait and see what's actually going on and spend some time talking about it. The issue begins to clarify itself' (Bill 3.21)	13	6
	'When you reveal that problem, you see, you realise the depth of distress' (Liz 4. 21)	12	6
	'What's useful is to try to understand the human dilemma' (Bill 5.6)	17	6
	'I probably have a high anxiety threshold' (Robert 6.11)	4	3
	'I need to believe I've done everything in my power to help that person and if they decide to commit suicide then there's nothing more I can do' (Jason 7.3)	8	3
	'I've got first-hand experience that this happens' Bill 6.20)	12	4
	'The baggage we bring to every blooming client' (Alistair 4.2)	17	4
	'Personal experience influences some of my feelings about it' (Liz 4.1)	10	4
	'Because, (...) had done it,' (Janet 5.5)	17	4
	'I'm not sure what it was about (...) but it felt, at the time, to be around my personal stuff.' (Liz 6.21)	16	4
	'Trying to re-generate some understanding within. Otherwise, you can't do your work' (Janet 3.1)	12	4
Vulnerability	*'You see the person and they are okay. Then, you go home and review how you manage the risk, over and over'* (Sally 2.5)	12	6
	'It's the one thing in the work that stays with you, I	5	6

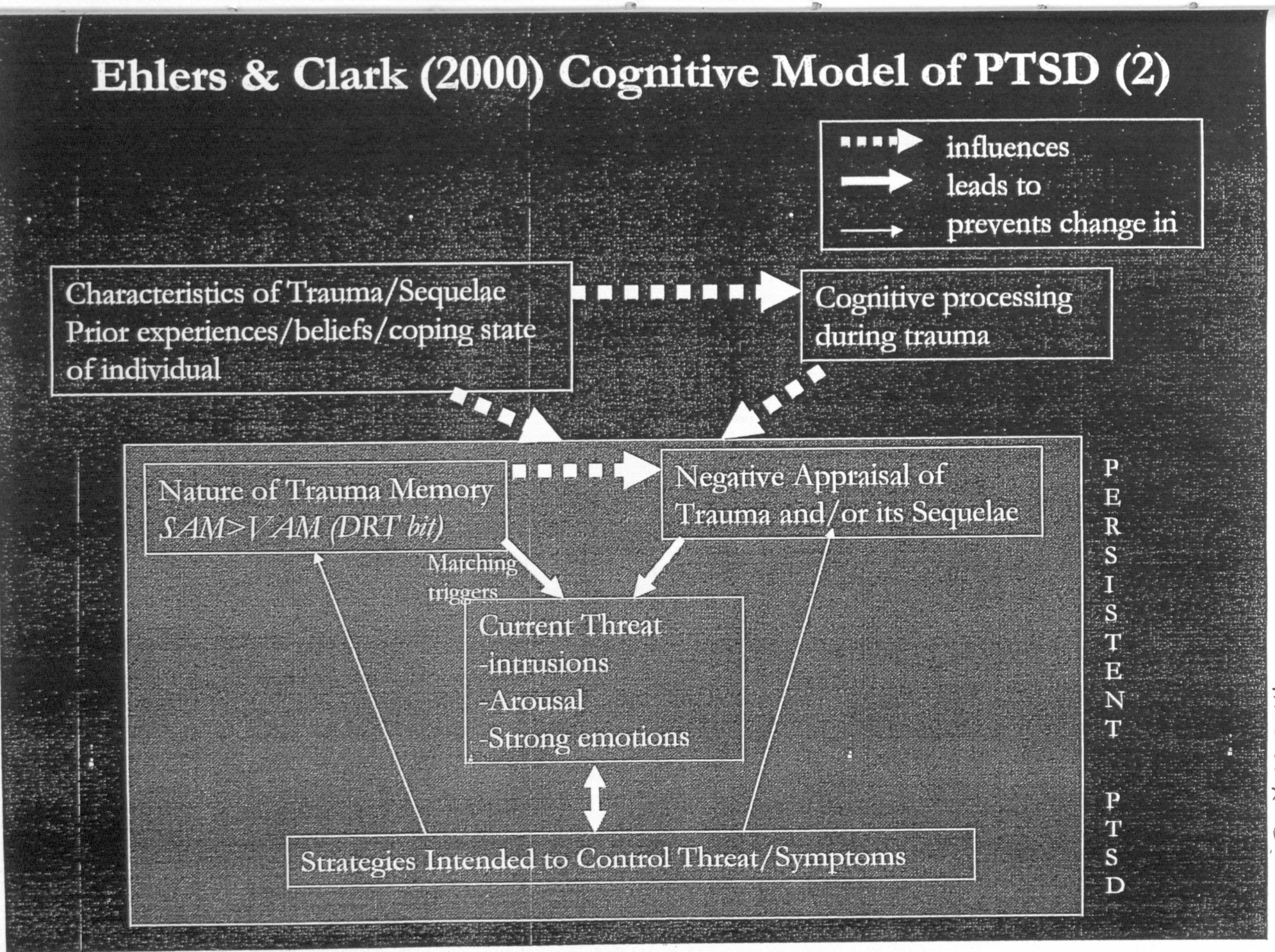
	think. You can't switch off at the end of the session, you do take it home with you' (Jenny 2.13)		
	'I would talk about it at home, I'd talk about it at work. I think: 'here we go again, what's happening here? The support is never enough. It doesn't matter what strategy you use, those who mean to do it, will do it. Is it going to affect your confidence?' (Ben 3.13)	5	6
	'If there is somebody you are really uncertain of, what are they going to do? I don't see how you cannot have that affect you, that will affect your outside life' (Sally 2.20)	12	6
	'You always question yourself. It only takes that one per cent' (Alistair 5.2)	19	6
	'Sometimes, you feel almost impotent, because there isn't anything you can do' (Alistair 2.18)	5	5
	'It can be some of our most anxious times' (Bill 2.24)	7	6
	'I always worry about them' (Jason 4.15)	5	6
	'What if he's not found? If it happens, is it accidental?' (Sally 2.4)	4	6
	Superordinate theme 2: Impact of client death		
Inexplicability and fear	*'She was a lovely lady... she was so well'* (Liz 6.1)	17	5
	'It really upset me more, because she was getting better' (Ben 6.12)	15	5
	'I was gobsmacked. I would have put him at the bottom of the list' (Jenny 2.21)	18	5
	'God, have I done something wrong here?' (Pam 1.19)	19	4
	'Are my notes up to date? Which was an awful thing to think of' (Jenny 2.31)	12	4
Starting to make sense	**The therapeutic relationship**		
	'She had a wonderful sense of humour...she made me feel welcome' (Jim 3.17)	9	4
	'You do have an attachment, you can't help it' (Liz 2.7)	12	4
	'I suppose, professionally speaking, you don't have favourites' (Jason 4.12)	11	4
	'She was new to the service, so I think it was harder'. (Sally 1.7)	13	2

	'This was a planned attempt over a period of time. I felt abused' (Jim 6.1)	9	3
	'There was no concern for us, though' (Alistair 4.12)	11	3
	'He did not allow me in, not that one' (Peter 3.19)	7	4
	'when she died, I realised you almost go through a bereavement process, it does affect you'	12	3
	'I was very sad. I think it's important to grieve' (Jenny)	12	3
	'I had a similar reaction to that of (...)' (Sally 5.8)	7	3
	Failure		
	'I felt quite disturbed, and I felt, in some sort of way- I think there was a sense of failure around' (Ben 4.2)	16	4
	'You cannot help, despite everything else, taking it your track record as a failure' (Jim 6.3)	17	4
	'Despite our good rapport, I wasn't able to help her' (Jenny 4.9)	18	4
	'I did feel that I'd failed him. It was awful' (Jane 5.12)	12	4
	Searching for reasons		
	'All the questions about whether it was deliberate' (Jason 4 19)	15	6
	'Rattling around is that she hadn't meant to do it' (Alistair 7.3)	12	6
	'Should he have been higher risk? You do go through that' (Robert 4.7)	8	2
	'Her, as a sort of risk...I still question my judgement' (Jason 2.12)	9	2
	Superordinate theme 3: Subsequent Influential Experiences		
Being under scrutiny	**Powerless in unfamiliar territory**		
	'We had some lectures on suicide risk at college, but I had no idea of what comes after' (Jason 3.21)	6	4
	'I had no preparation for it, and I can remember being quite shocked' (Jason 4.13)	7	4
	'We were not prepared' (Alistair 2.15)	4	4
	'I discovered that the relatives were there, it was distressing' (Ben 6.12)	8	4

	'If you haven't been through it, you don't know what it's like, and some of the newer ones, they have no comprehension' (Jenny 6.2)	12	4
	Exposure		
	A battery of questions, attempting to challenge my reliability as a practitioner. I felt it violated me'. (Alistair 7.3)	10	4
	'Oh, it was a witch-hunt at the inquest, I had an hour and a half in the witness box' (Jim 4.1)	9	4
	'It was awful, to have to justify absolutely everything that I did' (Jim 4.21)	16	4
	'I don't like going to coroners court, I don't really like going to any court' (Jenny 3.11)	3	2
	'It goes through every one of my clients' letter boxes. That was hard' (Liz 3.19)	7	2
	'We get slated in the press, you know' (Alistair 7.3)	3	2
Seeking comfort as protection	*To basically say, wait for the complaint, which was almost like a threat'* (Liz 3.14)	4	6
	'Working in this team, I really kind of felt reassured by the team manager' (Alistair 6.12)	3	2
	'The procedures were explained to me, I felt supported by my managers' (Sally 6.17)	3	2
	'Our cluster is very supportive of each other' (Jason 3.14)	4	2
	'We have a sort of 'group anxiety' (Ben 3.21)	4	2
	'Everyone starts looking at you, you feel quite terrible' (Pam 3.17)	3	1
	'Only the receptionist' (Jason 4.20)	1	1
	'He was very good, he was very fair' (Jason 3.18)	3	2
	'This is a form of support, this meeting this afternoon' (Sally 3.19)	4	
	'Supervision is absolutely essential' (Liz 2.21)	3	6
	'At supervision and at home, I needed to have space to talk. Supervision helped me to detach' (Alistair 3.14)		
	'I didn't have the opportunities, you know, to talk, I still met this person and it was a lot of hurt' (Jim 5.18)	6	7
	'The way supervision was, a lot of supervision is looking at current caseloads, and once you have died,	7	3

	you are not on the current caseload' (Liz 7.5)		
Evolving	**Changed responses**		
	I get quite anxious now, you know, if someone has a history of suicide' (Liz 7.3)	5	6
	It's left me with a lot of anxiety with suicidal people' (Jenny 6.17)	4	6
	'It's always there and it makes me worried' (Pam 7.3)	3	6
	'I don't angst about it, I feel quite clear about it if I put everything into place' (Peter 5.13)	2	5
	'I usually see it coming, it's part of the territory now' (Sally 7.2)	4	5
	'If I didn't have some anxiety I'd be almost negligent' (Jane 8.2)	3	5
	'It does challenge your practice' (Jim 6.13)	4	
	'I've only had one client top themselves. I was upset at the time, but we have to live with that' (Peter 7.12)	4	5
	'My risk profiles are immaculate, purely because I now understand that people do kill themselves' (Sally 5.11)	3	2
	'I have now have very clear boundaries with people who are suicidal' (Ben 6.21)	2	2
	Emotional needs		
	'A group is what is needed' (Sally 6.17)	4	2
	'We need adequate follow-through, a group where we can share these issues' (Jim 4.20)	3	2
	I've always had my doubts about the value of de-briefing' (Peter 6.19)	3	2
	'I see this as part of my de-briefing. I think that de-briefing is absolutely crucial' (Ben 4.25	2	2
	'The support you need gets lost. We need someone neutral and more objective, impartial, the personal touch. It needs to be delivered by a skilful person, a psychologist' (Liz 3.23)	4	2
	'We need lots of communication, you could employ somebody full time' (Jim 4.10)	4	2
	Self perception		
	'I have become more fatalistic' (Sally 3.21)	3	2

	'I don't know how I will react, how it would challenge me' (Peter 4.18)	3	2
	'How would I feel? I-I would ***hope*** *that I would be okay. That would affect me greatly'* (Jenny 6.13)	4	2
	'I was left with an effect on my confidence as a practitioner (Liz 7.21)	14	6
	'You try to make yourself tough over the years, not to make yourself compassionate' (Jason 4.17)	3	1
	'It's real work, life and death, it's a privilege, despite the difficulties' (Alistair 4.20)	2	1
	'Deal with suicide more pragmatically. Maybe I'm doing a marathon' (Peter 4.12)	3	3
	'I suppose I've got more used to it, as time has gone by' (Jim 3.12)	6	3
	'Somebody said to me: 'treat it as a learning experience" (Jason 8.3)	3	2
	'It was much, much later, when I had a supportive supervisor, that helped me come to terms with it' (Jenny 5.17)	4	2
	' Everyone now comes to me' (Jim 5.4)	1	2


Ehlers & Clark (2000) Cognitive Model of PTSD (2)
influences
leads to
prevents change in
Characteristics of Trauma/Sequelae
Prior experiences/beliefs/coping state
of individual
Cognitive processing
during trauma
Nature of Trauma Memory
SAM>VAM (DRT bit)
Negative Appraisal of
Trauma and/or its Sequelae
Matching
triggers
Current Threat
-intrusions
-Arousal
-Strong emotions
Strategies Intended to Control Threat/Symptoms
PERSISTENT PTSD

APPENDIX 13

- The answer to this lies in the way in which the individual responds to their experience of having undergone a traumatic event.

If the person is able to think about and talk through the traumatic experience, this will slowly cause their VAM memories to be updated (remember this is possible with VAMs). As they do this, they will gradually increase the number of features of the trauma that are included in the VAM memory, and in doing so, increase its power to "trump" more and more SAMs. So whereas immediately after the event, the person may have only 50 of the 100 features of the trauma encoded as a VAM, after a couple of weeks of thinking through and talking about the incident, this may have increased to 80 features. Eventually all 100 features will be encoded in the VAM and the person will no longer be bothered by the SAMs anymore.

However after a traumatic event, some people feel so upset and frightened that they try not to think or talk about what happened. Alternatively, the person may have coped with difficult situations in the past without needing to talk things through and may simply not consider this as a coping option. Whilst these responses are very understandable, the problem is that they do not allow the VAMs to develop and be updated, leaving the SAMs free to intrude.

Furthermore, because the SAMs are so unpleasant, often people will try to avoid any situations or reminders of the traumatic event. Whilst this may help to reduce the occurrence of some of the SAMs in the short-term, it means that in the long-term the chances of actually talking about and thinking about the event, and therefore developing the necessary VAMs are reduced further.

- **So how can we go about treating PTSD?**

One treatment that has been shown to be very effective in helping people who suffer from PTSD is called "reliving". This involves the person with PTSD working with their therapist to develop the VAMs needed to trump the SAMs. This is done by the individual telling the therapist the story of the traumatic event, and then repeating this several times, each time elaborating the story in more and more detail. The number of times that the "reliving" needs to be done varies between individuals. For some just a few times will be sufficient, whereas others may need to go through the story more frequently.

Whilst the idea of "reliving" might seem like a frightening thing to do, the therapist will make sure that you are safe at all times and will help you to deal with the feelings that might arise during and after the reliving process. People can sometimes feel anxious immediately after the session when they do the reliving, and it is important to recognise that whilst this feeling is unpleasant, it is not harmful and will gradually fade away. Furthermore, actually allowing yourself to experience this anxiety without avoiding it or distracting yourself from it is an important way of helping to process the trauma more fully which in the long term will lead to much less anxiety overall.

- This factsheet provides a lot of information but there may be bits that you feel unsure about, worries that you have about the PTSD or about the options for treatment. If you have any questions or concerns then you should raise this with your therapist who will be happy to address these with you.

PTSD: The role of memory

- We all use our memories on a daily basis without even realising it, but if you stop and think, you will realise that we have lots of different types of memories.

- Some memories are in a verbal, story-like form. These memories allow us to think back to something that happened to us and tell a story about this in words.

> *For example, imagine two friends, John and Emma having a conversation. John asks Emma what she had for breakfast this morning, and Emma is able to think back, recall what happened at breakfast time and tell John in words "Well actually I didn't have any breakfast this morning. My husband usually makes it while I get the kids ready but he didn't get out of bed in time today."*

- Other memories are in the form of a picture or image that we can see in our "mind's eye".

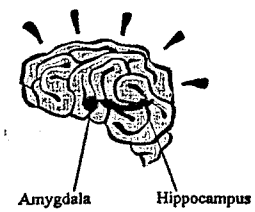
> *E.g. when Emma is telling John about her lack of breakfast, she might have a picture in her mind's eye, a bit like a photo or a painting, of her husband lying in bed snoring.*

- We also have memories linked to our other senses (i.e. touch, hearing, smell and taste).

> *E.g. Emma can recall the sound of her husband snoring, and the smell of bacon cooking from her next door neighbour's house.*

- Sometimes we are able to deliberately bring memories to mind *(e.g. when someone asks us for our mobile number we actively try to remember it)* but sometimes memories are outside of our control and just pop into our minds without us wanting them to *(e.g. Emma might keep having the image of her husband lying in bed snoring pop into her mind while she's at work, even though she doesn't want to and is trying to concentrate on what she is meant to be doing).*

- Memory plays a crucial role in PTSD. In order to understand how PTSD occurs, and the treatment that is likely to help, it is useful to understand the kinds of memories that are formed, both in normal circumstances and at the time when a traumatic event is happening. In order to understand this we need to know that there are two important bits of the brain called the Hippocampus and the Amygdala.



Making memories under normal conditions:

- On a day to day basis, it is the hippocampus that is largely responsible for making our memories. These hippocampus memories have several characterstics:

  1) They have a verbal story-like element to them

  2) We can choose to deliberately retrieve them OR they can be triggered automatically, without us having any control over them.

  3) They can be updated over time to fit in with new information that we become aware of.

     (In the earlier example, when Emma tells John about her husband not getting her breakfast, her memory has an angry "quality" to it and recalling it makes her feel annoyed again that he did not get up to get her breakfast. However, if she went home and found out that the reason he had not got up was because for the last few nights he had been staying up really late to make all the arrangements for a surprise holiday for her, then this could change her memory. The next day, if asked about her previous days breakfast again, the memory would have been updated with the new information and so she would still remember her husband sleeping in and snoring, but this time there might be a loving "tone" to the memory).

- These day-to-day usual hippocampus memories are called **VERBALLY ACCESSIBLE MEMORIES** or **VAMs** for short.

Making memories during a traumatic event:

- During a traumatic situation however, things work differently. When something happens that is very frightening, lots of bodily changes occur. Scientists have found out that one such change is that the blood flow to the hippocampus decreases which means it is unable to work as well as usual. Therefore although, VAMs are still made, they are not as detailed as they would usually be so they may not be able to form a complete account of the event.

- At the same time as the blood flow to the hippocampus decreases, blood flow to another part of the brain, the amygdala, increases. The amygdala is also able to make memories, but these are different to the hippocampal ones in several ways:

  1) These memories cannot be deliberately recalled. They only occur when triggered and this process is completely involuntary.

  2) These memories are not verbal memories like the VAM ones. They do not enable us to tell a clear story about what happened. Instead they tend to be "sensations" and can be
     - physical (e.g. a particular bodily sensation such as feeling sick),
     - sensory (e.g. a particular image, smell, taste, sound, or tactile feeling such as the smell of smoke or the sound of somebody screaming) or
     - emotional (e.g. a particular emotional feeling such as fear or horror).

     When one of these amygdala memories is experienced, the person will NOT remember a verbal story (e.g. "I was driving my car, and I saw a cat in the road so swerved and went straight into an oncoming van"). Instead the person will experience the sensation that they felt at the time again (e.g. they might actually hear the sound of the car brakes screeching, or smell the burning rubber).

  3) These memories cannot be updated over time. Therefore when an amygdala memory is triggered, there is no sense that these sensations are a memory of an event that happened in the past. It is as if the person is *currently* at the scene of the trauma and experiencing these sensations all over again. Therefore when triggered, these kinds of memories can be very frightening because it is difficult for the person experiencing them to remember that they are not in danger now, because it feels to them as if they are.

- These trauma memories made by the amygdala are called **SAMs (SITUATIONALLY ACCESSIBLE MEMORIES)**. It is the SAMs that account for many of the unpleasant experiences that people have after a traumatic event (e.g. recurrent dreams about the event, flashbacks, intrusive thoughts/images about the event).

After the Trauma

- After a traumatic situation therefore, a person is left with both VAMs and SAMs of the event. Because the hippocampus was not working well at the time of the trauma, we have relatively few VAMs and lots of SAMs.

- So imagine that there are 100 features of a traumatic event that can be stored in the memory. In the example given above these features may be things like the sight of the cat in the road, the noise of the tyres screeching and the path that the car took from one side of the road to the other.

  Because of the changes in blood flow that occurred at the time of the trauma, a person may only have VAMs for 50 of those features, but have SAMs for all 100. So there will be some features that have been stored in both a VAM and a SAM format, and others that do not have a VAM memory, and only have a SAM.

- There is an interesting relationship between the VAMs and the SAMs. If a particular feature of the traumatic event has both a VAM and a SAM associated with it, then later on when something triggers the memory of that feature (e.g. reading an article about cars) the VAM memory will "trump" the SAM memory. So what will come into the person's mind is the verbal story of what happened (e.g. "I heard the tyres screeching on the tarmac") rather than experiencing the SAM sensation (e.g. actually hearing the sound of the tyres as if it was happening at the current time).

  If however, there had been no VAM covering that feature, then the SAM of the feature is free to come into the mind unchecked and the person would experience the SAM in its full force.

- Because of the imbalance between the number of VAMs and SAMs following a traumatic event, it is very common for people to experience lots of SAMs in the days/weeks following a trauma. However, whilst for some people these experiences will gradually disappear over time, for others the SAMs continue to intrude and don't seem to go away. These are the people who we would say have PTSD. This all leads us to one big all-important question:

  Why do some people stop being bothered by SAMs and go back to normal, whereas others continue to experience these intrusive memories and develop PTSD?