Title: Talking Through the Silence: How do Clinical Psychologists Who Have Experienced Suicide Bereavement 'Make Sense' of Suicide? – A Thematic Analysis

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Acknowledgements

Firstly, I would like to express my deepest gratitude to all of the participants' who contributed to this piece of research. I thank you for sharing your stories of loss and resilience. I want to also acknowledge those who lost their lives to suicide, whether loved ones or clients, their memories and voices are never forgotten…

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I feel more connected now than ever to the philosophy of Ubuntu: "I am because we are"… I am forever grateful to those who have guided me throughout this process…as it is through them, that I am.

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Abstract

Aims: From the perspective of an insider researcher, this study focuses on how clinical psychologists make sense of suicide, specifically when they too hold their own personal or professional experiences of suicide bereavement.

Method: Twelve semi-structured interviews were carried out with clinical psychologists who had experience of losing a client or a loved one to suicide. The interview data was transcribed verbatim and analysed using Thematic Analysis, according to six-phase framework proposed by Braun and Clarke (2006).

Results: Three themes were identified following analysis. The first theme identified was, 'How talk is experienced as a way of making sense of suicide', followed by the subthemes 'Talk as inhibited', 'Talk as valued', and 'Talk as triggering'. The second theme, "*The messiness of being human*" was followed by the subthemes, 'Suicide as the solution', 'When views are not aligned', 'Walking in the family's shoes', 'The right to live and the right to die', and 'Self-doubt – what could I have said or done differently?'. The third and final theme was identified as, 'An experience that helps clinical psychologists face it', which was followed by the subthemes 'Resilience in the face of risk', 'Suicide loss shaped career', and 'The light within the dark clouds'.

Considerations & Implications: This study offers rich insight into an area with limited research. However, it is acknowledged that there is an underrepresentation of

participants from diverse backgrounds within the participant sample, and limitations related to the author's position as an insider researcher. The results from the study have been considered in light of existing theory, and implications for clinical, policy and research domains are discussed.

Key words: clinical psychologist, sense making, suicide, client, friend, family, colleague.

Chapter 1. Introduction

1.1.   Overview of Introduction

This research investigates the experiences of qualified clinical psychologists who have lost a loved one and/or client to suicide, in order to explore how they made sense of this experience and how this may impact on their clinical practice.

Within this introductory chapter, I will outline my relationship to this topic and outline the definition of key terms. I will offer an overview of the research into suicide bereavement and the key policy documents, and I will outline my epistemological position. I will then present the systematic literature review on the existing research exploring how clinical psychologists experience the suicide of a client, a loved one or a colleague, as well as a narrative synthesis of the evidence base. Following this, the chapter will conclude with the rationale and aims for the current study.

1.2.   My relationship to this research topic

It is important for me to be transparent and inform the reader of my relationship to this topic. I am of Mauritian ethnicity, and British Nationality, both of which I feel very connected to. I was first introduced to the possibility of someone ending their own life in 2001, when my two cousins took their own life within the same year. I remember feeling confused and heartbroken. Growing up in an Islamic community, conversations related to suicide felt too painful, thus a silence prevailed and their suffering remained

unacknowledged. This experience led to my interest in how people understood this phenomenon.

During the second year of training, I was informed that a client I worked with during my first year placement took his own life. This saddened me and shook my confidence as a trainee. Through informal conversations, I became struck by how many other clinical psychologists share a similar story, having lost a friend, family member, or client to suicide. This led to me wonder about the possible impact and unintended consequences of carrying these experiences whilst working within a field where we regularly assess, evaluate and manage suicide risk. Thus, when the opportunity arose to embark on a thesis of my choosing, this topic felt incredibly important.

1.3. Epistemological Position

This thesis employs a qualitative approach using thematic analysis methodology, and adopts a critical-realist epistemological position. This position facilitates the exploration of individual experiences (Wynn & Williams, 2012) and offers the advantage of going beyond the conversation to consider the broader social, historical and cultural context (Miller & Tsang, 2010). As the thematic analysis methodology is theoretically flexible (Braun & Clarke, 2006), it can therefore be conducted within the critical-realist paradigm, which enabled me to situate the participants' responses within their context. All the while recognising that their constructions of suicide will be mediated by their work, their understanding of suicide, and their personal experience itself, along with working within the regulations and policies of professional bodies and services.

1.4.   Reflexivity

My own personal experience of having lost two family members and a former client to suicide has undoubtedly inspired the theme of this project. It is not uncommon for researchers to gravitate towards exploring issues within their own comfort zone which they feel passionately about (Burnham, Palma & Whitehouse, 2008). Paradoxically for me, whilst this is a topic I feel strongly about, it remains out of my comfort zone as it is a topic I have not previously explored in such depth. And based on the sparsity of literature within this field, one might infer that that it is also out of the comfort zone of other researchers also. I am acutely aware of the potential drawbacks of being personally connected to the research, yet I am also mindful to consider the benefits. For example, being an insider researcher has been noted to enhance the depth and breadth of understanding the participant population (Kanuha, 2000). It also facilitates quicker acceptance from the participant population (Dwyer & Buckle, 2009) and allows me to be acutely tuned-in to the experiences of participants (Maykut & Morehouse, 1994).

I acknowledge that my role within this research is not a neutral observer and that I will inevitably shape and influence the research process (Willig, 2013). As I am entering this research from a 'survivor of suicide' and a 'researcher' position, I am aware that this may influence how I analyse and interpret the data. This is seen as operating from an *'insider researcher'* perspective whereby the researcher is a member of the group they are researching (Dwyer & Buckle, 2009; Kanuha, 2000). To support me to monitor the process and become more aware of my biases, regular meetings were arranged with my research team. The team research consultant was

specifically sought out due to the similar themes explored in their thesis, as well as their personal experience of being a 'survivor of suicide'. As mentioned earlier, to promote reflexivity throughout the research process, a reflective journal was kept (see Appendix 1), and a section dedicated to capturing reflections is located in the discussion chapter. In addition to this, reflective sections have been added to offer an overview of some key points of interest and to share some of the reflections experienced during the research journey. These sections will be italicised to help the reader differentiate between the content of the research and the reflective content.

1.5. Key Terms

Survivor of suicide

This term refers to people who have been bereaved by suicide. Farberow (2005) describes the term as "*any and all people, both close and distant, who experience the pain of a suicidal death*".

Suicide

This term refers to the act whereby an individual has intentionally ended their own life (O'Conner & Nock, 2014). Terms such as 'committed suicide', 'ended their life', 'taken their own life', and 'killed themselves' will be used interchangeably when referring to suicide. The evolution of the language around the term 'suicide' is well documented (Wertheimer, 2013) and reflects the challenges the term 'suicide' itself presents. The language has shifted to reflect how the perspective of how suicide is viewed. For example, the term 'committing suicide' derives from the criminal act which

until 1961, would lead to prosecution. The 'Suicide Act' in 1961 decriminalised suicide, yet the language can be seen to be embedded in society i.e. someone has committed suicide. Alterative terms have since emerged reflecting personal choice and agency, such as 'taken their own life', or 'ended their life'. Furthermore, deaths ruled by inquests as a 'death by misadventure' and an 'accidental death' will also be considered and referenced during this thesis. This is because the verdict of a 'death by misadventure' and an 'accidental death' have at times been given for what would otherwise have been a suicide verdict, as findings show that this verdict can vary between coroners (Neeleman & Wessely, 1997).

Clinical Psychologist

For the purpose of this study, the term clinical psychologist refers to an individual who is accredited as a clinical psychologist and currently works within the National Health Service (NHS), private sector or a third sector organisation in the UK.

Loved one

The term 'loved one' may refer to a family member, partner, child, or someone considered dear and close to that person.

Colleague

The term 'colleague' may refer to work colleagues, or a university/school colleague.

Client

The term 'client' refers to a person whom the participant has worked with within a clinical or therapeutic capacity.

Make sense

The term 'make sense', as referred to in the title of the study, refers to how the participant understands the death by suicide, and their thinking around how it may influence their practice, as well as how it is understood within a wider context.

Religion

According to the online Oxford English Dictionary (n.d), religion is defined as "*A state of life bound by religious vows; the condition of belonging to a religious order*". Alternatively, the Latin definition of religion infers a connection between a transcendent power and humankind (Hill et al, 2000).

Spirituality

Spirituality is defined by the online Cambridge Dictionary (2018) as *"The quality of being concerned with the human spirit or soul as opposed to material or physical things"*.

Reflections

When I began reading into the history of the term "committed suicide", I discovered how this term was entrenched in religious and socio-cultural ideologies, so much so that suicide was considered a crime until 1961. I began to think deeply about how I position myself in relation to suicide. I saw myself aligning strongly to the view of suicide as a choice that someone makes. I noticed feeling more comfortable using the terms such as "taken their own life" to describe someone who had "committed suicide" because the term recognises that that the person has some agency. I also feel strongly that when someone ends their life, they do so because they are deeply unhappy, and in despair, and they are even perhaps feeling hopeless. I feel strongly that the language used should reflect this and acknowledge this in some way. It was important to notice these feelings and thoughts that I held in relation to the terms used, in order to be aware of the biases and assumptions that I may hold should participants use the term.

1.6. Prevalence of suicide and suicide survivors in the UK

The topic of suicide is a complex and multifaceted issue. In 2019, the World Health Organisation reported that one person dies by suicide every 40 seconds across the world (WHO, 2019), and globally it is the 14th leading cause of death (O'Conner & Nock, 2014). Statistics indicate that 6,859 people were reported to have taken their own lives across the United Kingdom and the Republic of Ireland in 2018 alone (Samaritans, 2019). Despite this figure, suicide prevention and research on suicide has not received the financial or human investment it needs (WHO, 2014), therefore it

is an area that remains relatively under researched. The impact of suicide bereavement is an emerging field in the UK, and psychologists have contributed to the research by formulating suicidal behaviour (BPS, 2017).

It has been suggested that for every person who dies by suicide, a further 6 to 135 people are affected (Pompili et al, 2008; Cerel et al, 2017). Amongst this figure are friends and family, commonly referred to as 'survivors of suicide'. Each suicide also affects a multitude of systems, including schools, workplaces, faith communities, sports organisations, and healthcare professionals. Within these systems sit mental health professionals who are often faced with risk related concerns. It is understood that one third of people who die by suicide are under the care of specialist mental health services, one third are in contact with their GP but not receiving mental health treatment, and one third had not been in contact with health services 12 months before their death (BPS, 2017). Literature into people bereaved by suicide indicates that they have a higher probability of going on to attempt or complete suicide in comparison to people who have lost someone to sudden natural causes (Pitman, Osborn, Rantell & King, 2016).

There is an emerging literature base into posttraumatic growth which suggests that positive psychological change can occur in the wake of struggling with a highly challenging, stressful, and traumatic event (Tedeschi & Calhoun, 2004). Emerging research indicates that PTG has been shown to be prevalent in suicide loss survivors (Levi-Belz, 2015).

1.7. Overview of suicide bereavement literature amongst healthcare professionals

When discussing the general responses to suicide bereavement, it has been identified that this form of loss is unique to any other type of bereavement as it is associated with blame, rejection, anger, shame and perceived stigmatisation (Jordon, 2001). The stigma attached to suicide in many cultures and societies can taint the grief experience of the bereaved (Biddle, 2003). For these reasons, as well as shame and embarrassment, silence is often employed. Interestingly, it is not just the directly bereaved who may be silenced but the wider system too, as people are often at a loss as to how to respond to others who are experiencing suicide loss (Maple, Edwards, Plummer & Minichiello, 2010).

Amongst healthcare professionals, feelings of empathy, distancing, guilt, anxiety and fear can be evoked when supporting people who are feeling suicidal (Høifødt & Talseth, 2006). This is likely to be related to suicide being the feared outcome. Additionally, therapists may struggle with their own feelings towards suicide, which may manifest and disrupt the development of a therapeutic rapport. In one study, it was found that health professionals were experienced as lacking patience, lacking empathy, and being dismissive of the suffering experienced by people who are feeling suicidal (Corrigan, 2017). Attitudes towards suicide can often be intertwined with both moral and religious perspectives (Domino, 2005). This may have the potential to influence a professional's willingness to help (Bagley & Ramsey, 1986) and may impede the ability to create an effective, therapeutic relationship. Suicide is difficult to talk about and clinicians can vary in their tendency to explore suicidal ideation (Davidsen, 2011). Language may also play a role in how clinicians distance

themselves from conversations about suicide. For example, the use of euphemisms such as "topped himself" and "this sort of incident" (Foggin et al, 2016) may act as a way of avoiding the actual loss and may serve to protect the clinicians by distancing the self from the social stigma of suicide (Malik, 2018).

Moving from an overview of professionals dealing with people who are feeling suicidal to people working in mental health settings, a survey by Neimeyer & Pfeiffer (1994) found that when assessing risk in people who were expressing suicidal feelings, clinical staff (medical and non-medical) engaged in superficial reassurance, avoidance of strong feelings, professional distancing, inadequate assessment of suicidal intent, and failure to identify precipitating problems. The medically trained staff favoured defensive, distancing, advice-giving and dismissive interactions, and non-medically trained staff i.e. counsellors, displayed excessive passivity and failure to structure interactions with a potentially suicidal client. According to Frey, Hans and Cerel (2016), people with a history of suicidal behaviour have reported feeling stigmatised during their conversations with mental health professionals – this included therapists and counsellors. According to Neimeyer, Cerel & Maple (2017), the level of training and experience with suicidal clients is positively associated with suicide intervention skills. An interesting finding by Neimeyer, Fortner & Melby (2001), was that a personal history of suicidality and tolerant stance towards suicide as a '*personal right'* were negatively associated with appropriate responding. In their study, those with a history of suicidal behaviours and thoughts, who considered suicide to be morally acceptable, tended to respond less appropriately to others who verbalised feeling suicidal. Therefore, having a personal history of suicide behaviours, predicted poorer suicide management skills. In line with this, participants who considered suicide

as an unacceptable option were more likely respond in a timely and proportionate way to people reporting suicidal feelings. Findings suggest that personal attitudes regarding suicide may be important to consider for effective risk management of those who report feeling suicidal. The authors suggest clinicians should examine their own attitudes and beliefs towards suicide, and consider the extent to which this helps or impedes their ability to effectively engage with clients who report feeling suicidal.

1.8. Suicide and Clinical Psychology

One in five clinical psychologists are likely to experience a client loss through suicide (Bongar & Sullivan, 2013), yet despite its likelihood of occurring, there have been some queries regarding how much input psychology training programmes offer to this topic (Knox, Burkard, Jackson, Schaak & Hess, 2006). It is important to consider how clinical psychologists make sense of suicide for a number of reasons. Firstly, within the role of a clinical psychologist, assessing and monitoring suicidal risk is an important part of the role and it is often an essential skill listed on a job description. As clinical psychologists work closely with people in distress, conversations are likely to take place relating to suicidal ideation and safety. Secondly, how clinical psychologists understand suicide may influence how they approach the topic and the intervention they decide upon. Therefore, I am curious as to why as a profession there is not a larger emphasis on suicide research, and I am interested in what contributes to the absence of conversation.

1.9.   Spirituality and Religion amongst Clinical Psychologists

The make-up of religion and spirituality amongst clinical psychologists has been a relatively under researched area despite active efforts to promote diversity across the profession. With findings indicating that some psychologists consider God to be guiding their therapeutic work (Lopes de Jesus, 2015), I am also interested in how clinical psychologists navigate the boundaries between their religious or spiritual beliefs and their professional identities. This curiosity is largely inspired by my own understanding of how suicide is conceptualised across different faiths i.e. that suicide is viewed as a sin (Gearing & Lizardi, 2009).

Interestingly, the experience of clinical psychologists who also hold religious beliefs has been fairly overlooked in research and practice guidelines. This may be explained by findings by Post and Wade (2009), who found that psychologists were generally less spiritual and less religious than their clients, therefore the topic may be viewed as less of a priority for exploration. Delaney and Bisonó (2007) investigated the religious and spiritual positions of 489 clinical psychologists via a self-report questionnaire, of whom 258 replied. The findings also indicated that clinical psychologists were less religious than the clients they worked with. This finding is supported by Smiley (2001), who investigated clinical psychologists and their religious status as part of a doctoral dissertation. A questionnaire was sent to 246 clinical psychologists in England, as previous studies took place in the United States. Findings saw that 62% of respondents did not identify with a religion. Figures from the Office of National Statistics (2011) indicate that only 25% of the population across England and Wales

did not identify with a religion. This figure indicates that the religious make up of clinical psychologists is not representative of the population they support.

Research indicates that where clinical psychologists identify as belonging to a faith, this has a positive impact on their work and informs their understanding of complex presentations (Myers & Baker, 1998). Baker and Wang (2004) interviewed fourteen religiously committed Christian clinical psychologists, who reported that they perceived their faith as instrumental to their work, often using prayer as a form of support when working with complexity. As part of a doctoral dissertation research in Counselling Psychology, Potts (2008) interviewed five Christian clinical and counselling psychologists to explore their religious and spiritual belief systems and the impact of these on their work. The author found that they were employing boundaries as a way of navigating differences between their religious beliefs and their professional role as a psychologist (Potts, 2008). Although it was a small study, and despite the focus on a specific religious faith group, the findings suggest that religion remained a central part of the participants' personal and professional identity. As religion and spirituality can be integral to how we make sense of life and death, this has led me to wonder how, if at all, the religious beliefs or spiritual positions of clinical psychologists shapes their view of suicide. This is an area which will be explored as a prompt during the interview.

1.10. Key Policy Documents

I will now present an overview of the key policy documents which relate to managing risk and suicide prevention initiatives in the UK. Whilst this is not an

exhaustive list of policies relating to managing suicide risk, these policies are likely to be the most relevant to how clinical psychologists work with and formulate suicide risk.

The National Institute of Clinical Excellence (NICE, 2019)

In 2019, the National Institute of Clinical Excellence (NICE) published guidance in the form of five quality standards relating to how healthcare services and third sector organisations approach suicide and risk, as well as how they support those bereaved by suicide. The guidance acknowledges the value in including the voices of people bereaved by suicide in the development of strategies and interventions, and acknowledges the support that survivors of suicide require. It is important to note that this guidance currently lacks supporting evidence for its effectiveness and usefulness. It is also unclear whether survivors of suicide were consulted or involved in the creation of the guidance. This may be likely due to this guidance building on previous government strategies which has integrated the voices of people who have been bereaved by suicide (Department of Health, 2012). Despite the document emphasising the importance for people who are bereaved to access support services, there also appears to be no acknowledgement that staff are also survivors of suicide. This oversight highlights the need for the current study, which sheds light on the impact of suicide bereavement from an insider-researcher perspective.

Department of Health (DoH, 2012)

In 2012, the Department of Health published best practice guidance titled '*Preventing suicide in England: A cross-government outcomes strategy to save lives'.*

The strategy is a product of the contributions of those who have been bereaved by suicide, and the National Suicide Prevention Strategy Advisory Group. This document places a large emphasis on ways to support people in the aftermath of a suicide including stating that people are to be provided with support that is timely and effective to prevent long-term distress. Additionally the document stipulates that health services need to ensure that local input is made available in the aftermath of a suicide, and that families, friends and colleagues are provided with information relating to how to access support.

However very little attention is given to the reality that healthcare workers and support staff are also included within this group. It is important that the national guidance recognises the impact that suicide can have on staff groups, which is an area the current research hopes to contribute towards. The guidance does, however, acknowledge that healthcare workers are at a higher risk of suicide, an area which the NICE (2019) document does not acknowledge. Both the NICE (2019) guidance and the DoH (2012) strategy focus on practical changes to suicide prevention, and suggestions for what to do in the aftermath of a suicide, however they do not formulate suicide risk, which would be a key step when considering suicide prevention. Contributions from the BPS (2017) attempt to address the understanding of suicide from a psychological perspective.

The British Psychological Society (BPS, 2017)

In 2017, the British Psychological Society (BPS) put forward a position statement titled '*Understanding and preventing suicide: A psychological perspective'*

(BPS; 2017). Within this position statement, key points relating to how psychological thinking and formulation could facilitate a better understanding of the suicide phenomenon are made. The statement proposes that it is critical that people receive the effective care and support they need, and that early identification of suicidal thoughts and behaviour is key to ensuring this. The statement also points out that, in order to create effective intervention and preventative approaches, it is vital to consider the psychological processes that underpin suicidal thinking and behaviour. Wider contextual factors such as health inequalities, socio-economic deprivation and wider social factors can all contribute to the sense of despair and hopelessness often attached to suicide. The position statement does focus on prevention and intervention programmes, however it does not appear to acknowledge the ethical dilemmas that clinicians may find themselves in. For example, how do clinical psychologists manage any potential conflicts between their own values and that of the wider service policy? And how do clinical psychologists manage when they are working with people who are feeling suicidal, when they too are considered as 'survivors of suicide'?

There is an awareness that those exposed to suicide are at a risk of experiencing traumatic grief (Melhelm et al, 2004), and that those close to the person who died may also experience thoughts of suicide (Joiner, 2005). However, similar to the guidance delivered by NICE (2019) and DoH (2012), the position statement neglects the impact that suicide bereavement may have on clinical psychologists. Further to this, there is no mention of the consultation or inclusion of survivors of suicide in the development of the statement, nor is there a recognition of the dual position that clinical psychologists may hold, as both professionals and survivors of suicide.

1.11. Cross-Government Suicide Prevention Workplan

In January 2019, the UK government published a plan to support the delivery of suicide prevention initiatives across the NHS. One of the key actions of this work plan is to ensure "*every mental health trust has a zero-suicide ambition plan for mental health inpatients by the end of 2018/19*" (HM Government, 2019). The ambition for a zero-suicide initiative was first set out by the former Health Secretary Jeremy Hunt in January 2018, starting with people in inpatient settings but looking to expand to all service users across services. The inspiration for the 'zero suicide' programme in the UK came from the Henry Ford Hospital in Detroit, USA, where a pathway was set up to reduce their suicide rate to zero, which they achieved over a ten year period. Key learning points were brought to the UK in 2013 to attempt to emulate this programme. Twenty-five million pounds was pledged to support the zero suicide initiative and to improve suicide prevention, across three years starting at the end of 2018/2019 (HM Government, 2019). The initiative requires Trusts to *"strengthen the package of suicide prevention measures*" and encourage thorough investigations after all suicide attempts, with a focus on learning from errors. Finally, the initiative promotes a message that suicides in mental health services are not inevitable and are preventable.

1.12. Risk Assessment

Risk assessment forms a key part of managing risk within healthcare settings. This is also the case amongst clinical psychologists. Risk assessments are completed at

the point of assessment and throughout therapy sessions to assess risk and monitor change in the level of risk. This process shapes how clinical psychologists formulate suicide risk and may guide the intervention or response that follows.

How vulnerable someone is to ending their life is likely due to an interaction of social, psychological and biological factors (BPS, 2017). Understanding the cause of suicide remains a heavily debated topic, however current research suggests that the most consistent finding reported by psychological autopsy studies is that the vast majority of people who die from suicide are suffering from some form of mental health difficulty at the time of their death (Muang, 2020 ; Appleby et al, 1999). In a systematic review of psychological autopsy studies, it was estimated that ninety percent of suicides were connected to the person's mental health (Cavanagh et al. 2003). The diagnosis that is reported to have the strongest association with suicide was identified as depression, but comorbid mental health related disorders and substance misuse were also reported as having significant associations. Understandably, social factors were also reported as being strongly associated with suicide, such as adverse events, including but not exclusive to interpersonal problems, abuse, bereavement, and unemployment (Appleby et al, 1999).

However, even with this knowledge, Franklin et al (2017) asserted that risk factors have minimal predictive value in establishing the likelihood of a suicide occurring. NICE (2011) recommend that risk assessment scales and tools are not used in clinical practice as a way of predicting the likelihood of suicide or repetition of self-harm. Rather an emphasis is placed on completing a compassionate and caring psychosocial assessment, which promotes a positive therapeutic alliance between the client and clinician.

1.13. Psychological approaches towards understanding suicide

I will now explore some of the key psychological theories and models, in order to assess how psychology has attempted to understand this phenomenon. Psychological theories are both clinically and theoretically important as they offer a framework to understand the complex interactions that when combined, increase the risk of suicide. It is not yet known whether clinical psychologists use these frameworks as there is no existing research to show which models clinical psychologists use, but they could potentially be helpful in making sense of suicide. The following psychological models and theories consider the factors involved when people experience suicidal ideation (Klonsky, 2014), as well as the factors involved in the progression from suicidal ideation to suicide attempts.

Suicide as an escape from self

In 1990, Baumeister asserted that the main motivation underpinning suicide is to escape from a painful self-awareness and to achieve respite from an unbearable pain and state of mind. He proposed a six step model which starts from a perceived incongruence between reality and expected standards that can lead to a sense of personal failure. Personal failure is interpreted as a reflection of the person's own qualities, skills or characteristics, leading to self-blame which progresses to distorted and negative comparisons of the self with the unachieved standards. The person's self-awareness begins to evoke painful and aversive negative emotional responses and the person attempts to seek respite and escape into a numb state of cognitive deconstruction. Finally, this leads to behavioural disinhibition with the emergence of suicide attempts and suicidal behaviours. Baumeister (1990) emphasises that the

motivation behind suicide is the cessation of psychological pain and the loss of consciousness. This theory offers a valuable contribution to the understanding of why people may take their own life, however it does suggest a linear process and does not appear to account for the wider context, i.e. health inequalities and socio-economic factors. It also does not account for why people may not progress onto the next step.

Shneidman's Theory of Psychache

Sneidman (1993) built on Baumeister's theory and proposed that suicide is caused by '*psychache'*, which was defined as an intolerable and intense emotional pain which varies from a sense of hopelessness, in that the person is considered to have no other solution to resolve their pain but death. Sneidman (1993) suggested that there are two types of needs; primary needs (biological) and secondary needs (psychological). The psychological needs include love and belonging, positive self-image, sense of control, and meaningful relationships. He suggested that '*psychache'* results from failures of the secondary needs being met. This theory can be helpful for clinical psychologists when working with people who have attempted suicide or in trying to make sense of a suicide, as it allows for the exploration of what preceded the suicide attempt and promotes a curious stance. However, this model also does not appear to consider the role of social and economic factors in contributing to a sense of hopelessness. The focus on internal processes may be problematic as this model appears to place the problem within the person by not acknowledging external factors.

Arrested Flight Model (Cry of Pain)

A model which does appear to consider social factors was proposed by Williams and Williams (1997). This model also expanded upon Baumeister's (1990) conceptualisation of suicide and defined suicide as a result of feeling defeated, humiliated or rejected, which subsequently goes on to trigger perceptions of entrapment, which is coupled with an inability to find other ways to resolve the problem. The model considers the role of rescue (i.e. social support) as a mediating factor between suicidal ideation and attempt. The model was inspired by the idea of *arrested flight* in animal behaviour literature and suggests that when people view their attempts to resolve problems as unsuccessful, they perceive themselves to be powerless. This sense of powerlessness is followed by a sense that there is limited opportunity in the future which inevitably leads to a position of hopelessness (Williams & Pollock, 2000). Thus, the risk of suicide is increased when feelings of entrapment are high, and potential for rescue (i.e. social support) is low.

This model conceptualises that suicide and suicidal behaviour is a *cry of pain* and a response to an intolerable emotional state, or an intolerable situational state. The model does consider the interactions between cognitions and emotions, and also acknowledges the role of hopelessness and entrapment in the development of suicidal ideation and suicidal behaviours. This can support clinical psychologists to formulate suicidal thoughts and suicide attempts, and can help in understanding why people may complete suicide. However, this model does not consider the role that previous self-harm and suicide attempts play in conceptualising suicide, which Joiner (2005) integrates into the interpersonal theory of suicide model. Unlike the theory of '*psychache'* (Shneidman, 1993), this model does consider the role of social factors

and social support as a mediating and contributing factor towards suicidal ideations and suicidal attempts.

The interpersonal theory of suicide (IPTS)

A widely used approach is the interpersonal theory of suicide model, proposed by Joiner et al (2005). This theory asserts that suicide risk is heightened by the interplay of three factors: a) the experience of loneliness and isolation known as 'thwarted belongingness', b) the perception of being a burden on others 'perceived burdensomeness', and c) the capability to act on that desire following habituation to self-harm, self-injury and previous suicidal behaviour known as 'acquired capability'. If these factors are present, the theory suggests the person will engage in serious suicidal behaviours (Joiner, Van Orden, Witte & Rudd, 2009; Van Orden et al, 2010), as the belief is that dying is beneficial or worthwhile to others.

A critique of the IPTS model is that it suggests that only the interplay of the three interpersonal factors lead to suicide. This consequently overlooks the role of living with physical pain, incurable terminal illnesses, social factors, cognitive factors and negative life events in contributing to suicide. However, the model has achieved some supporting evidence for the association between suicide attempts and acquired capability (Van Orden et al, 2008). Longitudinal research on a large population-based sample identified that 'thwarted belongingness' and 'perceived burdensomeness' were positively associated with suicidal thoughts (Batterham et al, 2017). However, these studies relied on retrospective reporting, and only included quantitative methodologies.

The psychological models complement the policy frameworks by offering a psychological insight into the different factors which may contribute to people attempting suicide or completing suicide, and these may influence how suicide is conceptualised by clinical psychologists. The psychological approaches appear to promote the message that that suicide is understandable. Yet these messages conflict with the policy message that suicide should be prevented by services, either by force i.e. removing the person to a place of safety where suicide is not possible, or by offering 'support' as described in the policies. This may imply that the 'support' should always be sufficient enough to make life tolerable enough, so that suicide is no longer an active plan. Considering these conflicting messages, I wonder how clinical psychologists, who are involved in supporting people who are suicidal, who are also 'survivors of suicide' themselves, make sense of suicide. These questions led me to completing a systematic literature review.

Reflections

In relation to the zero suicide approach, I found myself trying to maintain a position of neutrality but inevitably found myself critiquing the approach. I found myself thinking that that such an approach overlooks the needs and distress of the person, and places the complete responsibility on the mental health services and clinicians. By doing further reading around this, there appears to be a split between those who advocate for such frameworks, and those who oppose it because of what it may insinuate. By framing suicides as "preventable" and "not inevitable", I thought this indirectly suggests that clinicians are therefore accountable. I noticed myself feeling angered by this, because I believe that clinicians work incredibly hard to support people who present with risk, and each person wants to do their utmost best to alleviate the distress of others, but sometimes this support and preventative measures may not be enough to prevent a suicide from occurring. These reflections are strongly connected to my own experience. When I learnt that a client I worked with took his own life, I remember feeling saddened, but also deeply ashamed that I may have "missed" something, or that I could have put something in place to support the client, which may have prevented him from choosing to take his own life. It was important for me to acknowledge my own stance, and to acknowledge that participants may hold alternative perspectives which may be "for" such an approach.

1.14. Systematic Literature Review

The purpose of the literature review is to offer a narrative synthesis and critique of the relevant research relating specifically to how clinical psychologists make sense of suicide when they themselves have a personal experience of losing a client, colleague or loved one to suicide.

1.14.1. Literature search strategy

The following databases were used to search for and retrieve journal articles and research papers:

- PubMed
- Scopus
- Google Scholar
- Wiley
- APA
- PsychNet

The terminology for the literature review was reviewed and agreed upon by the research team so that the terms would enable a precise search and produce a relevant results. Table 1 demonstrates the search terms used alongside Boolean expressions. The term 'parasuicide' was not included as a search term. This decision was made as the intention was to gather articles based on clinical psychologists and/or psychotherapists, who have experienced a completed suicide, rather than an attempted suicide, in order to understand what the existing literature shares about their experience.

Concept # 1: Therapists including Clinical Psychologists	"Psychologist" OR "Psychotherapist" OR "Therapist"
"AND"	
Concept # 2: Suicide	"Suicide" OR "Take one's own life" OR "End their life" OR "Kill themselves"

Table 1: Literature Search Terms

To structure the literature search process, the PRISMA (2009) flow diagram was used (see Figure 1). A detailed overview of the inclusion and exclusion criteria can be seen in Table 2.

Exclusion criteria	• Articles not in English • Published before 1980 • Grey literature • Non-peer reviewed articles • Letters/reviews/editorials • Commentary articles
Inclusion criteria	• English language • Articles on Therapists/Clinical Psychologists who experience suicidality • Publication date: 1980-2019 • Journals, Abstracts • Published and unpublished theses • Articles on therapists/Clinical Psychologists who have lost a loved one/client to suicide • Articles from any geographical location • Peer-reviewed articles • Studied using qualitative methods of analysis • Studies using quantitative/mixed methods of analysis • Studies with participants aged 18+

Table 2: Inclusion and Exclusion criteria for literature review

1.14.2.   Result of Literature Search
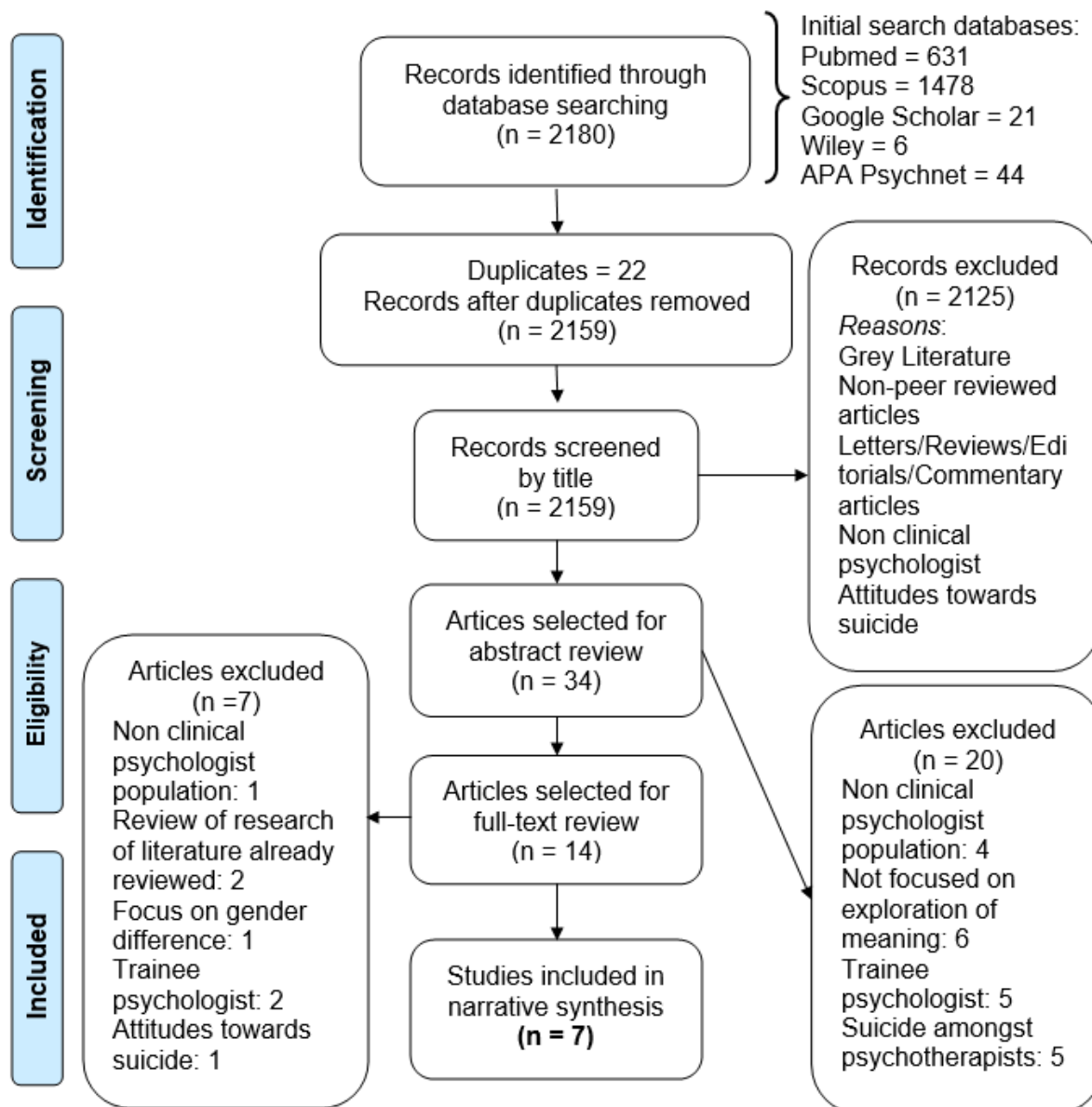
Figure 1: PRISMA Flow Diagram

The search terms for concept 1 (Psychologist, Psychotherapist, Therapist) and concept 2 (Suicide, Take one's own life, End their life, Kill themselves) were entered in each of the previously mentioned databases, and produced the following results.

The initial search identified 2180 articles, 21 duplicates were removed and 2159 articles remained. These articles where subsequently screened by title, which resulted in 2125 being excluded as they met the exclusion criteria and thus were not suitable. Examples of the excluded articles include grey literature, letters, editorials, commentary articles, non-clinical psychologist population, and articles based on attitudes towards suicide rather than actual experiences of suicide bereavement. Articles focusing on trainee experiences were also excluded from the review as the literature search intended to investigate the experiences of qualified clinical psychologists and/or psychotherapists. Once the excluded articles were removed, 34 articles remained and were selected for abstract review whereby 20 were excluded, which left 14 articles that were selected for full text review. Of the 14, 7 were identified as the appropriate articles for the literature review. To support the identification of these articles, the following search parameters were used for each article:

- Between 1980-2019
- Full text
- Abstract available
- Peer reviewed
- English only

1.14.3.   *Quality assessment of research*

Of the studies in the systematic review, five were qualitative and two were quantitative. Of the five qualitative articles, two are written as first person accounts based on the experiences of losing a client or family member to suicide. As the research into this area is so limited, I have decided to include both first person accounts and will endeavour to offer a robust critique of this. Each of the qualitative

articles were assessed using the Critical Appraisal Skills Programme (CASP) checklist which offers a valid framework that is widely accepted in the academic field to systematically appraise the quality of qualitative research (See Appendix 2). To assess the quality of the quantitative studies, the Mixed Methods Appraisal Tool (MMAT) by Hong et al (2018) was used (see Appendix 3). This was selected as it offers a framework to appraise the quality of empirical studies which are concerned with monitoring the population, planning and the generating of hypotheses (Grimes & Schulz, 2002). This tool was deemed appropriate to appraise the two quantitative descriptive studies, which focus on assessing the frequency and impact of client suicides amongst psychologists using self-report questionnaires.

1.14.4.   Outcome of literature search

The literature search resulted in seven articles being identified, a summary of each article can be seen in Table 3 below.

	Author(s), Year, Title	Aim & Methodology	Findings	Implications	Quality
1	Veilleux, J. (2011). Coping With Client Death: Using a Case Study To Discuss the Effects of Accidental, Undetermined, and Suicidal Deaths on Therapists	Review article based on one case study.	Experience of suicide bereavement influenced attention to suicide. Emphasis given to the value of supervisors' non-judgemental position.	Case study of one Written from an insider researcher perspective which may be prone to bias, blind spots and research conflicts. Highlighted need for further research into therapists responses to client death. Implications for support programmes and training programmes.	Assessed using CASP, 2017). Identified as offering limited contribution due to nature article reviewing a case study.
2	Darden, A. J. & Rutter, P. A. (2011). Psychologists' experiences of grief after client suicide: A qualitative study	Qualitative study: Interviews with six psychologists who have lost a client to suicide using Consensual Qualitative Research (CQR) methodology.	Three themes identified: Participants met the criteria for prolonged grief. The work setting influenced the clinicians recovery. Male clinicians reported no personal impact. Participants' did not question their clinical skills after the client suicide.	Lack of generalisability of CQR methodology, Small sample size Ethical consideration – participants likely to re-experience the memories of difficult subject matter.	Assessed using CASP, 2017). Identified as offering valuable contribution to the field of suicide bereavement.
3	Finlayson, M. & Simmonds, J. G. (2018). Impact of Client	Quantitative descriptive study assessing the frequency and impact of	Psychologists' with more years of experience reported more client	Quantitative approach may elicit a limited range of responses.	Assessed using MMAT (2018)

	Suicide on Psychologists in Australia.	client suicide on 178 psychologists in Australia via online self-report questionnaire.	suicides, and a range of emotional, cognitive and behavioural reactions. Ratings of responsibility, preventability and predictability of a client suicide were associated with emotional and/or professional impact.	Does not explore meaning of the questions. Reliance on self-selection sampling. Qualitative exploration is needed in this area.	Identified has having a clearly justified sample, variables, and statistical analyses.
4	Chemtob, C. M. Hamada, G. H. & Rodney, Y. T. (1988). Patient suicide: Frequency and Impact on Psychologists.	Quantitative descriptive study. To study the frequency and impact of patient suicide amongst 588 psychologists via questionnaire.	A client suicide has personal and professional impacts. 49% reported intrusive symptoms of stress in the weeks after the suicide. Client suicide is an occupational hazard for psychologists.	Raised awareness of frequency and impact of client suicides. Large sample size in landmark study. Does not explore meaning, addresses 'what' not 'why'. Lack of validity of questionnaire.	Assessed using MMAT (2018) Identified has having a clearly justified sample, variables, and statistical analyses.
5	Murray-Swank, A. B. (2019). The crack where the light gets in: Exploring therapist transformation following the loss of a family member to suicide.	Qualitative case study sharing a first-person account losing a family member to suicide.	Three primary themes: Challenges of integrating personal experience into professional identity. Enhanced awareness of traditional masculine gender roles in psychotherapy.	In-depth reflections on the personal and professional impact of losing a family member to suicide. Offers an insider researcher perspective which may be prone to bias, blind spots and research conflicts.	Assessed using CASP, 2017). Identified as offering valuable contribution to the field of suicide bereavement.

			The impact on his practice of psychotherapy.		
6	Clark, J. L. (2009). The taboo of client suicide – silenced therapist narratives.	Qualitative study. Academic research paper (dissertation) offering insight into their narratives pertaining to the client suicide of 10 therapists (Psychologists, Counsellors, Psychotherapists) via in-depth interviews.	The findings highlight that client suicide is an inherently disenfranchising experience for therapists within their professional, social and personal arenas.	Small purposive sample Offers description-rich accounts of suicide loss. Ethical consideration –re-experiencing of the memories of difficult subject matter.	Assessed using CASP, 2017). Identified as offering valuable contribution to the field of suicide bereavement.
7	Tillman, J. G. (2006). When a patient commits suicide: An empirical study of psychoanalytic clinicians'.	Qualitative study. To gain a deeper understanding of the effects of patient suicide amongst 12 psychoanalytic psychotherapists via semi-structured interviewed analysed by thematic analysis.	Eight themes grouped into three general structures: Traumatic loss and grief, interpersonal relationships, professional identity concerns.	Offers description-rich accounts of suicide loss. The range of time following the death of the patient to the interview was quite wide (6 weeks to 12 years) and likely affects the data set.	Assessed using CASP, 2017). Identified as offering valuable contribution to the field of suicide bereavement.

Table 3: Summary of selected articles for literature review

1.14.5.   Overview of findings

Within this literature review, an overview of the key findings across the articles will be discussed. Themes were identified through a scientific process of firstly reading each full-text article thoroughly, and extracting the information that was considered relevant (Siddaway & Wood, 2019). Some examples of information that was considered relevant are; participant samples, methodology, research design, and research findings. This information was grouped and critiqued according to the quality of the research. From this process, four themes were recognised to cover the key points across the seven articles (see Table 4).

Theme 1	The "Occupational Hazard"
Theme 2	The Professional Impact
Theme 3	Emotional Reactions to Client Suicide
Theme 4	Supervision

Table 4: Themes from Systematic Review

1.14.6.   Summary of findings

The "Occupational Hazard"

In the early work of Chemtob et al (1988), the term "*occupational hazard*" was coined to describe the occurrence of client suicide as it was reported that one quarter of psychologists will experience a client suicide (Chemtob et al, 1988), with many

experiencing this whilst they are training. At present, the term may be used to refer to a range of dangers people may experience within their workplace or job role, Chemtob et al (1998) first used the term "*occupational hazard"* to refer specifically to client suicide. The authors conducted the original study into the frequency and impact of patient suicide among 365 psychologists. The statistical analysis demonstrated no significant difference in age and years of practice between those who had a client who did commit suicide and those who did not. However, more training was associated with a lower suicide rate. Whilst this was a landmark study which acknowledged the implications of patient suicides on psychologists, the sample itself was heterogeneous in that they included participants with different degree awards (i.e. Masters to PhD level). The quantitative approach did achieve a response from a large participant sample, but did not offer meaningful insights into the qualitative impact of losing a client to suicide. Equally, implications are made regarding training programmes offering more support relating to preparing trainees for the event of a client suicide, but no recommendations are made as to how this can be executed.

Veilleux (2011) offered a review of coping with an unexpected client death, whether that be suicide, accidental or undetermined. The author described how the death of a client can feel like being in '*unchartered territory'*, with no knowledge of how to process a death with professional implications. The literature review reported the benefits of using supervision to '*speak about the unspeakable*'. Differences between survivors of suicide, and survivors of accidental death were described, asserting that that suicide survivors struggle with questions relating to the meaning of life, feelings of abandonment, isolation and feeling stigmatised. Veilleux (2011) advocated for more attention to be given to this topic, and also promoted the importance of training and

support to therapists who experience with the loss of a client to suicide, accidental death, and unexpected death. Veilleux (2011) also writes from an insider-researcher position, offering personal reflections alongside the academic review of literature.

The professional impact

Losing a client to suicide can have a significant impact on one's sense of self, both personally and professionally (Chemtob et al, 1988; Veullieux, 2011). It is not uncommon for psychologists to question their clinical decision making skills (Darden & Rutter, 2011), and become more hyper-vigilant and reactive to suicide risk. For example they may scan for risk factors more often, focus more on the scale of suicidality, and complete suicide contracts with clients more frequently (Veuilleux, 2011; Darden & Rutter, 2011). It can also contribute to an increase in attending to suicidal cues, increased consultations with colleagues (Chemtob et al, 1988). Veilleux (2011) talks about "*professional guilt*" as a response to feeling a sense of relief after a client has committed suicide, particularly in cases where clinicians have struggled to engage a client. A professional crisis after a client's death by suicide has also been reported, this includes, contemplating changing professions, worrying about competence, and a scepticism about the value of treating severely unwell patients (Tillman, 2006). These findings tie in in with the wider literature relating to clinicians' engaging in defensive practice following a critical incident (Passmore & Leung, 2002). Defensive practice is understood as a deviation from usual clinical practice to reduce or prevent complaints or criticism by patients or their families (Toker, Shvarts, & Perry, 2004). It is therefore understandable that a culture of defensive practice emerges following the death of a client by suicide, as the clinician experiences a range of

emotional reactions, i.e. guilt, self-blame, and self-doubt, which will explored in more depth in the next section. Thus, to some extent defensive practice can be understood as protective response.

From a psychoanalytic perspective, a client suicide represents a dual loss, the loss of a client to suicide and the loss of the professional ideal, both involving mourning and melancholia, alongside moral self-reproach and criticism (Tillman, 2006). However there appears to be limited exploration into the impact of suicide bereavement on the personal identities, professional identities, and practice of psychotherapists.

Murray-Swank (2019) offered a first person account exploring the experience of losing a family member to suicide, and reported how this affected his professional and personal identity. It is important to note that this was the only study identified which explored the impact of a personal loss of a loved one to suicide on clinical practice. The author writes from an insider-researcher lens, sharing reflections of losing a family member to suicide, whilst practising as a clinical psychologist. He acknowledges this experience can represent a pivotal point in a person's life, and begins to explore how this personal loss impacts his professional identity, and he also outlines the challenges of integrating the two. However, because it is only one account, the reader should be cautious about generalising the outcomes to the wider Psychology profession, as this may prove difficult due to the subjective nature of insider-research. Nonetheless this article does shed light upon an important area, and adds to our understanding about the impact of a personal loss to suicide amongst clinical psychologists.

Psychologists often work with people whereby suicide is a primary part of their presentation, which can provide both opportunities and struggles for the clinician. Risk

management is considered an integral part of the psychology assessment and preventing suicide is considered central to the work carried out by Psychologists (Darden & Rutter, 2011). The literature indicates that the fear of litigation is high when a client takes their own life, and this can contribute to feelings of inadequacy (Darden & Rutter, 2011). It is unclear how this might apply to NHS UK contexts, and how litigation concerns are experienced by clinical psychologists currently working in the NHS.

A client suicide can lead to concerns related to how colleagues will perceive the clinician and can also contribute to worry, which can in turn contribute to professional isolation. Further to this, the grief process may be complicated by the fear of judgement from colleagues and potential legal issues, procedural requirements and organizational pressures (Tillman, 2006). It is this sense of professional responsibility that differentiates the responses to suicide from responses to other forms of death i.e. accidents or homicide (Veuilleux, 2011). A study by Finlayson & Simmons (2018) used a self-reported questionnaire to gather information relating to the frequency and impact of client suicide. The authors concluded that the greater the sense of responsibility, the greater the emotional response and therefore the greater the professional impact. Results from this study also demonstrated an association between responsibility and self-doubt, as well as responsibility and low self-esteem. Whilst the study was broad and allowed for the feedback of 178 psychologists, this consequently meant that there was little exploration into the meaning and impact behind the themes of responsibility and self doubt.

Recognising the profound impact of the suicide of a client, Clarke (2009) explored the experience of therapist disenfranchisement following the suicide of a

client as part of a doctoral dissertation. Clarke (2009) conducted ten in-depth interviews with therapists to explore their narratives following the loss of a client to suicide. The data revealed three core themes which captured the different features of disenfranchised grief. The findings of this research indicate that the death of a client by suicide can be a disenfranchising experience for therapists, which can have an impact across their professional, social and personal domains. The author identified that there is a 'taboo-ness' surrounding suicide at both an organisational level and at a societal level. This was found to shape the codes of ethical practice, supervisory frameworks and organisational policies. The author also noted a lack of understanding of the impact of client suicide amongst therapists which contributed to the silence around the stories around the death of their clients to suicide. The author offers valuable insight into this topic, which acknowledges the on-going impact of experiencing a client suicide. However, whilst this research focuses on the grief process and the role of disenfranchised grief, how the therapists conceptualise suicide was not considered, which the current study attempts to address. Furthermore, Clarke (2009) interviewed school and mental health counsellors as well as psychologists. In order to gather insight into the specific experience, the current study only seeks to interview clinical psychologists. It is important to note the observation that all of the studies identified in the literature review do not mention the role of spirituality or religion amongst clinical psychologists, nor do they explore the impact this may have had on their experience of suicide bereavement.

Emotional reactions to client suicide

The death of a client by suicide can be emotionally catastrophic (Darden & Rutter, 2011). The authors noted that a large portion of the research in this field was carried out amongst psychology trainees or psychiatrists, and a quantitative methodology was often utilised which does not capture the complexities of this experience. This was also reflected in my systematic literature search. Darden and Rutter (2011) set out to qualitatively investigate the experiences of client suicides amongst six clinical psychologists as participants, using the Consensual Qualitative Research (CQR; Hill et al, 2005) methodology. Some key themes identified from this research are that all participants met the criteria for prolonged grief, and the participants' recovery process was heavily shaped by the work setting they were in. Further observations were that the male participants did not report any personal impact from the suicide of their client whereas the female participants experienced the client suicide as traumatic, and all participants acknowledged the client's decision to end their life was beyond their control. The authors acknowledged the limited sample of six clinical psychologists, but propose that this enabled a richer exploration of experiences of client suicide. It was suggested that feelings of shame and embarrassment about losing a client to suicide, may have prohibited participants from expressing interest in the study. I feel that this is an area that warrants further exploration. As an insider researcher, I noticed that there continues to be a neglect in recognising clinical psychologists as survivors of suicide.

In Finlayson and Simmonds's (2018) study, 56 of 178 participants reported one or more client suicides, with the senior psychologists reporting more client suicides. It was found that psychologists with more than 11 years experience were more likely to

have experienced a client suicide, and psychologists with less than 5 years experience were less likely to experience client suicide. It is understandable that psychologists in the profession for longer are more likely to experience a client suicide. Clinical psychologists were identified as the professional group who were most likely to experience a client suicide, against other disciplines of psychology, accounting for 55% of the overall sample. However the study did not state what services the clinical psychologists worked in, which may have been associated with an elevated risk of client suicide. Given that clinical psychologists were the identified professional group with a greater likelihood of experiencing a client suicide in the study, I believe there is a greater need to explore the impact of suicide bereavement and how suicide is understood within this professional group.

Building on the previous paragraph, a qualitative study by Tillman (2006) offered a deeper understanding of the effects of patient suicide on the clinician. Tillman (2006) described the death of a client by suicide as the most humiliating and traumatising experience of a clinician's career. The study interviewed 12 psychotherapists and transcripts were analysed using thematic analysis. Eight themes were identified which offered insights into the effects of client suicide on the clinician. These themes were subsequently grouped into three main structures; trauma loss and grief, interpersonal relationships, and professional identity concerns. Relating to the theme of trauma loss and grief, clinicians reported a traumatic response to learning of a client's death, intrusive thoughts and dreams were experienced, and the avoidance of risk and disassociation were also reported. Over half of the clinicians reported dreaming about the client, such as dreams relating to dismemberment, gruesome death scenes, violent death, and other nightmare phenomena (Tillman, 2006).

Relating to the theme of interpersonal relationships, it was reported that contacting families was a source of comfort for some, for others this was too painful. This study offers an in-depth understanding of the impact of client suicide on psychotherapists, however it did so amongst participants who had lost a client within a time frame of 6 weeks to 12 years. As an insider-researcher, my sense is that inviting participants to participate in a study 6 weeks after client death is too soon. Following my own experience of suicide bereavement, I valued the time and space to process these events, which contributed to my ability to make sense of the experience. Similar to the previous articles, the study by Tillman (2006) also does not integrate the experiences of suicide bereavement of loved ones amongst the sample.

The research papers suggest that the common therapist reactions to suicide involve anger (Tillman, 2006; Clark, 2009), shock (Darden & Rutter, 2011; Clark, 2009), helplessness (Finlayson & Simmonds, 2016), self-doubt, self-blame, loss, disbelief, professional isolation and feelings of incompetence (Veilleux, 2011). A loss of prestige is also experienced (Tillman, 2006), as well as relationship difficulties, and clinical psychologists themselves may also experience intrusive thoughts about suicide (Chemtob et al, 1988).

Supervision

It is well documented, but not surprising, that part of the healing process after a client suicide involved talking to co-workers (Darden & Rutter, 2011). An obstacle to the healing process was identified as a sense of feeling isolated, which can be 'anti-healing' (Darden & Rutter, 2011). Veuilleux (2011) reported the value of the supervisor

offering 'tea and a Kleenex', it was of particular significance when the supervisor encouraged the message of 'all emotions being acceptable', and that all feelings are appropriate for discussion. Finlayson and Simmonds (2018) found that talking to supervisors was considered a coping strategy. However, the authors also noted that one in five participants in this study did not approach their supervisors following the client's death, and one in four reported that they found it unhelpful to talk to their supervisors. Tillman (2006) identified that supervision could be used as a space for containment. In the study, eight of 12 participants found supervision helpful and crucial for support, however one participant reported that they felt angry at their supervisor's response, as they experienced them as distant. Peer relationships were identified as either a source of support or a source of shame, due to the anticipated sense of guilt and questioning of one's competence (Tillman, 2006). It was reported that there was an undercurrent of fear of what colleagues would think, and it was found that some clinicians felt they could only talk to other clinicians with a similar experience.

Reflections

At the start of this journey into this study, I noticed feeling a mix of excitement and trepidation. I felt appreciative that I had this unique opportunity to explore this important research topic, which is both under researched and deeply personal, and also I felt nervous about not doing this research justice. I began to notice how I did not feel confident as a researcher, and self-doubt began to grow in relation to my research skills. However, once the research design and methodology became more refined and structured, I noticed a shift towards feeling more confident in the research and its potential contribution to the field.

1.14.7. Rationale of the study

The systematic review identified the following key points:

- Client suicides are referred to as an "*occupational hazard*" for psychologists.

- A quarter of psychologists, both qualified and in training, will experience a client suicide across their professional life.

- A client suicide is considered to contribute towards:

    o Psychologists questioning their clinical decision making skills.

    o Psychologists experiencing a significant impact on their sense of self, both personally and professionally.

    o Psychologists meeting the criteria for prolonged grief, and experiencing the client suicide as traumatic.

    o Psychologists scanning for more risk factors.

    o Psychologists focussing on using scales to measure of suicidality.

    o Psychologists completing more suicide contracts with clients.

- The grief process may be complicated by the fear of judgement from colleagues and potential legal issues.

- The healing process after a client suicide involved talking to co-workers.

- Supervision could be used as a space for containment.

Despite the literature in the systematic review, there are clear gaps in research which the current study hopes to address. For example, only one study was identified as exploring the impact of losing a loved one to suicide, and only two of the pieces of research were conducted from an 'insider researcher' perspective. Further to this,

there is need for qualitative exploration via semi-structured interviews, as recommended by Finlayson and Simmonds (2018), which the current study intends to achieve. The literature has identified that losing a client to suicide can contribute to lasting cognitive, behavioural and emotional impacts on clinical psychologists. However, the studies do not account for how clinical psychologists make sense of suicide. Nor does the research explore what would help clinical psychologists with managing the complexities which arise in the face of a client suicide. This points towards why this research is so important and needed.

Therefore this research, from the perspective of an insider researcher, aims to address these gaps in the literature by considering how clinical psychologists think about suicide, talk about suicide, and manage the ethical dilemmas which surface when managing suicide risk and in the aftermath of a suicide. Finally, this research will also consider how the conceptualisation of suicide may be influenced by ones' religious or spiritual position.

1.14.8. Research questions

Within this study, the following research questions will be explored:

- How do clinical psychologists who have lost a loved one and/or client to suicide make sense of this experience?

- What impact does the above have on their ability to work with people who are suicidal?

2. Methodology

2.1. Overview of methodology

The purpose of this research is to explore how clinical psychologists who have lost a loved one and/or client to suicide, made sense of this experience. This chapter will now describe how this research was executed, along with outlining the participant sample information, data collection procedures, data analysis procedures, ethical considerations and the quality appraisal of the current study.

2.2. Design

2.2.1. Rationale for qualitative design

This research study adopted a qualitative methodology which enabled an in-depth exploration into a research topic which has not been qualitatively explored. This approach allows the researcher to "…*examine phenomena that impact on the lived reality of individuals or groups in a particular cultural and social context...*" (p.9, Mills & Birks, 2014).

This research is well positioned to offer a deeper, richer understanding into the lived experiences of losing a loved one or client to suicide, with a view that the findings and themes would inform clinical practice and have wider implications within the field of clinical psychology.

2.2.2. Qualitative Design – Thematic Analysis

The framework of thematic analysis developed by Braun and Clarke (2006) was deemed the best fit to analyse the data for this current study as this method offers a flexible way of systemically identifying meaningful patterns across a data set. This methodology enables researchers to make sense of shared experiences and explores how a topic is discussed and thought about (Braun & Clarke, 2006).

2.2.3. Strengths of Thematic Analysis

Thematic analysis is known for being a theoretically-flexible analytic method. The proposed six-phases of thematic analysis offers a robust and systematic way to code and analyse qualitative data in an accessible way (Nowell, Norris, White & Moules, 2017). Thematic analysis goes beyond text and involves identifying implicit and explicit ideas (Guest, MacQueen & Namey, 2012), whilst working with a wide range of questions relating to experience, understanding and meaning-making.

2.2.4. Weaknesses of Thematic Analysis

The flexibility of thematic analysis can also be considered a weakness of the method, as it can lead to inconsistencies and a lack of coherence during the theme development stage (Holloway & Todres, 2003). To overcome this, it is suggested that the epistemological position should be made explicit and that the data analysis is

underpinned by this throughout (Holloway & Todres, 2003). A further weakness of thematic analysis relates to lack of reliability of the data due to the large variety of interpretations from different researchers (Javadi & Zarea, 2016). Additionally, thematic analysis could miss the more nuanced data if the researcher is not careful at the analysis stage.

2.2.5. Alternative qualitative and quantitative methods

Other qualitative approaches were considered as possible methodologies, these approaches will now be discussed, along with their suitability in relation to the aims of the current research. The rationale for the methodology that was chosen will then be discussed.

Narrative analysis

Narrative analysis (NA) places an emphasis on the stories of participants, and focuses on how these stories have evolved (Emerson & Frosh, 2009). However, because this methodology is rooted in a social constructionist methodology, I felt that it did not suit the epistemological stance of this study.

Interpretative phenomenological analysis (IPA)

IPA focuses on the lived experiences of people's lives through a phenomenologically focussed lens. However, this methodology was not deemed

suitable for this research due to the emphasis on in-depth descriptions of lived experiences (Smith & Shinebourne, 2009). As this is integral to the IPA methodology, I felt this may have been challenging and distressing for some participants in the current study.

Grounded Theory

Grounded theory explores how processes occur within multiple contexts and works towards the development of an overarching theory (Charmaz, 2006). It also focuses on sociological processes, whereas the current study is predominantly focused on exploring individual experiences and understanding of meaning.

Rationale for Thematic Analysis

The current research aimed to explore how the significant life event i.e. the suicide of a loved one or client in this instance, was understood by the clinical psychologist population. I felt it was vital to explore the breath of this topic and to capture key themes and perspectives. It is for this reason that thematic analysis was elected as the methodology of choice.

Quantitative approaches

Quantitative approaches were not considered for this study as it was identified that this type of methodology would not adequately answer the research question. Furthermore, previous literature have used quantitative methods to capture attitudes,

behaviours and views from large heterogeneous participant samples. The current study intends to capture an in-depth and rich insight into this research area, which would not be suited to a quantitative approach.

Epistemological stance and Theoretical Orientation

I have elected to write this piece of research from a critical realist perspective. This position presumes that a real and knowable world exists behind the socially-located knowledge, and that this can be *discovered* via research (Joffe, 2012). This perspective is also in-keeping with the research question and methodology in that thematic analysis is theoretically-flexible and can be used to answer a range of research questions, i.e. questions relating to peoples' experiences (Braun & Clarke, 2006).

2.3. Research Design

2.3.1. Recruitment

Once ethical approval was granted, the initial stages of recruitment used a purposive sampling approach to recruit participants. This approach enabled the "*deliberate choice of a participant due to the qualities the participant possesses*" (p.2, Etikan, Alkassim & Abubakar, 2016). A purposive sampling technique was deemed suitable for this research as the inclusion and exclusion criteria specified what needs to be known for each participant, and thus provided a sample of participants who were

suited and willing to participate by virtue of knowledge or experience (Bernard, 2017).
The research study was advertised (see Appendix 4) on social media which was likely
to be accessed by clinical psychologists, including Facebook, Twitter, and the ClinPsy
forum (http://www.clinpsy.org.uk/forum/).

A snowball sampling approach was also employed to recruit further participants.
This approach involved participants recruiting other potential participants from among
their acquaintances who they know share characteristics of the research interest
(Biernacki & Waldorf, 1981).   This also involved directly contacting known
acquaintances and requesting that they share the research advert to their wider
network, inviting those who were interested to make contact to enquire about
participating in the study. These two approaches were effective in recruiting the
desired number of participants who met the criteria for the study.

2.3.2. Participation criteria

There were a number of criteria which participants needed to met in order to ensure
they were suitable to participate in the study. These criteria will now be discussed in
more depth.

- Each participant confirmed that they worked in the UK as clinical psychologists.

- Each participant had two or more years post qualification experience. This
  ensured that had experience of working with a range of complexities and risk.

- Each participant confirmed that they had been closely affected by issues of
  suicide. These losses were either in personal and/or professional contexts.

- Each participant confirmed that the suicide had taken place over two years ago. From an ethical perspective, it was important to have left enough time for participants to be in a position to reflect on the event. Thus, two years post-suicide was deemed suitable and allowed for a psychological distance between the experience of the death and the interview (Darden & Rutter, 2011). Research into bereaved individual's experiences indicate that participants feel it is appropriate to participate in research after the first two years since a suicide bereavement, whereas it was deemed inappropriate within the acute phase of bereavement (Beck & Konnert, 2007).

- Participants were recruited who work across NHS services as well as the private sector and third sector organisations.

- Participants were over the age of 21, and came from any diverse background in accordance with social GGRRAACCEESS (Burnham, 2018).

- Participants were not personally known to the researcher.

2.3.3. Participants

Once a potential participant expressed interest in taking part in the study via email, a participant information sheet (see Appendix 5) was sent to each participant offering an overview of the research, as well as the inclusion and exclusion criteria. If the participant met these criteria, they were subsequently invited to take part.

Overall, interest was expressed by 16 potential participants, of which 12 confirmed their participation. The study sought to interview twelve participants overall, as it has

been identified that twelve interviews are offer a sufficient sample for thematic analysis (Ando et al, 2014).

Participants were informed that interviews would take place in a booked room at the University of Hertfordshire campus, or at a booked room at the their workbase. Telephone interviews were considered to collect data, as well as Skype technology. This was considered a viable alternative to conduct interviews (Lo Lacono, Synmonds & Brown, 2015) and it was the preferred option for some participants. Participants lived across England, including Devon, London, Bedfordshire, Hertfordshire, Yorkshire and Suffolk.

Within the sample of twelve, all participants were female and aged between 32 and 49 years old. The number of years of post qualification experience ranged from 3.5 years to 20 years. Four participants reported losing a client, six participants lost a loved one (i.e. family member, friend, colleague), and two reported losing both a client and a loved one to suicide. Nine of the twelve participants were married, two reported their marital status as single, and one reported co-habiting with their partner. In order to bring the reader closer to the experience of each participant, and to offer a brief context of participants' experience, Table 5 presents the demographic information of each participant, along with their relation to the person who took their life. Table 5 also includes the duration since qualification, this data is presented in a grouped manner (i.e. 2-5 years, 6-10 years, 10+ years) in order to further protect the anonymity of participants.

	Pseudonym & Ethnicity	Sex	Age	Religious/ spiritual position	Relation to the person who took their life	Duration since qualification
1	**Hazel** White British	Female	32	Atheist	Two clients	2-5 years
2	**Lily** White British	Female	36	None	One uncle	6-10 years
3	**Nina** White British	Female	34	Christian	One friend One work colleague	2-5 years
4	**Rose** White British	Female	47	None	One uncle	10+ years
5	**Belinda** White British	Female	35	None	One cousin	2-5 years
6	**Amber** White British	Female	43	Atheist	One uncle	2-5 years
7	**Jade** White British	Female	49	None	One client	10+ years
8	**Ruby** White British	Female	35	None	Once close friend	2-5 years
9	**Maeve** White British	Female	42	Atheist	One client	10+ years
10	**Theresa** White British	Female	42	Atheist	Two friends	10+ years
11	**Rosie** White British	Female	42	Atheist	Two clients	10+ years
12	**Katie** Mixed White British	Female	42	Buddhist	One client	10+ years

Table 5: Demographic information for participants

2.3.4. Ethical Considerations

Full ethical approval was granted by the University of Hertfordshire's Health and Human Sciences Ethics Committee (see Appendix 6). Once the initial application was submitted, amendments were suggested by the committee in relation to ensuring the participants had access to post interview support in the form of a debrief sheet. An updated application was submitted which included this debrief sheet (see Appendix 11), and ethical approval was subsequently granted. The protocol number for this study is: LMS/PGR/UH/03869. To maintain an ethical standing, the following ethical considerations were included in the participant information form and was followed throughout the research process. These ethical considerations remain in line with the British Psychological Society's Ethical Guidelines (BPS, 2014).

Confidentiality

Participants were informed that the interviews will remain confidential.

Anonymity

Participants were informed that all their details in the interview transcripts will remain anonymous and that no identifiable information (i.e. names, place of work) will be shared or published. I ensured that this information was removed or changed before drafts are seen by the primary supervisor and secondary supervisor. Participants were also assigned a pseudonym for this final thesis write up.

Informed consent

A description of the purpose of the research was shared with the participants in the participation information sheet to achieve informed consent. Participants' were also sent a consent form (see Appendix 7) which they were invited to sign to confirm their participation.

Protection of participants

Due to the sensitive nature of the topic, participants were advised to consult their supervisors or support network should the interview elicit feelings of distress. Should any of the questions be potentially distressing, participants have the right to elect not to answer and move on to the next question. In addition, participants were offered the opportunity to take breaks during the interview. If the interview continued to cause distress, I as the researcher considered terminating the interview in the interest of avoiding undue distress.

Protection of researcher

Due to the sensitive and personal nature of the topic, my own personal wellbeing as the researcher was routinely monitored by the research team. This also included being mindful of when the data analysis was distressing for me. For additional support, regular meetings with the supervisory team was arranged where we discussed the emotional impact of the research project. Additionally, a reflective journal was also kept alongside the research process.

Withdrawal from investigation

Participants were offered the opportunity to 'pass' on questions and were offered the opportunity to withdraw from the interview at anytime. Support numbers were offered to all participants. Participants were reminded that they do not need to offer a reason for ceasing participation if they opted to do so. Despite these considerations, no interviews were terminated due to participant distress.

Data storage

Participant data was stored securely. The interview recording and interview transcript was stored on a device which was encrypted for data protection purposes. Forms related to the research, such as consent forms and participant information forms, was kept in a separate location from the data.

Debriefing

Following the completion of the interview, an informal verbal debrief took place. A formal debrief in the form of a participant debrief sheet which list organisations offering support was also distributed to each participant after each interview.

Researcher Connection

From the offset, the participants were informed that I too identify as a 'survivor of suicide'. I made this explicit both in the participant information sheet and at the end of

the research interview. I remained mindful of the costs and benefits of this decision, and I took steps to maintain my own awareness of biases and prejudices.

2.4. Service User Consultation

Service user consultation was considered for this research as it was valuable to ascertain feedback in regards to the research proposal, interview schedule, and research design. It was important to consult with people who identify both as therapists and 'survivors of suicide' to offer an insider perspective on the research. This remains in line with NHS Patient and Participant Involvement policy (NHS England, 2017).

The service-user involvement was also in the form of consultation with the Research Consultant who identifies as having experienced losing a loved one to suicide, and who also works as a clinical psychologist. It was valuable to be able to connect with the Research Consultant as they brought with them a wealth of knowledge and experience. The Research Consultant was able to review the participant information sheet, the interview schedule, and the debrief sheet, and offered valuable feedback.

A further consultation took place with a member of the 'Experts by Experience' committee. This committee is part of the Clinical Psychology doctoral programme at the University of Hertfordshire. I met with a member of this committee, who also worked as a therapist with adults who experience mental health difficulties. The purpose of approaching this committee member was to invite feedback to help inform and shape the research process. This meeting helped me to understand how they

experienced other clinician's completing risk assessments with them, and how they complete a risk assessment with their own clients within their therapist role. This process made me more curious of the dual positons that clinicians often occupy, and led me to explore how this is managed in more depth.

In relation to research dissemination, the participants of the study, the Research Consultant and the Experts by Experience, were invited to inform me whether they would like a summary of the research findings upon completion. It was agreed that a summary of the study will be sent to participants who opted 'yes'.

2.5. Data Collection

2.5.1. Interview Schedule

The interview schedule was developed with a view to cover three main areas. This was reviewed by the primary supervisor, secondary supervisor, Research Consultant and a member of the 'Experts by Experience' committee (see Appendix 8). Semi-structured interviews were deemed appropriate to enable a flexible interview style which offered the opportunity to explore the depth and breadth of the research topic, whilst maintaining a focused thread throughout (Smith, Flowers & Larkin, 2009). Within the semi-structured interview, open-ended questions were used to offer the participants the opportunity to speak openly and freely about their experiences, feelings and views.

The interview questions were focused on the themes related to the research question, such as:

- Briefly, the participant's own experience of losing someone to suicide.

- The participant's own experience of people taking their own life, including considering the participant's own spiritual position, and how this relates to their beliefs about suicide.

- The emotional impact and how this experience shapes the participant's response to distress or people presenting with suicidality

In the interest of emotional safety, an overview of the interview schedule was discussed in the introduction of the interview to offer the participant the opportunity to be aware of the type of questions being asked.

2.5.2. Pilot Interview

The purpose of using a pilot was to be alert for preconceptions and biases, and to be aware of any challenges with the interview schedule (Tillman, 2006). Two pilot interviews were carried out and reviewed with my supervisor, some revisions were suggested regarding prompts, otherwise no major revisions were indicated. The two interviews have been included as part of the overall data collected.

2.5.3. Procedure

Participant consent and demographic information was obtained by inviting participants to sign a consent form at an earlier stage (see Appendix 7). The interviews either took place in a private office area at the participants work base, via Skype or via telephone. Participants were informed that interviews would last up to 60 minutes, this included an introduction and overview of the interview schedule, the main interview itself, and a verbal debrief at the end of the interview. During the interview, confidentiality and right to withdraw was reiterated to participants.

Once the interviews began, the interview schedule was followed to ensure a focus was maintained, but a conversational tone ensured the interaction was as natural as possible. Upon completion of each interview, participants were sent a debrief form and asked whether they would like to receive a copy of the research. The interviews were subsequently transcribed verbatim. To ensure the accuracy of the transcription, I listened to each interview after each interview was transcribed (Mishler, 1986). I completed this process myself as I felt it was important to remain close to the data. In addition, the listening and re-listening of the interview can be considered as part of phase one of the thematic analysis which involves familiarising oneself with the data. A summary of the procedure can be seen in Figure 2.

After the completion of each interview, my reflections on the process and reactions to the interview were recorded in a reflective journal (see Appendix 1).
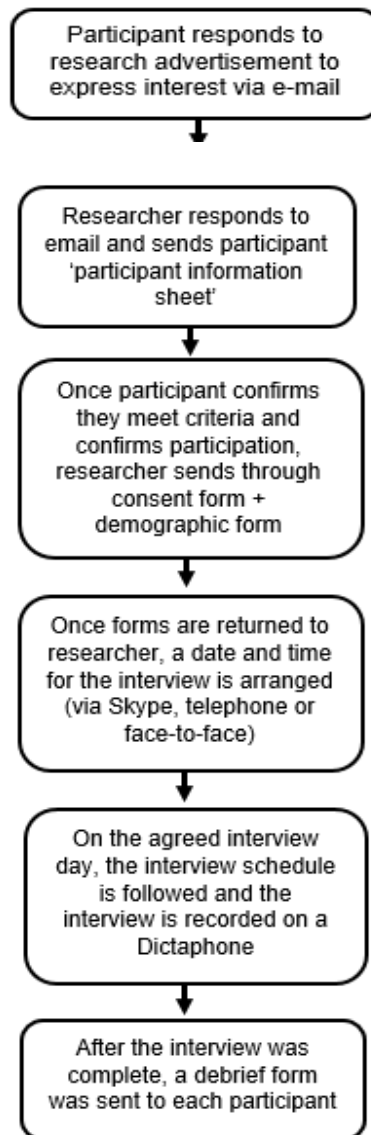
Figure 2: Flow chart of interview procedure

The forms used for each stage of the procedure can be found in the appendices.

2.6.   Data Analysis

The development of themes were guided by the six-phase analysis approach (Braun & Clarke, 2006), as demonstrated in Table 6. I arrived at these codes and themes using an inductive approach, which means I employed a bottom-up approach and I was guided by insights and interpretations within the data itself, thus the codes and themes derived from the content alone. This approach suited the epistemological position of the research and remains in line with the recommendations by Braun & Clarke (2006). An example of how this coding and theme development process evolved can be seen in Appendix 9.

Phase one	Familiarisation of the data through the repeated reading of the transcription**.**
Phase two	Generating initial codes from features of interest.
Phase three	Reviewing the initial codes and searching for themes.
Phase four	Reviewing the initial codes against themes and generating a thematic map.
Phase five	Defining themes and subthemes which capture the overarching story.
Phase six	Producing a report which illustrates the themes alongside supporting extracts.

Table 6: Summary of Thematic Analysis phases

To assess for quality, the transcription and coding was reviewed by the primary and secondary supervisor. To ensure inter-rater reliability, an external reviewer was

invited to review two transcripts, and their coding was reviewed for similarities and differences. This process revealed a high-degree of agreement between the coding of transcripts which assured me that I was appropriately coding my data, this was important to ensure that my own biases were minimised. A detailed overview of the data analysis will now be presented.

Once the interviews were completed, I transcribed the data which involved listening and re-listening to the recording. I then read and re-read the transcription which enabled me to immerse myself and remain close to the data. During this process, I began engaging in phase two, the generating of initial codes. Coding was done by hand and no computer software was used as I wanted to remain close to the data throughout the analysis, and I felt that using the computer software would create an added layer of distance between the interviews and myself. Codes are described as *"… features of the data (semantic content or latent) which is interesting to the analyst, and refers to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon'"* (p.63, Boyatzis, 1998). In accordance with phase two, along the right side of each transcript, I recorded line-by-line codes, and at the end of this process I was left with a collection of codes which I later reviewed to identify patterns and themes. I followed this process for each interview transcript and ensured I completed this active process equally across all data sets. An example of this coding process is demonstrated in Appendix 9.

Once the data was coded, I began to move on to phase three, which involved searching for themes from the coded data. This phase involved organising similar codes into themes. A thematic map was generated from this process (see Appendix

10). This phase enabled me to begin to build a story emerging from the connections between themes. This phase progressed into phase four, which saw me reviewing the themes from phase three to ascertain how the potential themes form the central organising concepts. At this point I reviewed whether there was enough meaningful data to support each theme, and whether the theme worked in relation to coded extracts and the wider data set. Following this step, the themes were finalised along with the thematic map and I was able to move on to phase five, which involved the naming and defining of each theme. This phase enabled me to identify the primary themes, and the subthemes within them. The final phase of the process involved producing the final report to bring together the themes which tell the story of the data. Within this phase, the data extracts were used both illustratively and analytically. This process of data analysis is flexible and recursive.

2.7.   Quality Appraisal

To assess the validity and quality of this research study, the *'Eight "Big-Tent" Criteria for Excellent Qualitative Research'* as proposed by Tracey (2010) was used. This approach asserts that high quality qualitative research should embody eight markers that can improve the integrity of qualitative practices (Tracey, 2010). I acknowledge that the CASP framework was used to appraise the research from the systematic review, however for the purposes of this thesis I used Tracey's (2010) framework as it offers a richer, broader, and more nuanced approach to appraising qualitative research. I will now describe how I upheld the quality of this research through addressing these eight markers.

1) Worthy topic

This research topic meets the criteria for being a *worthy topic* in that it is a relevant and significant area of research. Given how limited the research literature is related to suicide bereavement in clinical psychologists, this research qualifies as worthy and intrinsically interesting.

2) Rich rigour

This research study meets the *rich rigour* criteria through interviewing a participant sample of twelve clinical psychologists. Thus, the interview data offers an in-depth and rich insight into this research topic. The line-by-line coding was reviewed by the research team to add rigour to the development of codes and the themes. I demonstrated the thoroughness of my analysis through visual examples and the inclusion of the data analysis in the appendices (see Appendix 9 & 10).

3) Sincerity

Sincerity was achieved through transparency, self-reflexivity, vulnerability and honesty. From the offset of the research, I outlined my relationship to this topic and I outlined my intention to remain aware of my biases throughout the research process. I negotiated ways to address this with the research team. To promote self-reflection and acknowledge this process, a reflective diary was kept throughout the project. This was a priority given theme of the research and the personal connection that I hold with the topic of suicide. This process enabled me to maintain a level of self-awareness throughout the study, and offered me a space to record the errors I made and triumphs

I experienced. This was prominent when reviewing the transcripts with the primary supervisor, as I was able to notice 'blind-spots' within the interview data, exploring areas where I could have prompted further but did not. My own reflections can be seen in the discussion chapter and in Appendix 1 which are in line with suggestions by Tracey (2010) who promotes the weaving of one's reflections in the report, to endorse a "*show rather than tell*" approach to self-reflexivity. To maintain transparency, each step of the research was well-documented, including documenting each decision made (Creswell & Miller, 2000). Transparency in this research study achieved by acknowledging the contributions and support by the members of the research team and Experts by Experience.

4) *Credibility*

This research study attempts to achieve the credibility criteria by demonstrating trustworthiness when reporting the data, this involved selecting extracts which are persuasive and plausible, and producing a thick description of the themes. This resulted in embodying a *show* rather then *tell* approach to reporting the data, enabling readers to arrive at their own conclusions of meaning. Another approach to achieve credibility involved triangulating the data which meant that two or more researchers reviewed the data and arrived at the same conclusion (Denzin, 1978). Within this study, the coding of themes and analysis of themes was reviewed by the primary and secondary supervisor in order to gain feedback. The triangulation process did not yield significant differences, rather it deepened the curiosity of the participants' response and led the inclusion of further prompts in the interview. This process thickened my understanding and promoted the re-evaluation of the data (Tracey, 2010).

5) Resonance

The resonance criteria refers to the ability to impact or move the audience through the sharing of the report, and illustration of findings. It is hoped that the topic of the study may resonate with readers, and may promote empathy and identification with certain experiences (Dadds, 2008). The two practices described by Tracey (2010) have the potential to lead to resonance are generalisability and aesthetic merit. Aesthetic merit is achieved through writing in an evocative and meaningful way. This research study achieved this through weaving in selected extracts to support the themes, and writing in a first person narrative. Aesthetic merit was also achieved through the inclusion of extracts from my reflective journal in the Appendices and the inclusion of reflective sections throughout the thesis. This approach is intended to encourage the reader to relate and engage with the content (Tracey, 2010). Resonance is also achieved through the generalisability of the study. I believe that the findings are transferable across a variety of contexts, as clinical psychologists work not only within the NHS setting, but privately, and within third-sector organisations.

6) Significant contribution

This study offers a significant contribution to the limited research base that currently exists within the field of suicide bereavement and clinical psychologists. This study's contribution is valuable in that it broadens our understanding of these experiences, and it has the potential to improve practice and training. It has the potential to "*make visible what is hidden or inappropriately ignored, and generate a sense of insight and deepened understanding*" (p.209, Tracey, 1995).

7) *Ethical*

This research considered its ethical stance deeply, this was especially important given the potential to cause emotional distress in participants. Procedural ethics were maintained through the maintenance of confidentiality, informed consent, emphasising the right to withdraw, and avoiding deception. Relational ethics were also considered for this research study, this relates to the mutual respect, reciprocity and connectedness between the participant and the researcher (Ellis, 2007). This was demonstrated through the transparency of the research topic, achieving informed consent, seeking permission throughout the interview, and reminding the participant about their right to withdraw. This enabled me as the researcher, to conduct the interview in a compassionate and caring manner, whilst remaining mindful that the wellbeing of the participant is a priority.

8) *Meaningful coherence*

The final criteria of achieving quality in qualitative research is meaningful coherence. This research has achieved this criteria in that it is exploring what it has intended to explore, and the findings do address the research question. The research procedure and methodology do fit with the research aims and are aligned with the epistemological position of the study. Additionally, to strengthen the meaningful coherence of this study, the conclusions and recommendations are meaningfully connected to the data and literature presented.

3. Results

The following chapter will report the outcome of the thematic analysis of the twelve semi-structured interviews, which were carried out to explore how clinical psychologists make sense of suicide. The following three themes were identified from the analysis:

- Theme 1: How talk is experienced as a way of making sense of suicide

- Theme 2: *"The messiness of being human"*

- Theme 3: An experience that helps Psychologists face it

Within this chapter, I will be examining the three main themes and their related subthemes. To illustrate each theme and subtheme, verbatim extracts from the interview transcripts will be used to demonstrate support for each identified theme. Whilst careful consideration to select quotes which offer insight into each theme and subtheme was made, it has been at times necessary to omit extracts in the interview data for the purposes of being concise and also being mindful of the word limit. Any words or sentences which have been omitted will be demonstrated by three dotted lines inside brackets i.e. (…). To offer some contextual information to the participants quote, brief sentences in brackets will be used i.e. (when speaking about risk assessments). For the purposes of anonymity and confidentiality, all identifying information has been altered or removed and pseudonyms will be used.

3.1. Visual Overview of Themes

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┌─────────────────────────┐
│   Theme 1: How talk is  │
│  experienced as a way of│
│   making sense of suicide│
└─────────────────────────┘
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Talk as inhibited	Talk as valued	Talk as triggering
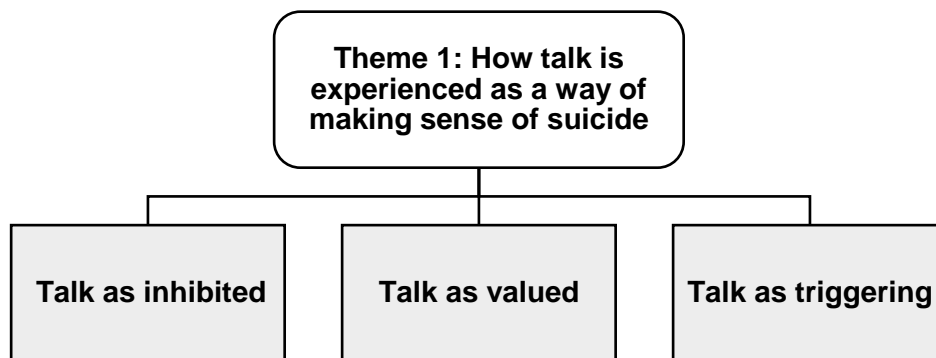
Figure 3: Overview of Theme 1 and Subthemes

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┌─────────────────────────┐
│   Theme 2: "The         │
│   messiness of being    │
│   human"                │
└─────────────────────────┘
```

Walking in the family's shoes	Self doubt: "*What could I have said or done differently?*"	When views are not aligned	Suicide as 'the solution'	The right to live, the right to die
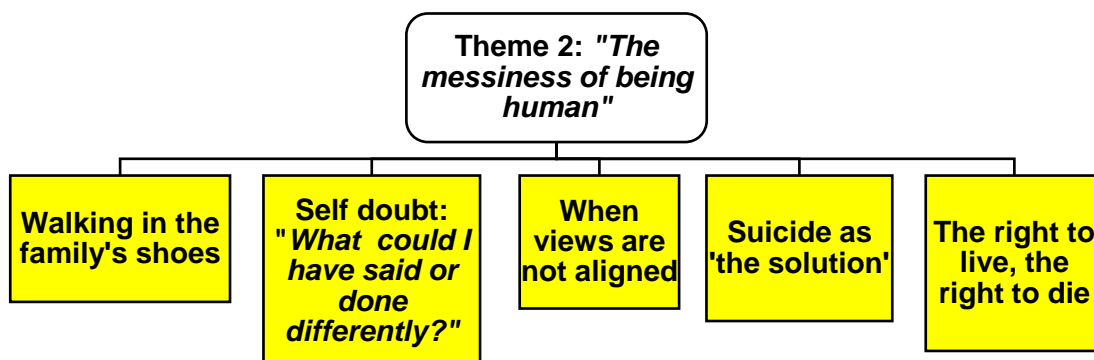
Figure 4: Overview of Theme 2 and Subthemes

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┌─────────────────────────┐
│  Theme 3: An experience │
│  that helps Clinical    │
│  Psychologists face it  │
└─────────────────────────┘
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Resilience in the face of risk	The experience of loss shaped career	*"The light within the dark clouds"*
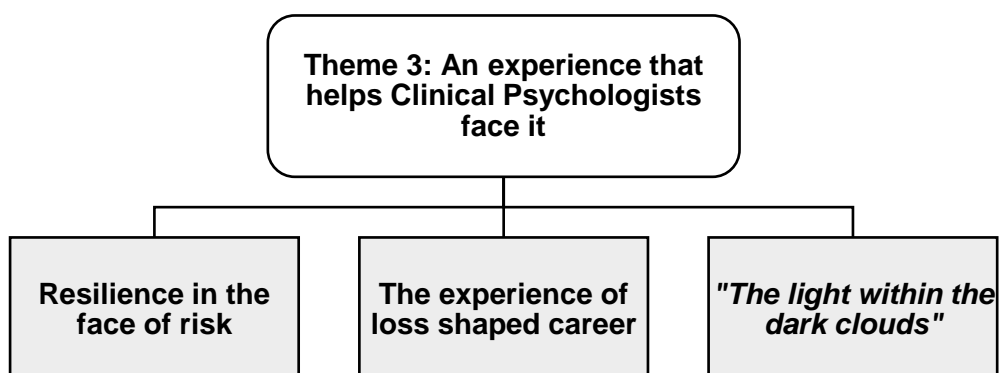
Figure 5: Overview of Theme 3 and Subthemes

3.2. Theme 1: How is talk experienced as a way of making sense of suicide?

The first theme captures how talking about suicide is experienced by each participant. This includes how talk is both valued and inhibited, and how hearing others talk about suicide can activate feelings of anxiety and disassociation for participants. This theme begins to address how talk is used as a way of making sense of suicide, in both a helpful and unhelpful way. The three subthemes that collectively form this overarching theme will now be discussed in detail with relevant excerpts from the interview transcripts.

3.2.1. Subtheme 1: Talk as inhibited

This subtheme illustrates how talking about one's personal view of suicide and talking about one's experience of suicide bereavement is inhibited as it evokes a sense of apprehension in participants as well as the wider system.

Some participants talked about the sense of discomfort which is experienced when talking openly about suicide to colleagues.

"…it's sort of uncomfortable isn't it, it's an uncomfortable topic but erm, it's quite useful to step back and examine one's principles really that we are operating from, because again we probably don't do enough of that in sort of day to day working…" – Nina

Some participants reported that the apprehension stems from the anticipated judgement from colleagues i.e. that one might be a 'bad' psychologist.

"Even though your personal does come into the professional, there is that 'keeping it separate as well', maybe I don't want to be or feel judged for having the feelings that I do" - Belinda

Some participants also reflected on the perceived discomfort of talking about suicide, and the view that it feels like a breach of privacy to embark on such a conversation.

"…it (suicide bereavement) affects you personally to such an extent, that it feels like an invasion of somebody's privacy to talk too much about it, because its making me think about colleagues of mine that…I've had superficial conversations and I've offered support and I've make cups of tea…but I haven't had an in-depth meaningful conversation about how their feeling about, how their making sense of it…..the fact that these things shake you so much on a personal level, that it feels uncomfortable for colleagues to go there…" - Maeve

This indicates that in order to not feel judged for holding views or beliefs, there is a need to maintain the personal and professional boundaries when interacting with other staff members and clients.

Some participants reported that they have experienced colleagues saying that they are worried that talking about suicide with clients may make their experience worse, suggesting that the avoidance of the topic is perhaps protective for both the client and clinician.

"I think people are genuinely scared to talk about this, actually, to have conversations where it's okay to talk about that, it's okay to talk to that person about that it's not going to give them ideas or make things worse…"
– Amber

One participant reported how difficult conversations can be with clients beyond the risk assessment process, this was referenced in regards to the challenge of sitting with someone who is in a state of hopelessness, and communicating to them that they are trying to understand their experience.

"I think…it is really hard erm… to have those conversations with people, and I think a lot of the time, other than on the risk assessment…coming alongside someone and really hoping to understand and trying to let them

*know that you're trying to understand exactly what it might be like for that
person at that time, devastatingly hopeless…it is hard…" - Belinda*

One participant talked about the complexity of suicide being such an
overwhelming topic, that it can lead to a reductionist approach.

*"I think we are quite good to reducing it to one thing, erm or just to an 'it
mustn't happen', and then its like we should ban dialogue around it…" –
Hazel*

Hazel makes an interesting point about how talk around suicide may appear
reductionist which consequently limits further conversation or exploration. In relation
to an absence of conversation related to suicide, another participant talked about the
absence of psychologists talking from their own experiences, and asserted that
psychologists can and should own their own despair in an attempt to encourage
conversations about suicide and suicidal ideation.

*"When we think about bringing in experts by experience, I think it speaks to
the mind set of, other people have these experiences but not us…but I think
as a profession we can hold our own despair…" – Rose*

This quote suggests that the invitation of experts by experience positions psychologists as not holding their own experiences. This may inadvertently contribute to the inhibited conversations within the field. These quotes indicate that despite carrying their own personal experiences of suicide bereavement, conversations related to suicide or suicidal risk remain uncomfortable and difficult.

Some participants talked about conversations about suicide being conducted in a manner that felt devoid of the context and detached from the content within their service.

"I remember for a very long time in MDT meetings people get blasé about suicide…because we talk about it quite a lot, quite clinically and quite matter of a factly, we almost forget about…the person themselves…" - Katie

How suicide is talked about and responded to within the NHS Trust is explored in this theme and in theme number two, titled *'The messiness of being human',* under the *'When views are not aligned'* subtheme. In relation to talk being limited, some participants described how this was associated with a fear of blame which occurs in the context of how the Trust responds when a suicide has occurred within a team. This is illustrated by Rose's extract.

"There's quite a blaming culture if something goes wrong, um I think the Trust tries, and says one thing…but at the same time, I think there's secretly an amount of finger pointing" - Rose

Some participants reflected on how the NHS Trust may respond to serious incidents and suicides by introducing suicide prevention initiatives which were reported to feel unrealistic. Participants acknowledged how these initiatives are a way of managing the anxieties and complexities that are present in relation to suicide, as presented below.

"I think a lot goes on in the health services and organisations in terms of policies procedures and protocols, its an attempt to manage some of that anxiety but it sometimes feels a bit that becomes a bit of a denial or pretence really, like if we just did it all right then we'll tick all these boxes and it will all be OK…" - Nina

This extract indicates that in an attempt to manage suicide, the employing Trust's approach may feel reductionist. This is then likened to a 'tick-box' exercise, a process which is also described in the following extract:

"…the electronic documentation has very unhelpfully steered people away from good practice, so we went from good questions that work, to a very very basic electronic format that stopped people being curious and stopped them from asking what might be the right question…" - Jade

This quote indicates that the way suicide is being explored and talked about may often be limited by the standardised practices used to assess and manage risk, which can be limiting in that it restricts curiosity and further exploration.

Overall, this subtheme highlights how conversations about suicide with colleagues and clients are often limited. This is due to a sense of anticipated discomfort, a fear of invading privacy, a fear of being judged or misunderstood, a lack of sharing from professionals themselves, and finally by the initiatives and standardised measures put in place by the NHS Trust in which participants worked.

3.2.2. Subtheme 2: Talking as valuable

Alongside the subtheme of '*Talk as inhibited'*, most participants reported that having meaningful conversations about suicide whilst reflecting on their own position, was overall a valuable experience. Some participants reported that following their experience of suicide bereavement, they were able to talk to colleagues, their own family, and their supervisor in an open and honest way, with less fear and anxiety.

"I think I come at them (referring to clients during a risk assessment) *from a position of less fear…I guess beforehand I might've absolutely dreaded a response of yes actually, I do think about ending my life, and afterwards (after the bereavement) I would want to engage with it, yeah, emotionally I was less frightened by the conversation…it was positive in that sense…it puts you in a more, in a more useful place." – Maeve*

This quote indicates how the experience of suicide bereavement led to participants feeling able to engage in conversations about suicide risk. Most participants reported that supervision was enormously beneficial in supporting them to reflect on their experience, and to explore the potential impact of this experience on their own clinical practice. This included requesting supervisors to review risk assessments, requesting second opinions, and to explore the emotional impact.

"… I had a client who, she was trying to kill herself…so the first thing I did at that point is go in and speak to my supervisor at that point, and say I think I this is really affecting me right now erm…and I just needed someone else to be my rational mind and just check my risk assessment, and just go through it a bit more coherently…" - Ruby

Some participants offered an alternate perspective, in that talking about their experience of losing a client to suicide within a psychology meeting was an unhelpful

experience. This was associated with a sense that it was not the appropriate timing or forum.

"…it was the wrong thing for me, I just didn't find it supportive, erm, I wasn't at the time ready to talk about it with a bigger group of people? Erm so it made me realise people go through these processes in very individual ways, erm, and I am much more private person…I'm not sure it would ever have felt helpful for me…" - Jade

Some participants reported that the experience of a suicide in their family led to more conversations about suicide with their own family members.

"I think its kind of started to open up a few conversations in my family to get them to see a different point of view, and it be OK to talk about these kind of things…I mean, there's a lot of stigma around it isn't there? There's a lot of shame…" - Ruby

This participant did not expand upon what the shame or stigma was related to, but did highlight how the suicide loss of a family member shifted how suicide was perceived within the family system.

Overall, this subtheme highlights how talking openly about suicide has been a largely valuable experience, and the ripple effects have been beneficial as it has

opened up conversations between the participants' families and between their clients.
Talking about the suicide bereavement and its wider impact also generated a sense
of safety within the supervisory relationship. It is important to note that, the usefulness
of conversations was measured by whether it felt like the right time and the right
context for people to share their experiences.

3.2.3. Subtheme 3: Talk as triggering

Many participants shared that, following their own experience of losing a client or
loved one to suicide, when suicide was mentioned within a context of a team meeting
or within a client's therapy session, they would notice feelings of anxiety being
activated. They also noticed feeling disembodied and dissociated.   This was
particularly the case when the methods of suicide being discussed were similar to the
method used by the person known to the participant.

*"…I also found myself in a meeting which was really hard actually, there
was a meeting were somebody in the MDT was talking about suicide risk
and they were talking about the same method my friend used…and I found
myself you know, in quite a dissociated, I found myself dissociating as they
were just describing you know…"* - Theresa

To add to the finding that hearing people talking about specific suicide methods
activates feelings of anxiety, a few participants also reported that witnessing someone

who completed suicide using the similar method to their relative would be so distressing that it would lead them to feel unable to return to work.

"I started working in the inpatient unit which was…2 years after that happened, and I remember thinking to myself, if I ever see anybody hanging, because that's what my uncle did, I couldn't cope with that…I wouldn't be able to back to work…" - Amber

Other participants reported that the experience of hearing about suicide or hearing about the similar method would generate such a sense of anxiety that they would need to contain those emotions and try not to respond to them.

"Up until that point, it wouldn't have affected me or impacted me, erm but after that, after my uncle it really you know it really had an effect on me, and it really kind of, I was then acutely aware of really trying not to react…" - Lily

This subtheme reflects the challenges faced by clinical psychologists within their clinical roles as they notice physiological and emotional responses upon hearing the mention of suicide methods.

This theme captures how making sense of suicide is shaped by how it is talked about, but more importantly this theme highlights how even entering a conversation about suicide can be limited by assumptions related to invading privacy, fearing being

judged, a worry about making the situation worse, and it can also be limited by a lack of curiosity and an absence of professionals sharing their own experiences. When conversations are happening, on the whole it is experienced as meaningful and valuable, with participants reporting that they feel able to talk to clients and explore their experience of suicidal ideation, and participants felt able to have open conversations with family members. This theme also demonstrated how participants notice themselves feeling anxious in response to hearing conversations about suicide. Again, this demonstrates the complex nature of suicide, and how talking about this topic is influenced by a range of experiences.

3.3.   Theme 2: "*The messiness of being human"*

The second theme addresses the dilemmas and complexities which arise in attempting to make sense of suicide. These include an awareness of how it feels to be the family member of someone who has ended their life, and therefore the awareness of what it might be like for the family of a client who has died by suicide. This theme also covers how suicide is understood, the right to live and die, a disparity in personal and professional views, and self-doubt.

3.3.1. Subtheme 1: Walking in the family's shoes

Participants who lost a relative to suicide reflected on how the experience enabled them to empathise strongly with the families of people who complete suicide. Most

participants cited that as survivors of suicide, they understood the traumatic complex grief process of the families. Participants reported that this experience allowed them to hold the family in mind as they can understood their struggle and they understood the impact that suicide bereavement can have on the family.

"I guess it just made me never forget the (bereaved) person and the wider family because I've been that person, that family…" - Katie

Most participants went on to describe the dilemma they face by occupying the role of psychologist and 'survivor of suicide'. They described not knowing how to navigate this unknown territory, whether to share their experience as a way of connecting to the grief of others, and as a way of validating or normalising the questions and complexities that arise in the aftermath of a suicide.

"I get this real dilemma, because there's a part of me that just wants to go, I know I know, I know this is horrible, I know its tough…I find myself often reflecting and wondering actually you know how do I professionally empathise with this family and I understand what they're going through…"
- Lily

This quote demonstrates how this participant feels drawn to a both-and approach, both holding a position of understanding the families' pain, and maintaining a position to offer empathy within a professional boundary.

Despite experiencing this level of empathy for the families of clients, some participants expressed feeling angry towards them and experienced this physiologically. In the following extract, this was reported to have occurred at a client's funeral who had died by suicide and for the anger to be towards the family and services.

"I mean it felt, physically, the red hot anger, I went to her (client's) funeral which I'm glad I did, and met mum and I had to really put a lid on it with mum…I remember a physical sense of feeling really tense and really angry, and feeling really that services, not even services, family had let her down, the system had let her down…" - Katie

This indicates that the anger was experienced when the family's actions are perceived as having been unsupportive. This subtheme demonstrates how the experience of suicide bereavement enabled participants to relate to the experience of the families of the clients they work with. Within this interaction, dilemmas are faced in relation to whether or not to share this commonality, and dilemmas are also faced when the family's actions have been unsupportive.

3.3.2. Subtheme 2: Self-doubt – "What could I have said or done differently?

This second subtheme is one that is echoed throughout many of the participants' stories. Almost all participants voiced that they questioned their abilities following the experience of suicide bereavement. Most participants reported that in the aftermath of a suicide, they would question what they could have said or done differently, with the view that this may have made a difference to the outcome, or perhaps prevented the death altogether. An interesting observation was that this sense of self-doubt was reported across the participants who experienced a personal and professional loss, regardless of years of experience and seniority as highlighted by the quote below from a participant with thirteen years of post-qualification experience.

"When something like that happens, there's guilt, you know, could I have done something differently that would have changed the outcome? Erm…did I do what erm, what I should've done? You know, also the worry of what if I am judged? You know by other people, and my action or inaction…" -Rosie

This sense of self doubt appeared connected to a sense of responsibility held by the participant. This may be precipitated by the idea that clinical psychologists can prevent suicide and therefore should be preventing suicides. Thus, when someone does complete suicide, self-doubt appears heightened, as demonstrated in the quote below:

"I did a lot of questioning, I should've done a better job…what if I checked this what if I noticed something that would've changed the outcome…I thought I'd failed, I felt very sad, I felt guilty…" - Katie

This quote indicates that the participant wondered what they could have done or said to affect the outcome, which was connected to a sense of failure. A sense of having failed was reported by most participants, this was described in relation to failing the person who died by suicide, and a sense of having failed to identify their risk or keep them safe. Few participants even went to so far so as to mention that they were uncertain whether they could continue working as a psychologist following the death of a close friend.

"I remember thinking I am struggling to go back to work like I can't go back to work, I can't imagine being a psychologist again…" - Ruby

Most participants reported a sense of fragility following a suicide bereavement, as captured by the quote below:

"One of the biggest impacts probably is, that kind of sudden the real sort of, sudden being hit around the head with the realisation that you never know what's going to happen…you don't know erm what's around the corner" - *Lily*

This indicates how following a suicide, some participants were left with a sense that anything can happen unexpectedly. Therefore, the experience of suicide loss impacted the participants' perception of their ability to predict or manage risk, largely due to their own experience of suicide bereavement being so unexpected. Feelings of self-doubt were reported across the participants' stories. These feelings may be underpinned by a sense that clinical psychologists should prevent suicide, and a view it is always possible to prevent suicide. In particular, it suggests that suicide is something that should be prevented, thus when it does occur, clinical psychologists may experience a sense of failure and self-doubt.

3.3.3. Subtheme 3: When views are not aligned

The third subtheme captures the incongruity between participant perspectives and their respective NHS Trust or service policies. Within this subtheme, we learn that the employing Trusts views are in conflict with other subthemes i.e. '*Suicide as the solution'* and '*The right to live, the right to die'*. An example of the dilemmas that arise when views are not aligned is illustrated below, where a participant talks about their uncle's suicide shaped her view around suicide and personal choice.

"…my uncle's death has left me with a feeling that's probably not in keeping with how the Trust wants us to see suicide. There's a lot of work around suicide prevention now as it should be a never event, and I sort of think well…it's people's choice." - Rose

This quote demonstrates the dilemma faced when the employing Trust's view may not sit directly alongside the participants' view around people's choice to decide to end their life. To manage this discrepancy, some participants reflected on the value of adopting a both-and position, both respecting the person's choice and acknowledging the clinical psychologist's own duty of care.

"I can sit with distress or the uncertainty of whether somebody may or may not commit suicide in the moment… however I am also employed by the NHS and my duty is to ensure that people stay alive…so there is something I have to do that might go slightly against my personal values…there's something in me that says, I'm tolerating it but I also have a job here and this is my job, my duty, to help and support, and hold on to some hope…" - Belinda

This quote indicates the tension between sitting with the uncertainty, but also holding a professional duty to keep people safe. All participants emphasised that they would always do their utmost best to keep people safe in line with NHS Trust policies and risk management. However, most participants also reported that they continue to

hold on to the view that clients do have a choice, which contributes to a dilemma. Most participants approached this dilemma by tolerating the discrepancy and maintaining a duty of care, once again we see a both-and approach being adopted as a way of navigating the complexities that arise in suicide bereavement.

When reflecting on the challenges of sitting between holding their own views and working alongside NHS Trust initiatives, most participants described a sense that the Trust initiatives are not achievable or realistic.

"It almost inevitably sets clinicians up to get it wrong…" – Jade

An unintended consequence of such initiatives are that they place unrealistic expectations on clinicians. Other participants described how the suicide prevention initiatives can often shift the agency and responsibility onto the clinician.

"I think it really emphasises the responsibility of clinician, its sort of somehow taking responsibility away from the person and putting it on clinicians…it's not something that's ever achievable…" - Nina

From these quotes, we can observe how participants shared concern about the consequences of these initiatives, in that the impact on the clinicians can lead to feeling responsible for suicide prevention.

Reflection

As the research progressed and I became more aware of my own position in relation to the "zero suicide" initiative and reflected on the likely origins of this. It made me realise that I wanted to remain as curious as ever with the participants I interview, and to explore how they position themselves and how they may view the "zero suicide" approach. As I continued to interview participants, I became aware that whilst some participants felt strongly that the "zero suicide" approaches were harmful, some participants also acknowledged the value of such an approach. It was helpful to engage in a meaningful conversation with participants about this topic, as there is not usually a space to have such conversations. I noticed that the interviews opened up new ways of thinking about the "zero suicide" approach, and enabled me to think about both sides to the initiative. I found it helpful to reflect on this in my reflective journal and to talk about this amongst my research team. For example, I understood that the approach can be beneficial for services to work towards reducing risk and improving the quality of life for people to then try and prevent a suicide from occurring. However I also became aware that this narrative does not fit when services are being cut and resources are stretched, as the expectation for no suicide feels unachievable within this context. I noticed becoming a bit more understanding towards this framework as the work progressed, I understood the importance of both striving towards suicide reduction and acknowledging that sometimes this is inevitable despite how much services intervene. This position felt most helpful for me as a researcher, but also as a clinician. This tension and discrepancy seems to be effectively managed by employing the both-and approach.

3.3.4. Subtheme 4: Suicide as 'the solution'

This subtheme offers an overview of how clinical psychologists make sense and understand the experience of suicide. Participants described making sense of suicide as a response to distress, an escape and an active choice which can be understandable given the person's context. Different words were used by participants to describe distress, this includes hopelessness, feeling too overwhelmed and unable to cope. Some participants expressed that they viewed suicide as occurring when people are living with unsurmountable amounts of pain. Suicide was also viewed as a way of ending suffering and as having no other options. Some examples of this sense-making are given below:

> "…there must've been something too painful for her to sort of remain in this world which is why she decided to do that….that's how I understand it really, it must've been too hard too unsurmountable…" - Theresa

This extract below illustrates how another participant understands suicide.

> "It's a way of solving deep emotional distress" - Katie

Other participants understood suicide as a way of escaping and seeking respite from their emotional distress. Participants differentiated between suicide when people want to die, and suicide when people no longer want to be here.

"Some clients who are looking for a kind of escape, a bit of respite from where they're at, and then there are clients who want to die and don't want to be here…" - Hazel

Most participants stated that suicide was an understandable response to having a poor quality of life or having suffered traumatic experiences. In these circumstances, the decision to end one's life is viewed as understandable.

"I think there are circumstances where, you know it's a reasonable decision to end your life, you know where, your quality of life is so poor, where that isn't likely to change…" - Rosie

The above quotes offer some examples of when the decision for people to take their own life may be an understandable solution. This account is similar to the proceeding subtheme and may overlap with the subtheme that people have a 'right' to decide to end their life through suicide.

Some participants reported that following the suicide of a client, relative or friend, they experienced a shift in how they viewed or made sense of suicide. Some

participants were honest in reporting that they had previously viewed suicide as a cowardly act, yet having experienced suicide bereavement, this view has shifted towards acknowledging the person's emotional struggle and pain.

"…so I used to think it was a very cowardly thing to do, but actually it's the opposite of that I can't contemplate to get to a point where you feel like that's the only solution, its just not at all cowardly, its really scary and horrible" - Amber

This quote highlights that the personal experience of loss by suicide transformed how suicide was viewed, but also indicates that the participant became acutely aware of the level of distress or despair that contributes to them making such a decision.

Some participants acknowledged that their pre-existing views were likely to be shaped by their lack of direct experience with suicide or suicidal behaviours, as indicated in the extract below:

"I think that's the first time I really engaged with or had to engage with suicide and what that meant…it is not as clear as, living is good and dying is bad… I think it's the first time I had to really confront the idea that some people may actually really want to die…" – Hazel

This quote demonstrates how the experience of suicide bereavement led to having to face the intricacies of death and dying, as well as having to engage with the meaning of suicide for the first time, which contributed to the change in perspective.

In response to the prompt of the role of religion and spirituality in the sense-making process, one participant expressed how she believed that God would also be understanding of the decision that someone makes to end their life.

"I like 100% believe in God, and I trust that he is merciful and will take into consideration the pain people are in and the reasons behind their actions…"
- Amber

3.3.5. Subtheme 5: The right to live, the right to die.

Building on the previous subtheme of suicide being conceptualised as understandable, this subtheme discusses the right that someone has to decide if they want to live or die, and what this means for clinicians. Most participants reported that they felt strongly that people had the right and agency to decide to end their life.

"…realisation that people have rights to make their own decision about their life…and...the decision whether to live or not, it's their decision to take their life, I kind of believe that erm, people can make considered decisions about these things…" – Rosie

Some participants reported discomfort at not acknowledging and respecting these rights, and likened this experience to stopping people and tying them down. The extract listed below demonstrates how participants viewed that, if someone has made the intention to end their life, they will complete suicide. This participant was referencing a client she had worked with within an in-patient context.

"…if she's going to do it, she's going to do it, and how much of that can we, how much can we tie a human down? And stop them? That doesn't feel right…I don't know how to feel about the fact that I feel she's got every right to do what she wants with her life…" - Belinda

From this extract, it is clear that the act of keeping people safe can also be understood as not respecting the right to die. This sense of not respecting people's choices and rights ties into a dilemma faced by the participants who reported questioning their role and position in relation to people who are suicidal or people who complete suicide.

"…it's always stuck with me, in terms of, that ideas of feeling who are we to force people to stay in a life that is making them miserable?" - Hazel

This extract indicates the predicament faced by a participant who reflected on their role in relation to risk management; this participant offered an alternative position

by sharing that keeping people safe can also feel as though people are forced to remain in a state where they feel so unhappy and distressed. This view is further supported by other participants who shared similar reflections.

"I don't think anyone has the right to tell someone whose been through an incident like that you have to stay alive…how can you tell somebody like that that they must have hope or purpose when they've got nothing left, literally nothing left…" - Rose

This extract reflects how this participant felt in relation to the loss of her uncle following a series of tragic events, which left her uncle in a state of hopelessness. The participant appears to express a sense of understanding his position and his decision, and asserts the view that no-one has the right to tell someone else to remain alive following such traumatic experiences.

Questions were raised relating to whether people with mental health problems, or people who are emotionally distressed, have the capacity to decide to end their own life. This was pertinent to whether they were able to make an informed decision, weigh up their options and whether they are aware that life could change or improve.

"…I kind of think he made the decision that was right for him and that's kind of okay, I think when it's not okay is when people have mental health

problems and its around assessing what is their capacity to make that

decision…" - Katie

Some participants felt strongly that people with mental health problems may benefit from a capacity assessment, to explore whether they understand the implications of making a decision to end their life.

These accounts capture how participants attempt to make sense of suicide, and brings to light the ethical dilemmas that arise due to the complex nature of suicide bereavement.

3.4. Theme 3: An experience that helps clinical psychologists face it

The third and final theme captures how the experience of losing someone to suicide has shaped how participants engage in their clinical work, and captures how it has led to a shift in their professional identity. The impact of losing someone to suicide resulted in having an increased awareness of risk both within their personal and professional contexts, as well as acknowledging the limits of the role as clinical psychologists. In addition, participants reported an increased sense of having more humanity within the supervision context and within their clinical work. Participants talked about personal growth and resilience which stemmed from their experience of suicide bereavement, they explored what they have noticed they do more or less of. Participants spoke about the psychological frameworks which they have leaned on to make sense of and cope with their experience, Compassion Focused Therapy (CFT)

was the model of choice. The value of belonging to a religious faith or holding spiritual belief was also acknowledged. And lastly, some participants talked about how the loss of a loved one, friend or colleague to suicide in fact shaped their career choice or shaped their decision of which service they wanted to work in. These themes will now be explored in more depth.

3.4.1. Subtheme 1: Resilience in the face of risk

This subtheme highlights the changes participants noticed following their experience of suicide bereavement. Overall participants reported more curiosity when talking to people about suicide or suicidal ideation. The increased curiosity and confidence to explore this topic led to participants thinking more about the meaning behind the method used by people who have attempted or completed suicide. This exploration was thought to be helpful as it may offer some useful insights into what the person may have been experiencing.

"…think about methods that people are thinking about using or, but why have they chosen that what is that about? What experiences have they had that they felt that they were going to do that…there must be a reason why people chose to do that?" - Ruby

This quote reflects the shift towards thinking more about the methods people use to end their life, something which previously, the participants reported they would not

usually explore further. This participant went on to share that they feel able to have this conversation and explore this with clients. The ability to have this conversation is rooted in their own experience. Having those questions about their own experience of suicide bereavement enabled them to hold these questions in mind when working with other people.

Another participant reported that they are more attuned to picking up on subtle interactions.

"I think it's about picking on the subtle stuff…if something feels uneasy for me then I won't sit on it I'll go back to the client and say look what's this about? So the hug at the end…this time around, you know if it happened again I would wonder at the time, what's going on here?" – Jade

This quote reflects how this participant felt able to have a conversation about a concern or curiosity they have with clients, being able to explore this openly was reportedly an impact of having experienced a client suicide. It was widely reported that once they have experienced the loss of a client, participants felt less apprehensive about engaging in conversations about suicidal ideation with people. Most participants reported less fear and more confidence in talking about suicide and suicidal ideation with others.

"It's definitely the worst thing I imagined happening and I survived it…so I'm maybe less scared to talk to people about suicidal ideation…its somehow less frightening to go into those sorts of areas" - Maeve

In keeping with the theme of resilience, participants reported a sense of feeling liberated at having experienced a suicide either within a personal or professional context. Participants expressed a feeling that they had survived their worst feared scenario.

"…there was also a sense of, I think, having dreaded something like happening, and then almost kind of erm, that worst case scenario had happened...and there was a bit of…I don't want to say relief but…reality checking your worst fear?...there was something liberating about you know the thing that I've been working really hard to avoid and worrying about happening had happened…definitely it's the worst thing I imagined happening, and I survived it…" - Amber

By engaging in these conversations, participants reflected on their increased ability and strength to face this otherwise avoided topic.

"…I think probably the thing I do differently is really face it head on…the more difficult it is the more I will try and face it…" - Lily

This extract demonstrates how this participant feels able to confront these conversations because of her own experience. Connected to the previous point of having survived the most feared situation, most participants reported having more of a capability to face the fear.

Whilst some participants reported confronting the fear and having more conversations to explore suicidal ideation and the meaning behind methods used, other participants reported feeling more alert for suicide and risk in their own personal lives. This heightened sense was described by one participant as having an antenna for risk, indicating that they would be looking out for suicidal risk within their own personal context. It was clear that this heightened awareness for risk was strongly connected to having previously lost someone to suicide.

"There may be a sense of, being more sort of alert in my personal life maybe, and having more of an antenna for it because of my professional training…perhaps being more willing to go there with somebody in the future if I was worried about them…" - Nina

For most participants, having the heightened awareness led to them to be able to engage in conversations about suicide, as illustrated in the quote above. This participant talked about feeling more inclined to check in with people if there was a sense that they were distressed, this would apply to both their clinical work and personal relationships. This is further supported by another participant who shared

that following the loss of her cousin to suicide and her experience working in a third sector organisation, she feels more vigilant when she observes people presenting with hopelessness, which leads her to check in on others more than usual.

"…there's always something around, checking in on people and I suppose, in my life I've always been a bit more weary of hopelessness coming to the forefront and rearing its head…" - Belinda

Many participants described how their experience was in some way helpful at the risk assessment phase with clients, but there were some exceptions such as the report of becoming hyper-vigilant about risk.

"…to add to personally, I suppose what it has made me think is, it's made me a bit more paranoid I suppose because…I wasn't expecting my uncle to kill himself so who's going to do it next? Personally it made me feel like, I can't judge, I have no clue, I'm oblivious to it, so I guess it's made me more wary about not kind of assuming people won't kill themselves because they do…" – Lily

This account illustrates that because the suicide was so unexpected, this participant was left with a sense that they were unable to detect who may commit suicide next.

Most participants reported a greater tolerance for sitting with risk and supporting with people reporting suicidal ideation, they reported being more attuned to people experiencing hopelessness or suicidal ideation.

"I don't know whether it's helped me to understand a bit more? Or maybe even tolerate a bit more when people are saying things erm you know erm finding it too difficult to be here…" - Theresa

This quote illustrates how the participants' experience of suicide bereavement led to her being more understanding and able to tolerate difficult conversations about people not wanting to be here anymore.

"I think erm…when everyone else around you is really anxious, I don't necessarily view it like that, and I wonder if that is my tolerance level? I can sit with distress or the uncertainty of whether somebody may or may not commit suicide in the moment…" - Belinda

This quote illustrates how the ability to sit with uncertainty is greater, and this participant also reports feeling less anxious about these interactions in comparison to her colleagues within the service. Interestingly, whilst participants reported a greater

tolerance for sitting with higher levels of risk, participants also reported that the experience of losing someone to suicide led them to become more aware of the limits of the support psychologists are able to offer. This came with realisation that as clinical psychologists their support can also be fallible.

"…it's helped me to be more empathic about that and to think we are not infallible, and this is a journey a route that people can take out of their life if they just find it too difficult too overwhelming to be here…" - Theresa

Most participants acknowledged that that within their roles following the suicide bereavement, their aim is to sit with people at a time of their life where they are suffering or in deep emotional distress. However, this did not mean that their role is specifically to save people or adopt a role of a saviour.

"…a lot of the time you're not able to, to necessarily save someone's life, so you know there's just a sense that you're not here to be a saviour, you're here to be with someone…" - Belinda

Most participants recognised that managing risk is not always possible, and this appeared to bring a sense of acceptance of the limitations of the role of a clinical psychologist.

"It's a balance of erm, trying to manage risk erm, and trying to do what needs to be done on a practical level, but also having to accept that you can't eliminate it either, there is no guarantee necessarily…" - Nina

Within this subtheme of becoming more resilient, participants reported that even though they feel able to sit with distress and risk, they each individually acknowledge their own limits. This self-awareness appeared to be important in order to recognise their own levels of tolerance.

Participants also spoke about having more humanity within their roles following the suicide bereavement, this was eloquently described by the participant below as taking off the professional mask.

"It's that 'both and' isn't it, I was both personally devastated but also very conscious that I had a professional relationship to the situation…I guess there was an awareness of their grief being greater than my grief…and that mask of professionalism does come off…there's more permission to be imperfect.." - Maeve

This account describes how the participant felt able to remain aware of their professional relationship, but also connect to their own grief towards the loss of the client, a process which was facilitated by giving themselves permission to be imperfect. This demonstrates how the participant was able to adopt a more

compassionate stance towards themselves. A striking point raised by Maeve, is the usefulness of adopting a both-and position, a position that has been considered helpful in the previous subthemes, 'Walking in the family's shoes' and 'When views are not aligned'. One participant described maintaining a balance between not promoting hope when it is inappropriate and not genuine, and also not also sitting entirely with the despair.

"It's often felt like a very difficult erm, a tight rope to walk, with the client not wanting to sit completely with despair but not promoting hope to a point that it feels disingenuous…" - Jade

These extracts demonstrate the layers of complexity faced by clinical psychologists in relation to suicide bereavement. Collectively, these accounts tell a story of a shift towards having a greater curiosity and tolerance for people presenting with suicidality and risk-related concerns. Due to the unpredictability and unexpected nature of suicide loss experienced, some participants also reported feeling increasingly vigilant for risk within their personal life.

3.4.2. Subtheme 2: The experience of loss shaped career

An interesting finding reported by most participants was that their experience of suicide bereavement led to them opting for a career in clinical psychology. One

participant suggested that those who enter the helping professions do so to try and rescue someone they know.

"…and probably without knowing it, all of us that go into helping professions and being therapists are really trying to rescue somebody else in our personal lives, I was probably trying to rescue my mum without knowing it…" - Rose

This quote was reported in the context of the participant observing her mother's distress at the loss of her uncle to suicide, she reflected that her mother was so deeply affected by the loss, that her choice to embark on a career in clinical psychology was likely to be an attempt to rescue her mother or to make sense of the experience. This account was also supported by another participant who shared that the loss of her friend to suicide led her to want to try and develop her understanding and formulate the experience.

"…I felt like I had the needed to do something to try and understand you know what might have led my friend to have taken that action at that time was kind of a way of sense making for myself…we all have our own things that we bring into it..." - Theresa

This extract illustrates that being able to embark on a career in clinical psychology contributed to the sense making process for this participant. An interesting reflection

was added in acknowledging that all clinical psychologists carry their own experiences with them into the profession.

3.4.3. Subtheme 3: "The light within the dark clouds"

This third subtheme portrays three main areas that clinical psychologists reported as helpful in coping with the challenges and dilemmas following a suicide bereavement. These were CFT, holding onto hope, and spiritual or religious beliefs. Most participants expressed that they found compassion focused therapy (CFT) helpful in understanding the distress of people who are suicidal.

> *…that's one of the amazing things I love about CFT is that kind of makes it make sense, because it draws on neurobiology and evolutionary ideas, and developmental psychology that I feel it somehow captures both sides…and also within that it has this kind of layer of, humans are complex and incredible creatures and capable of so much good…" - Hazel*

This quote illustrates how the participant valued the way CFT acknowledges ideas from developmental, neurobiological and evolutionary models. The participant voices how CFT acknowledges the complexity of human experiences which enabled them to connect with the approach to make sense of suicide. Other participants expressed using the CFT approach to support themselves through times of difficulty.

"…the compassion focused therapy models really stuck with me I think because I've been able to use so much of it myself in terms of helping me through the difficult times…its really like, it's the light within all the dark clouds for me…" - Ruby

From this quote, we can see how the CFT approach was used by the participant as a way of coping and helping her to make sense of the loss of a close friend to suicide, so much so that CFT was described as the "*light within the dark clouds*".

Another aspect which participants found helpful in supporting them to cope with the dilemmas arising following a suicide is holding onto hope that the situation may change for the better. Holding onto hope was reported by most participants as a key part of their role as a clinical psychologist.

"…although it makes sense for me that people want to end their life, I think the way I view the world is that there's always hope that things will improve and I think for me I feel like I have to feel like that or I feel I couldn't do my job…as a psychologist" – Ruby

This quote reflects how hope was recognised as instrumental when working with people who are experiencing suicidal ideation, but also forms a core part of the identity of a clinical psychologist.

In response to a prompt about the role of spirituality and religion, one participant expressed how she uses her religious beliefs in her work, which she has found to be helpful.

"I feel like it's not that hard to bring that aspect of God into my work…I often kind of pray that God should just use me in my work, and let people see his love through me, that's just a massive thing, to show people love, and show people understanding, and let them be listened to, let them be heard, and those are powerful things…" - Amber

This account offers examples as to how a clinical psychologists religion or spiritual position can be helpful in supporting people in distress.

"I am seeing a patient at the moment who is strongly Catholic, they have a firm belief that suicide is unacceptable and you never do it, which is good for me because then it means he doesn't attempt to take his own life no matter how desperate he gets…" - Rose

This account highlights how faith can be protective for the client, and therefore protective for the clinical psychologist.

Overall, the third theme highlights that participants have experienced a sense of growth following their experience of losing a loved one, friend or client to suicide.

Themes of resilience, hope, compassion and faith were identified, along with acknowledging the impact of the suicide on career choices.

3.5. Conclusion of Results

The first theme indicated how conversations about suicide were experienced as limited and this was attributed to a number of factors. There was a view that participants needed to maintain a boundary between their professional and personal self, which meant that conversations between staff colleagues and clients were somewhat difficult and uncomfortable. Participants also reflected that talking about this topic with colleagues felt like an invasion of privacy. The NHS Trust and employing services were viewed as adopting an approach to managing suicide which felt detached from the context by introducing suicide prevention strategies which were experienced as unrealistic, and by standardising risk assessments. Although the aforementioned aspects were thought to limit conversations about suicide, when conversations did happen, it was generally valued and helpful. Interestingly, the experience of suicide bereavement led to participants being able to reflect on their own views of suicide, approach supervisors to seek support, and enabled the opportunity to have more open conversations with both ones clients and own families. The experience of feeling distressed upon hearing conversations about suicide which resonated with their own experience was also reported.

The second theme demonstrates how suicide is understood from multiple and at times conflicting perspectives. Participants reflected on the dilemma that they often sit with, which relates to keeping people safe and alive but, on the flip side, feeling as

though they are forcing people to remain in a life they no longer feel able to cope with. Participants reflected on the difficulty of maintaining a balance between sitting with despair and maintaining hope which felt disingenuous. Participants also reflected on the dilemmas of not fully agreeing with the suicide prevention initiatives and the importance of maintaining the duty of care towards clients. Participants noted the challenges of holding views in relation to people having the right to live and a right to die, whilst being mindful around issues of capacity relating to people with mental health problems. A dilemma reported by most participants described how being both a clinician and a 'survivor of suicide' enabled them to feel more connected with the families' experience but also generates a quandary towards whether or not to reveal this commonality. Most participants reported one way of managing this was to hold on to the both-and position, by remaining aware of one's own views, and doing everything in one's ability to keep others safe in line with their duty of care. This position was reported as the most helpful irrespective of the conflict.

The third theme demonstrates that the experience of suicide bereavement shaped who they are as a clinical psychologist. For all of the participants, the experience of suicide loss led to a sense of increased resilience when working with or facing of risk. Participants expressed how there was an increased curiousness about methods people use to end their life, leading to them exploring the meaning behind the method. Participants reported picking up subtle non-verbal behaviours and reported feeling more confident to explore this with clients. Participants expressed a sense of relief following having survived the worst feared situation. This led to them feeling less frightened to approach conversations about suicide, and more willing and able to '*face it'.* The experience of losing someone to suicide within a personal or

professional context led to participants having more of an antenna for risk. This meant that they had become more attuned to noticing hopelessness, checking in with people more often, and some described it as being more hypervigilant about unexpected and unpredictable risk. Participants reported that the experience has led to them feeling more able to sit with high levels of risk. Interestingly, participants reported that the suicide loss led them to acknowledge how clinical psychologists were not infallible.

The experience of suicide loss reportedly led to participants connecting with grief within a professional and personal context which meant that they were able to step away from holding up a mask of professionalism. This is connected to the finding from theme two which saw psychologists experiencing feelings related to self-doubt and failure. Some participants reported that their experience of suicide loss influenced their career choice to become a clinical psychologist, or influenced their decision over what service to work in. Some participants reported that their reasoning for entering the profession is due to attempting to develop their understanding of why people take their own life. Some participants reflected that they believe that most people enter helping professions as a way to rescue someone they know. In relation to what helps clinical psychologists to navigate the dilemmas raised by a suicide bereavement, participants reported Compassion Focused Therapy (CFT) was helpful. Holding on to a religious belief or spiritual values was also considered beneficial. Being compassionate to others and to themselves was at the core of what participants found helpful, as was the notion of holding on to hope. Hope was related to a vague sense that somehow things will change for the person. This was thought of as an important part of the identity of a clinical psychologist.

Reflections

When completing the interviews and data analysis, I found myself being pleasantly surprised by some of the reflections. I noticed feeling assured when I would hear some participants reflect on how they would at times feel triggered by hearing people talk about methods of suicide which were similar to the methods used by the person they knew. I too notice throughout my clinical practice, feeling physiological changes when people talk about suicide by hanging. I was surprised to hear how common this experience was. I was also surprised by the level of curiosity and tolerance that people developed following the experience of losing a loved one and/or client to suicide. Admittedly, the experience of losing a client initially shook my confidence throughout training, however as time progressed I noticed myself being more able to sit with people who are presenting with suicidal ideation or people who engage in suicidal behaviours, and I felt able to explore this with them. I had not expected to hear that this was also experienced by a number of participants, and that the experience enabled them to "face" more risk which I strongly related to.

4. Discussion

Over the course of this chapter, I will offer a brief overview of the research findings, and make connections between these findings and the wider literature base. I will also discuss my reflections on the research process, the implications, and the strengths and limitations of the research study. I will end the chapter on suggestions for further research and concluding remarks.

4.1. Summary of Results

The aim of this research study was to interview clinical psychologists who have experienced a suicide loss of either a loved one and/or a client, and to explore how they made sense of the suicide. The research question focused on exploring how suicide is talked about and thought about, with the intention of bridging the current research gap. An overview of the findings will now be presented.

Three main themes were identified following the thematic analysis of the twelve semi-structured interviews. These themes captured how colleagues, clients and clinical psychologists themselves, talk about suicide, and whether this is experienced as a helpful or unhelpful event. The themes also highlighted the dilemmas which arise when a suicide occurs which influence how suicide was understood. And finally, the themes demonstrate how the experience of suicide loss strengthened resilience, and explores what clinical psychologists find helpful when managing the challenges in response to suicide bereavement.

4.2. Relevance of the findings to the theoretical and empirical literature

The first theme of *'How talk is experienced as a way of making sense of suicide'*, explores how talk is experienced in relation to talking about suicide. The subtheme of *'talk as inhibited'* captures how conversations are often impeded between staff, and between staff and clients. Two reasons that conversations were limited were reportedly due to a sense that having these discussions may be an invasion of privacy, as well as an apparent fear of being judged for holding certain views. This finding extends upon what was found in the literature, and adds new detail to the findings by Tillman (2006) who found that participants had a fear of being judged by colleagues for doing something wrong following a client suicide. The findings from the current study have a slightly different emphasis in that participants were worried about being judged for the alternative views they held. This adds a moral dimension about how society thinks about suicide, and what is deemed acceptable. This field is heavily under researched amongst clinical psychologists, and little is known about how clinical psychologists who do not have the experience of suicide bereavement, view and understand suicide. However, based on what is known, suicide in the face of physical illness has been judged to be significantly more acceptable than suicides committed in response to chronic psychiatric illness. Psychologists were identified as the most accepting of suicide in response to chronic pain (Hammond & Deluty, 1992). A study investigating psychotherapist's attitudes towards suicides found that those who practiced for more than 30 years were more accepting of suicide and took less action to prevent them from occurring than less experienced psychotherapists. Interestingly, 81% of 186 psychotherapists reported they believed in the idea of a rational suicide (Werth & Liddle, 1994). Anderson (2000) also found that participants were averse to

discussing their experience of suicide with other professionals, believing they would be viewed as unprofessional or incompetent. Also in the current study, some participants reported that colleagues believed that talking about suicide with clients may make things worse, but the research evidence indicates that this is not the case, as findings suggest that enquiring about suicide with clients may in fact reduce suicidal ideation (Dazzi, Gribble, Wessely & Fear, 2014).

There was also a reported sense that clinical psychologists may not openly share their personal experiences of distress and suicide loss with colleagues. This could perpetuate the lack of conversation, a finding which is also supported by Anderson (2000). An interesting and novel finding was that, when conversations did occur within team meetings and between colleagues, this was experienced as devoid of context or blasé. This finding appears to build on the report that because suicide is difficult to talk about (Davidsen, 2011), staff may use language such as "*this sort of incident*" (Foggin et al, 2016) as a way of avoiding strong feelings and professionally distancing themselves from the event (Neimeyer & Pfeiffer, 1994). If there is no platform for staff to voice what is difficult, they may be more likely to experience compassion fatigue (Figley, 2002), which may come across as lacking in empathy. Staff may then feel unable to address these topics with clients in distress, and may not approach the conversation with the sensitivity and respect it deserves.

The second subtheme of '*talk as valuable'* captures how the experience of losing a loved one and/or client to suicide led to conversations related to risk being approached with openness and less fear. This finding appears to add a new dimension to the existing literature which emphasises that talking about suicide is often limited. This shift may be understood as a greater ability to cope with challenges following a

traumatic event (Janoff-Bulman, 2004). This point will be explored in more depth at a later point when discussing the third theme. In some cases, when clinical psychologists were able to talk to supervisors about their experience of suicide bereavement, it enabled better communication with supervisors, this complements the first subtheme in that talking about suicide is an overall valued experience. This finding also supports Veuilleux (2011) and Finlayson and Simmonds (2018) who summarised that supervision can be a useful coping mechanism for processing the loss. However, few participants reported that talking to supervisors and colleagues was not a helpful experience. This finding demonstrates that usefulness of this interaction was influenced by the context and relationship with the colleagues and supervisors, thus indicating that if we can focus on improving the context, perhaps these conversations can be experienced as more helpful more often. This point is discussed further in the clinical implications section. When analysing the data, I was mindful that there may have been differences between how participants experienced talking about suicide bereavement in supervision, as this might have been experienced differently depending on whether the participant lost a client or loved one, or whether the suicide loss was experienced pre, during or post clinical training. In the current study, participants who lost a loved one to suicide pre-training shared a similar experience to those who lost a friend during their clinical training, in relation to talking about the impact of suicide bereavement to their supervisors. For participants who lost both a loved one and/or a client, talking about this experience during supervision was also considered valuable.

The experience of losing a family member or friend to suicide also appeared to promote more openness to talking about suicide loss between family members for

participants in this study. This finding conflicts with that of McMenamy, Jordan &

Mitchell (2008) who reported that communication about suicide within the family was

a source of conflict as many people felt uncomfortable to discuss the suicide or share

their grief. It appears that whilst talk was inhibited in some contexts i.e. MDT settings,

it was valuable in others i.e. in supervision and between family members. Perhaps this

is because the experience of losing a friend or family member is shared between the

participants and their wider family system, which may have made talking openly about

suicide loss more manageable. This subtheme demonstrates that how people

understood the experience of suicide bereavement was inherently connected to how

it is then spoken about, and visa versa. This point can be understood from the Co-

ordinated Management of Meaning (CMM) framework (Pearce & Chronen, 1980),

which views that how we develop relationships and create meaning is constructed

through communication. Based on this premise, the current study suggests that the

process of making sense of suicide is influenced by both the presence/absence of

talking about suicide and how suicide is talked about. A third subtheme related to the

experience of talking about suicide as a triggering experience. The experience of

suicide bereavement led to feelings of anxiety and dissociation being activated,

specifically upon hearing clients or colleagues talk about suicide which bore similarities

with their own loss. These feelings are similar to a reaction to a traumatic event

(Chentsova-Dutton et al, 1998). This finding is in support of Tillman (2006), who also

concluded that following a client suicide, participants reported trauma symptoms such

as dissociation and intrusive thoughts. These findings also add support and contribute

to the existing literature on vicarious trauma in mental health professionals (Pearlman

& Saakvitne, 1995). Vicarious trauma is a term used to conceptualise a process where

clinicians become negatively affected by an empathic connection with clients'

traumatic material.   This is a significant finding because we see from the key literature and policies, that clinical psychologists or health professionals are not always considered as 'survivors of suicide', yet this finding demonstrates the need for this dual role to be acknowledged in order for the appropriate support to be provided. This point will be returned to in the clinical implications below. I was mindful that the experience of feeling triggered may have been different between particpants' who lost a loved one and participants who lost a client. Some differences were observed amongst those who lost a loved one pre-training, as these participants reported noticing intense physiological changes when the methods of suicide reflected their own personal experience. This may warrant further investigation in a future research study.

The second theme, "*The messiness of being human*", captures the dilemmas that emerge when attempting to make sense of suicide. One finding which enhances what is already known, was the dilemma of navigating the dual position of a 'survivor of suicide' and a psychologist. This duality led to increased empathy towards family members of people who end their life, which is a finding that builds on the findings by Anderson (2000). Other predicaments included the experience of self-doubt which contributes to a sense that clinical psychologists could have done or said something differently to prevent the suicide, this led to a feeling of guilt and failure. This finding is consistent with that of Clark (2009) who also noted that participants experienced a crisis of confidence within their professional role following a client suicide. The unexpected and sudden nature of the suicide had taken place led to some clinical psychologists doubting their ability to predict and manage suicide risk. In some cases, this led to the questioning of the ability to work as a psychologist. This finding

enhances what was already known, as self-doubt is common amongst professionals who experience a loss of a client to suicide. For example Sanders, Jacobson and Ting (2005) found that of 145 social workers in mental health settings who experienced a client suicide, 44 doubted their clinical abilities and experienced a sense of professional failure. The current study indicates that this experience may be shared across professional groups. Interestingly, self-doubt was also experienced amongst those whose loss was a suicide in their personal life, which is a finding that adds to existing literature. Perhaps this was seen as a 'missed opportunity' to support someone in their personal life. This finding is linked in to the wider literature relating to defensive practice, as initially discussed in the introduction chapter. Findings in the current study illustrate that a way of managing self-doubt and the crisis of confidence would be to review notes regularly, request a supervisor to review clinical work, and for some participants this also involved working in services after qualifying where the clients present with less suicide risk. It is important to not that, this response was reported by participants who lost a client and/or a loved one before and during their clinical training, as well as post-qualification.

Another dilemma was the incongruity between personal views on suicide and the NHS Trusts' view on suicide management. Findings saw that some participants thought there was a need to respect the choice and agency that people have to end their life, a notion supported by the libertarian perspective that people should have the autonomy to decide to commit suicide (Szasz, 1999). However, all participants also acknowledged their duty of care as clinical psychologists. Nonetheless, most participants aligned themselves with this way of understanding suicide, i.e. that humans have the right to choose to end their own lives. This is an interesting finding,

especially as this is clearly not aligned with the formal position of health and care services in the UK i.e. the zero-suicide policy (HM Government, 2019), which causes a dilemma. To manage this dilemma, some participants employed a 'both-and' position. This enabled them to hold on to their values of respecting choice and also do everything they 'should' to protect life and prevent suicide, in line with formal requirements, despite this meaning putting their personal views aside. A further way of managing this was to not share these views, as demonstrated in the first theme by inhibiting conversations. However this can be difficult to maintain over time and may have unintended consequences, such as burnout, compassionate fatigue, or a reluctance to speak to staff about risk related concerns. These findings contributes to what is already known in the wider literature relating to trauma, compassion fatigue, burnout, and professional stress.

In the current study, suicide prevention initiatives were seen as placing the responsibility onto the clinician and overlooking the choice of the client, a view supported by Sisti and Joffe (2018), who describe such initiatives as representing a failure on the part of the clinician. There appeared to also be dilemma as to whether people with mental health problems have the capacity to end their life. Some participants expressed that people with mental health problems may benefit from a capacity assessment to explore the implications of making this decision is understood. However, this finding contradicts assertions by Hewitt (2013) who advocates that psychological pain should be regarded with the same significance as physical pain, thus even people with serious mental health problems can make a rational decision to end their own life. As such conversations and debates may not openly occur in NHS

contexts, it is likely that participants may continue to face challenges in navigating between their own positions and the expectations of the employing Trust.

And finally, the current study presents a range of descriptions in relation to how suicide is understood which reflects the wider thinking of the impact of suicide bereavement, and is an addition to the existing literature. For example, suicide was conceptualised as 'a solution', i.e. a way of ending deep unsurmountable and unresolved emotional pain, an escape from a place people no longer want to be in, and understandable act. These themes confirm what the literature says about how suicide is understood. For example, Sneidman's (1993) '*psychache'* theory of suicide, proposes that suicide is a response to intolerable psychological pain and an escape from life, often precipitated by a persons secondary needs (also known as psychological needs) not being met. Similarly, Baumeister's (1990) theory also conceptualises suicide as an escape from painful self-awareness in order to achieve respite from unbearable psychological pain, however the emphasis in Baumeister's theory is on negative self-evaluation as a precipitator to suicide attempts and suicidal behaviour. In relation to the current study, because suicide is understood in such a multidimensional way, this allows people to 'zoom out' and consider the range of reasons as to why someone has tried to end their life, or has ended their life. This can in turn help to inform the formulation and promote a more compassionate understanding.

The final theme of '*An experience that shapes psychologists'* captures how clinical psychologists are affected by suicide bereavement, such as increased

resilience when faced with risk related situations, and feeling that they have survived the worst feared scenario, which is a finding that adds to what is known already. Despite the experience of suicide bereavement initially relating to feelings of self-doubt, over time some participants reported a feeling more resilient and confident. This finding is consistent with the idea of gaining "*strength through suffering"*, in that there is a new found strength to cope with the unexpected following a traumatic event (Janoff-Bulman, 2004). This took the form of having more curiosity around the meaning of the method used to attempt or complete suicide, noticing subtle non-verbal cues and having the confidence to raise this with clients. This finding supports the outcome of Clark's (2009) research discussed in the literature review, who conceptualised the new found confidence as a '*positive transformation'* and a '*legacy'* of client suicide. This enriches our understanding of the impact of suicide bereavement amongst clinical psychologists. Based on the findings in the current study, this increased confidence to face what is difficult may also be understood within a context of post traumatic growth (Tedeschi & Calhoun, 2004), as the experience of suicide bereavement has been instrumental in generating new possibilities for exploring risk with clients. Considering this increased confidence as post-traumatic growth may help in recognising the significant impact of suicide bereavement on clinical psychologists, and may normalise the experience. The experience also strengthened how clinical psychologists relate to others, in particular the families who are bereaved by suicide (Tedeschi & Calhoun, 2004). Having more of an awareness of suicide risk in their personal life was also reported, coupled with a heightened awareness that suicide can happen to anyone, both clients and loved ones alike. This finding adds to the existing literature about the impact of suicide bereavement.

The experience of suicide bereavement leading to an increased tolerance to 'sit with' i.e. higher levels of risk was also identified. The experience also appeared to shape the choice of career and choice of services that clinical psychologists enter post qualification. Some entered the field of psychology to develop their understanding of suicide loss, and some reported entering the field to try and 'rescue' family members. This finding builds on Sussman's (1992) reflections that a powerful motivator to enter the profession is to resolve inner conflict coupled with an innate desire to 'work things out'. The concept of the "*wounded healer*" (Guggenbuhl-Craig, 1971) could support the understanding of the participants' experience in the current study. The *"wounded healer"* reflects the notion that psychotherapists search for their own self-growth and self-healing through entering the profession. Therefore, one might suggest that for some participants, their experience of losing a loved one to suicide may have motivated them to enter the profession of clinical psychology to develop their understanding of suicide and emotional distress. It is important to acknowledge the experience of clinicians who may consider themselves wounded healers. Research suggests that the concept of the *wounded healer* can serve to recognise that clinicians (including clinical psychologists, psychotherapists, and medical staff) also carry with them their own wounds and challenges (Hankir, Zaman & Evans-Lanko, 2014). The findings in the current study support the suggestions made by Zerubavel and Wright (2012), who advocate for more recognition, awareness and support of *wounded healers,* as the relative absence of conversations in the field of Psychology may promote a sense of shame and secrecy, which may prohibit the timely access to support and guidance when needed.

CFT has been used in the NHS organisationally i.e. the 'Compassion Ripple-Effect', developed by Frameworks 4 Change which drives the initiative of caring for ourselves to enable us to care for others (Bradley, 2014). The current study highlights a new finding which demonstrates the value of applying CFT within a context of suicide bereavement.

It is important to note certain contradictions in the findings. For example, some participants reported that talking about suicide felt inhibited in the work context, but valued talking about suicide when opportunities arose. Elsewhere, some participants reported feeling hyper-vigilant, and feelings of anxiety were activated, but participants also reported feeling more confident to approach the topic as time progressed. This demonstrates the fluid nature of navigating between these positions. Other factors which appear to influence how clinical psychologists navigate between these positions may be the time since the loss occurred, and a more supportive supervisory relationship.

4.3. Implications of the study

One clinical implication of this study is that it highlights the propensity for suicide bereavement to impact clinical psychologists in the long term, both emotionally and professionally. Findings illustrated that feelings of anxiety and disassociation were triggered upon hearing others talk about the same method of suicide used by their loved one, as well as a heightened awareness of suicide amongst both clients and

loved ones. As mentioned previously, these experiences may possibly reflect a reaction to a traumatic event. Therefore, it is important that clinical psychologists are encouraged to seek support in order to make sense of their experience within a compassionate environment. This may involve conversations in peer supervision and clinical supervision to explore the emotional impact and ethical dilemmas. This may in turn lead to feeling even more able to face the difficulties and promotes the opportunity for post-traumatic growth (Calhoun & Tedeschi, 1999).

Findings from the current study saw that some conversations about suicide and suicide risk in MDTs' described as blasé and not attending to the context and content of the event. To address this, conversations related to the impact of suicide bereavement could be facilitated across various forums i.e. away days, CPD slots, workshops, and seminars, in order to promote an openness and awareness. Schwartz rounds may also offer an alternative approach for conversations about the impact of suicide bereavement, as they provide a structured forum for clinical and non-clinical staff to come together to discuss the emotional and social aspects of working in healthcare and reflect on their roles (Farr & Baker, 2017). However, it is important to note that the absence of these conversations was related to not feeling safe enough and a fear of judgement. Therefore, it would be important to consider how to enable people to feel safe enough to speak about this topic. Staff may benefit from having an open non-judgemental space to reflect on their experience and reflect on how this impacts on their practice. This may involve reflective practice, and increased liaison with third sector specialist charities to gain insight into how to generate a sense of safety and promote discussions within groups. This may also be a useful space to navigate the feelings of self-doubt, blame and responsibility, and would enable

professionals with shared experiences to connect and not feel alone in their experience (Tedeschi et al, 2007).

Following on from this, in relation to the implications within the field of clinical psychology, similar to the above there should be opportunities within conferences, seminars, away days, workshops, and psychology meetings to engage in conversations about suicide bereavement. Perhaps it would be useful to set up a special interest group to ensure that the profession is actively engaging with research within the field. Findings demonstrated that for some participants supervision was a place where they could be open and reflective, and take some more risks in the conversation, whereas others experienced supervision differently. Thus, supervisors may also be supported with further training on how to support clinical psychologists who have experienced suicide bereavement of a client or a loved one. This may heighten their awareness of the role of self-doubt and self-blame, and enable supervisors to engage in an exploratory conversations about how the psychologist is experiencing the loss. This need is further supported by key findings from a very recent paper by Finlayson and Simmonds (2019) who concluded that psychologists need more open communication in the workplace following a client suicide, as well as a space to grieve, peer support as well as opportunities to engage in a learning process.

Doctoral training programmes would benefit from dedicating more lecture time or group discussion on the topic of suicide and suicide bereavement. It would be useful for training programmes to consider that many people have existing experience of suicide bereavement, and others may experience this at some point in their career. Thus, inviting a space for these experiences to be shared and reflected upon may be

helpful. Additionally, it would be useful to consider the psychological models of suicide and research relating to the impact of suicide bereavement. It would also be helpful to discuss the practicalities relating to the aftermath of a client suicide. These implications would support both trainees and qualified clinical psychologists alike to navigate this otherwise unknown territory. Further support for this implication is given by Oordt, Jobes, Fonseca and Schmidt (2009) who pointed out that further training in suicide bereavement can serve as a protective factor by improving the confidence of the therapist. In addition to this point, training in suicide bereavement can also promote preparedness should a client suicide occur (Ellis & Dickey, 1998).

It is not surprising that a lot of value was placed on CFT as a way of coping with the dilemmas raised following a suicide. This led me to consider how a compassion focused frame could be adopted by services at an organizational level to promote connecting with difficult feelings and challenges in the workplace. Compassion is one of the key values that healthcare workers need in order to be work with their clients. Gilbert (2009) describes compassion as the insight and sensitivity to the suffering of others, along with the courage and commitment to prevent such suffering. It may be worthwhile to consider this lens to address the structural matters which undoubtedly influence such conversations, before such a space could come to exist. The limitations of a culture of defensive practice and 'fixed' views of safeguarding and risk management, may make voicing alternative views potentially dangerous. If the conversations in the team can be met with a compassionate stance, and modelled by the service and managers, it may support the team to embody such principles in their work with clients and with themselves, potentially generating a circular process. As CFT offers approaches to work with issues of shame and self-criticism which can

contribute to feeling unsafe (Gilbert, 2014), it would seem appropriate to use this approach to cultivate a compassionate organisation which allows for different positions, and which promotes people talking openly, within a non-judgmental setting. In a qualitative study using an IPA methodology, it was found that organisations that nurture and promote self-compassion in healthcare workers improved their ability to remain compassionate towards others (Gustin & Wagner, 2013). Although this study was conducted amongst nursing teams in physical health settings, there are clear indications of the benefits of embodying a compassionate stance.

In relation to the policy implications from the research, it is clear that the suicide prevention initiatives bring up ethical dilemmas for clinical psychologists, such as whether suicide prevention initiatives or 'zero suicide' policies remove the right to choose to die, or whether they unintentionally place the blame on clinicians. An ethical way around this is to ensure that these initiatives are executed well, and that services are offered the resources needed to support people in a crisis to reduce the despair and the pain people are in, which would improve the effectiveness of such initiatives. Despite £25 million pounds being pledged to support the initiatives and to improve suicide prevention (HM Government, 2019), there remains a sense that this is not sufficient to deliver such a task (Matthews-King, 2018). If services are stretched for resources and underfunded, it is understandable that when a client suicide occurs, there may be the unintended consequence of blame on clinicians and fear within teams to discuss the dilemmas. A possible way to address this is to include clinical psychologists who have experience of suicide to engage in policy making, to generate policies which reduces the sense of blame. This is supported by the assertion by one participant aptly mentioning that suicide prevention policies and initiatives do not seem

to be made collaboratively with people who have been directly affected by suicide. This could contribute to why some initiatives can be experienced as unrealistic or unintentionally blaming the clinician.

4.4. Strengths & Limitations

A strength of this study was that it received an overwhelmingly positive response to participant recruitment, which was completed in under two weeks of the research being advertised. Participants also voiced their appreciation for the opportunity to share their experiences following the completion of the interview. This indicated how this research topic was one that appealed to many clinical psychologists and shows the need within the profession to open up conversation on this topic.

Another strength is that the participants were recruited with varying degrees of post-qualification experience, participants ranged from having three and a half years to twenty years' experience of working as a qualified clinical psychologist. Participants also worked in a variety of clinical settings, which offered a broad overview of the suicide risk across different services.

A limitation of this study is the lack of diversity in the participant sample. I intended to recruit participants across a diverse population of clinical psychologists in line with the social GRRAACCEESS (Burnham, 2018). Whilst efforts were made to achieve this by advertising on social media forums and BAME forums, and through the use of the snowball recruitment technique, it transpired that there was a lack of interest from participants from diverse backgrounds. It is likely that the underrepresentation of

clinical psychologists from diverse backgrounds in this study is a reflection of the current lack of diversity represented in the field of clinical psychology. This is an area that is being addressed through the Division of Clinical Psychology Inclusion Strategy (BPS, 2015). However, it is also important to acknowledge that the study was also advertised to BAME forums and to clinical psychologists from BAME backgrounds in an attempt to invite multiple perspectives, however no responses were acquired. I wondered whether the intersectionality between religion, ethnicity, culture, spirituality and being a 'survivor of suicide' acted as a barrier to participating in this study. I also wondered whether the fear of being judged about holding alternative views in relation to suicide (i.e. that suicide is understandable or that people have a right to choose to take their own life), is amplified where some participants may already experience a fear of being judged related to their intersectionality. I am hoping that naming this gap, and bringing in my own voice as an insider researcher of a BAME background and as a non-practising Muslim, will begin to promote an openness to having these conversations. One implication to address this may be to have people from different BAME backgrounds visibly speaking about the topic of suicide bereavement on training programmes, conferences, seminars and workshops.

Despite the significant limitation that the participant group were not diverse across the social graces, specifically in relation to culture and faith, it is a strength of the study that the participant group is more or less reflective of the demographic make-up of the profession at this time. From the demographic information gathered we see that all the participants were female, this is unsurprising as 80% of clinical psychologists are female (BPS, 2015). All but one identified as white British, again this is likely to mirror the current workforce (BPS, 2015). In relation to faith and spirituality, ten of the twelve

participants reported that they did not identify with a religion or spiritual position, or identified as an atheist. This reflects the literature discussed in the introduction which indicated that clinical psychologists are more likely to not identify with a religion (Smiley, 2001) and identify as less religious than their clients (Post & Wade, 2009). This may account for why the responses to the prompt on spirituality and religion did not generate strong themes as expected.

As an insider researcher, I occupy a dual role. I am aware that this allowed for more understanding of the phenomena relating to suicide (Saidin, 2017), and the dual role was reported to be a benefit to the experience of interviewees, with most participants reporting that knowledge of a shared experience enabled them to speak openly and tell their story. However, I noticed that during the analysis phase, I was mindful of being drawn to certain themes more strongly than others. The loss of objectivity and bias is a strong criticism of being an insider researcher (Greene, 2014). A further disadvantage that insider researchers face, is navigating between being both the researched and the researcher (Chavez, 2008). To mitigate this, regular meetings with my research team took place, and I recorded my thoughts and reflections via a "*stream of conscious writing*" (Van Heugten, 2004) in a journal (see Appendix 1) and reflections are also documented in the next section within this chapter. Collectively, these actions helped me to create some distance and remain impartial.

There are also limitations relating to the heterogeneity of the participant sample. I elected to interview participants who lost a loved one, a friend, a colleague or a client to suicide. I also elected to include participants who experienced their loss either pre-training or post-qualification. By not differentiating between the nature of the relationship (personal or professional) or between the timing of the loss (pre-training

or post-qualification), the study may have not captured the potential differences in these experiences. This is an area to consider for further research. It is also important to bare in mind, that clinical psychologists may not hold one experience over the other. Much like myself, clinical psychologists who have an experience of a personal suicide bereavement, may also experience the loss of a client throughout their career, therefore such experiences may not be straightforward to differentiate between.

A final potential limitation of the current study is the small sample size which may lead to limited generalisability. However, it was my intention to offer a rich and in-depth insight into accounts which have been previously unheard, and to explore a topic which may resonate with the reader.

4.5. Reflexivity

I have previously outlined my relationship and motivation to carry out this study. The personal loss of my cousins to suicide in 2001, and the more recent loss of a client to suicide during my first year of clinical training, led me to be increasingly curious about how we think about suicide as a profession.

At the start of this research process, I was acutely aware of my dual role as an insider researcher. I felt it was important to keep my own views and beliefs aside, and not allow this to skew or sway the participants' interview experience. However, sometimes I noticed how I would feel pulled into engaging with a topic or sharing a personal view, and I noticed myself attempting to remain neutral. Also at the start of the research process, I was mindful of the sensitivity of this topic and I noticed feeling anxious before interviews as I worried about participants feeling distressed in

response to the interview questions. Thankfully, I found very early on that the interview was a unique and valued space to talk about an experience which rarely gets talked about in such depth.

Throughout the interview process, I noticed moments of deep sadness when hearing about the experience of suicide loss. Despite my own curiosity and interest in this topic, I have not had such in-depth conversations about suicide loss and the pain attached to these experiences. Hearing such vivid accounts of losing loved ones to suicide was difficult, and I often found myself sitting with that sadness even after an interview had concluded. This was the case when speaking to a participant whose loved one hung himself, as this was the method used across all of my own personal experiences. I noticed feeling flushed and I noticed my breathing getting faster upon hearing their accounts. Interestingly, this difficult experience reflected one of the themes, that talking about suicide loss which resonates with your own experience, can feel triggering. I strongly connected with this theme and found myself aligning with the participants.

During the process of transcribing and analysing the interview data, my vested interest in this topic led me to feel surprisingly motivated. Doing my own transcribing enabled me to be close to the data. Despite the difficult topic, I felt eager to observe what story the data told. I anticipated that the analysis stage would be particularly difficult, yet this was not the case. Rather I felt very inspired as I connected with the stories of helplessness and self-doubt, and with the stories of resilience and new found confidence.

Over the course of this research study, I have held in mind the people who inspired this research, and the people whose death motivated the clinical psychologists to

participate. I wanted to remain respectful and thoughtful to their memory, and to bring to light the challenges faced in the face of a suicide bereavement. I also continue to wonder, what the experiences of people from different ethnicities and religious backgrounds would have sounded like, what reflections they would have shared, and what directions the themes would have been taken. As mentioned in the introduction, my own curiosity into this topic stemmed from the observations of how suicide was conceptualised from a Mauritian cultural lens, and an Islamic perspective within a multi-cultural context. With this in mind, I strongly connect to the aforementioned notion of the "*wounded healer*", in that I am using the skills I have acquired throughout this profession, to enable me to grow, heal and learn.

For further insight into the process of reflexivity, please see excerpts from my reflective journal in Appendix 1 as well as the italicised sections within the thesis.

4.6.   Suggestions for further research

In future research, it would be important to recruit clinical psychologists from diverse backgrounds in line with Burnham's (2018) social GRRAACCEESS, in order to capture their voices. It would also be interesting to carry out a further study to explore what prohibits talking about suicide within this profession.   A further area for exploration would be to consider researching the possible differences between clinical psychologists who have experienced the loss of a client to suicide, versus clinical psychologists who have lost a loved one to suicide. Similarly, it may also be worthwhile

to consider researching the possible impact from losing someone to suicide pre-training versus losses post-qualification, as they may have different implications.

4.7. Conclusion

This study explored how clinical psychologists made sense of suicide following their own experience of losing a loved one and/or a client. Given that this research area is relatively neglected, this study aims to bridge this research gap. This study found that suicide was understood as a response to unsurmountable and unresolved deep emotional pain, an escape from a life people no longer wish to be in, a choice, and at times an understandable response. The findings highlight that there continues to be a lack of conversation relating to suicide within mental health services. This is likely to be due the discomfort of talking and a fear of being judged for holding alternative views. The research emphasised the emotional turmoil experienced by clinical psychologists upon hearing colleagues or clients speak about suicide methods which resonated with their own experience, and the dilemmas faced by clinical psychologists was also discovered. Making sense of suicide was also shaped by the experience of self-doubt, and occupying the dual role of both 'survivor of suicide' and clinical psychologist. Compassion Focused Therapy (CFT) was suggested as a useful frame to support clinical psychologists and wider organisations to cope with the dilemmas that arise in the aftermath of a suicide.

As a profession, clinical psychology needs to better engage with this topic. This research highlights the need for broader conversations to be had about suicide bereavement and the complexities that may arise, and I hope I have been able to contribute to this area of research in a meaningful way.

Reflections

I noticed throughout the course of the research process, my confidence in carrying out the research improved significantly. Despite beginning the process doubting my own research skills and research abilities, once I began interviewing participants, analysing the data, discovering the themes and patterns and considering the potential implications, I felt ever more connected to my research.

I have enjoyed the experience of being an insider researcher. I felt that this position enabled me to relate to participants, and relate to their experiences in a uniquely close way. I also felt that operating from an insider researcher perspective enabled me to engage in what can often be experienced as a difficult conversation about a painful memory, in a compassionate and curious way. The most difficult part of researching from an insider research perspective was ensuring that the data analysis phase was analysed from a neutral perspective with minimal influence from my own biases and assumptions. I was very mindful of interpreting the data and generating the initial codes and themes from a position of a 'survivor of suicide' and from a 'researcher' position and I remained cautious not to be influenced by my own experiences. One of the challenges I experienced when researching from this position was not being able to notice the blind spots within the interview process. This became apparent when

reviewing the interviews and coding with my primary supervisor as it was pointed out that I had moved on to the next question perhaps too quickly. This was often the case in earlier interviews when participants talked about feeling angry in response to losing a client or loved one to suicide. Following this conversation with my primary supervisor, I became aware of this blind spot and noticed myself prompting and exploring the emotional responses in more depth thereafter.

I elected to interview participants who experienced a variety of relational losses (both personal and/or professional). I chose this because the literature within this field is very sparse, and I hoped to ascertain an overview of the experience and the impact of such losses to suicide. I wonder whether I elected to include all prior experiences related to suicide loss because this likely intersects with my own experience, which was the motivation for embarking on this research. I also did not want to hold the assumption that such losses may inherently elicit different emotional responses. I felt it was important to capture the range of experiences at this stage, and hope to build on the current study by conducting further research into the potential differences between a personal and a professional loss.

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6. Appendices

6.1. Appendix 1: Reflective Journals Excerpts
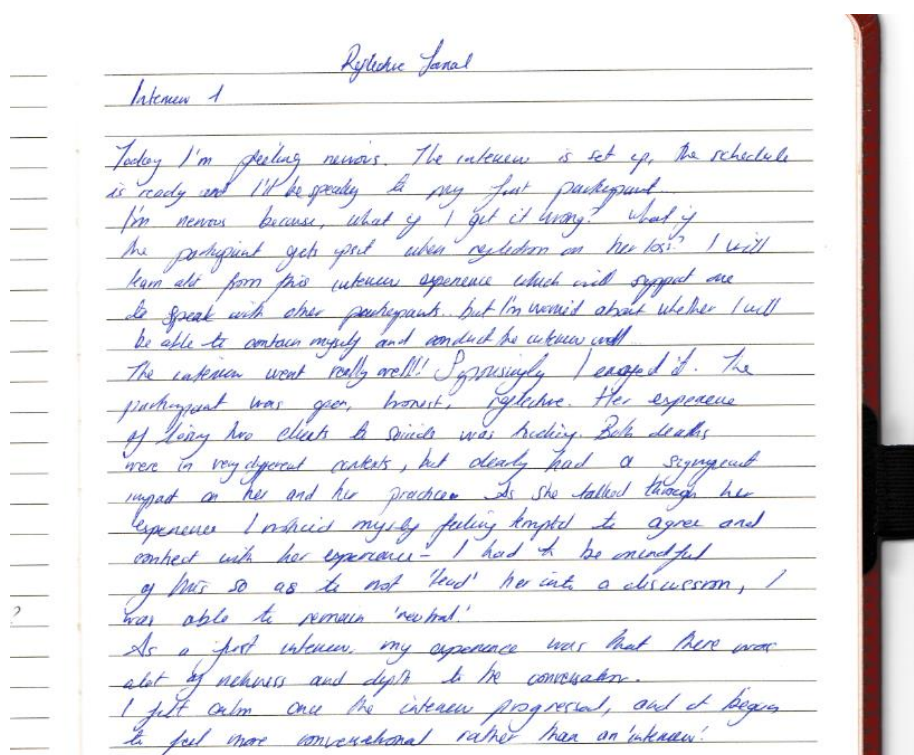
Interview 1

Today I'm feeling nervous. The interview is set up, the schedule is ready and I'll be speaking to my first participant. I'm nervous because, what if I get it wrong? What it the participant gets upset when reflecting on their loss? I will learn a lot from this interview experience which will support me to speak with other participants. But I am worried about whether I will be able to contain myself, and conduct the interview well. The interview went really well! Surprisingly I enjoyed it. The participant was open, honest, and reflective. Her experience of losing two clients to suicide was touching. Both deaths were in very different contexts but clearly had a significant impact on her and her practice. As she talked through her experience I noticed myself feeling tempted to agree and connect with her experience. I had to be mindful of this so as to not "lead" her into a discussion. I was able to remain neutral. As a first interview, my experience was that there was a lot of richness and depth to the conversation. I felt calm once the interview progressed, and it began to feel more conversational rather than an "interview"....
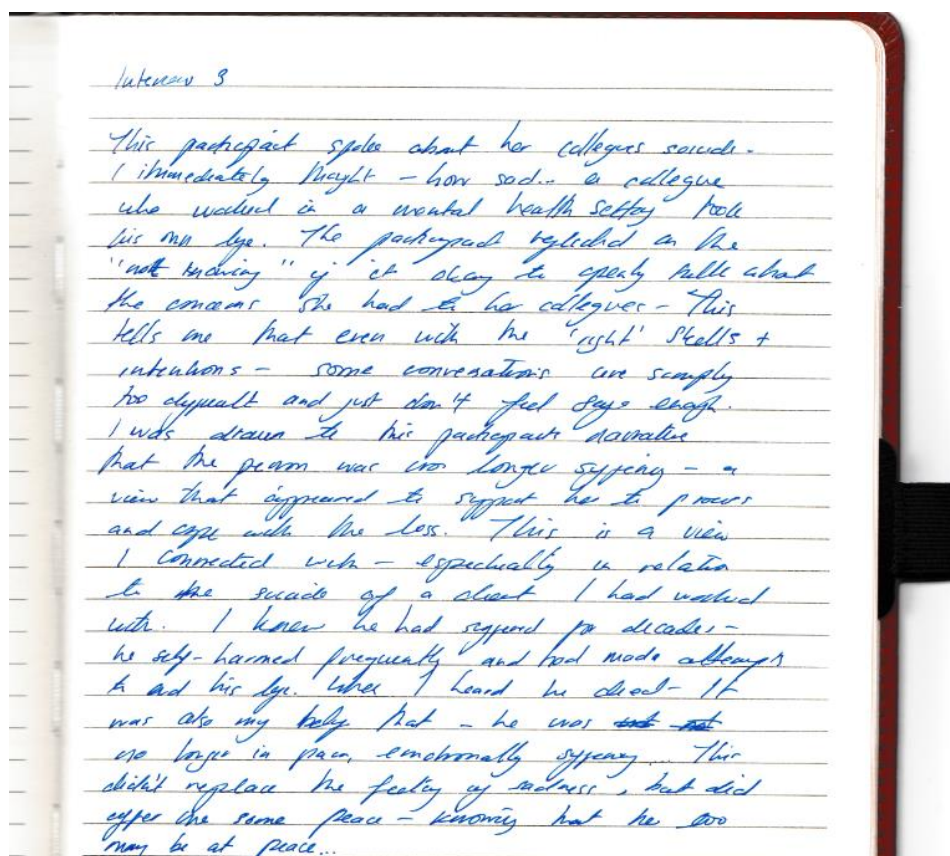
Interview 3

This participant spoke about her colleague's suicide. I immediately thought - how sad... a colleague who worked in a mental health setting took his own life. The participant reflecting on the "not knowing" it its okay to openly talk about the concerns she had to her colleagues. This tells me that even with the right skills and intentions, some conversations are simply too difficult and just don't feel safe enough.

I was drawn to this particpants narrative that the person was no longer suffering - a view that appeared to support her to process and cope with the loss. This is a view I connected with - especially in relation to the suicide of a client I had worked with. I knew he had suffered for decades - he self-harmed frequently and had made attempts to end his life. When I heard he died, it was also my belief that, he was no longer in pain, emotionally suffering. This didn't replace the feeling of sadness, but did offer me some peace, knowing that he too may be at peace...
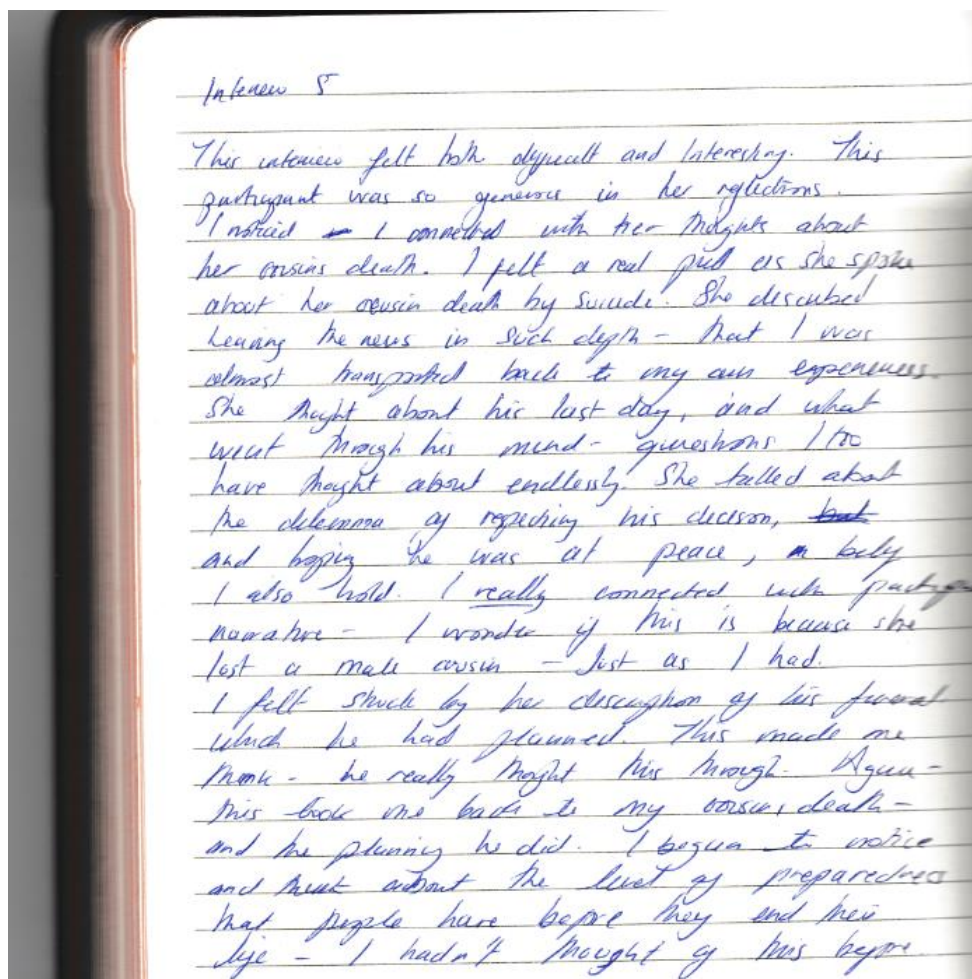
Interview 5

This interview felt both difficult and interesting. This participant was so generous in her reflections. I noticed I connected with her thoughts about her cousin's death. I felt a real pull as she spoke about her cousin's death by suicide. She described hearing the news in such depth - that I was almost transported back to my own experiences. She thought about his last day, and what went through his mind - questions I too have thought about endlessly. She talked about the dilemma of respecting his decision, and hoping he was at peace, a belief I also hold. I really connected with the participant's narrative. I wonder if this is because she lost a male cousin, just as I had. I felt struck by her description of his funeral which he had planned. This made me think, he really really thought this through. Again this took me back to my cousin's death, and the planning he did. I began to notice and think about the level of preparedness that people have before they end their life. I hadn't thought of this in such depth before.
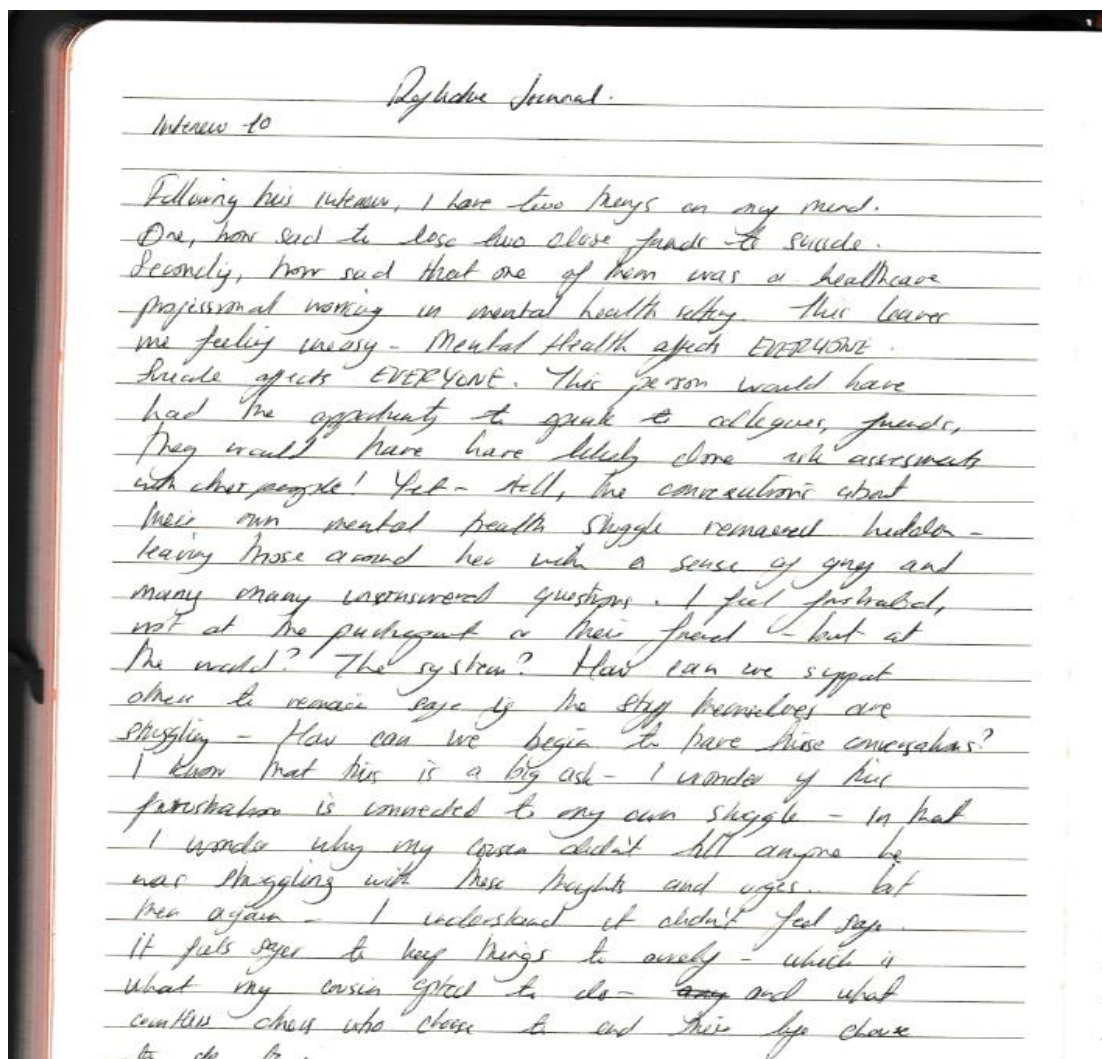
Interview 10

Following this interview, I have two on my mind. One, how sad to lose close to suicide. Secondly, how sad that one of them was a healthcare professional working in a mental health setting. This leaves me feeling uneasy. Mental health affects everyone. Suicide affect everyone. This person would have had the opportunity to speak to colleagues, friends, they would have likely done risk assessments with other people! Yet, still, the conversations about their own mental health struggle remained hidden, leaving those around her with a sense of grief and many many unanswered questions. I feel frustrated? Not at the participant or their friend, but at the world? The system? How can we support others to remain safe if the staff themselves are struggling - how can we begin to have these conversations? I know that this is a big ask, I wonder if this frustrated is connected to my own struggle - in that I wonder why my cousin didn't tell anyone he was struggling with these thoughts and urges. But then again - I understand it didn't feel safe. It felt safer to keep things to oneself, which is what my cousin opted to do and what countless others who choose to end their life choose to do too...
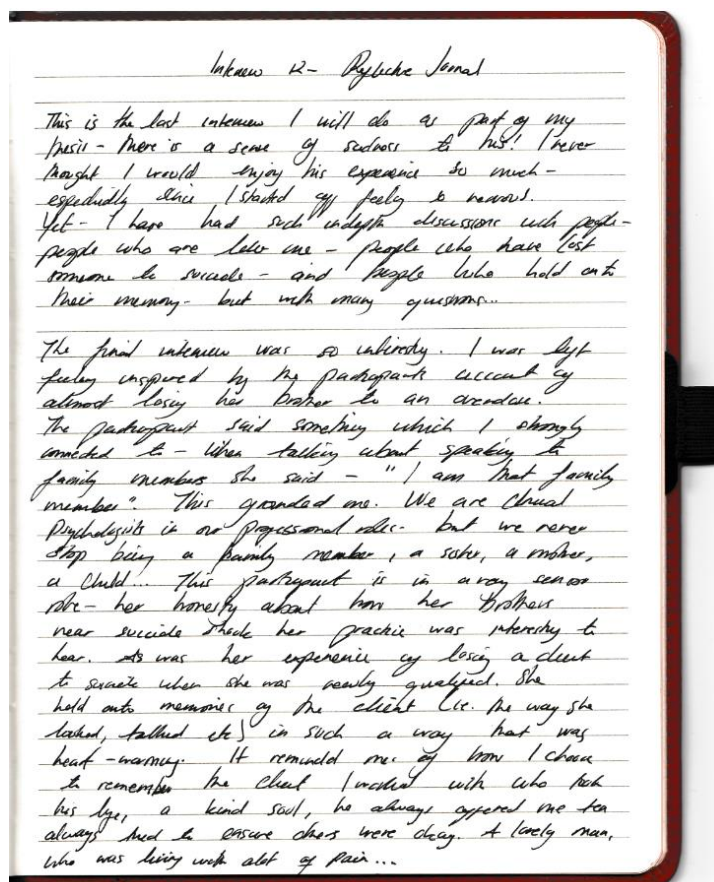
Interview 12

This is the last interview I will do as part of my thesis - there is a sense of sadness to this! I never thought I would enjoy this experience so much - especially since I started off feeling so nervous. Yet - I have had such in depth discussions with people - people who are like me - people who have lost someone to suicide - and people who hold onto their memory - but with many questions. The final interview was so interesting. I was left feeling inspired by the participant's account of almost losing her brother to an overdose. The participant said something which I strongly connected to - when talking about speaking to family members she said - "I am that family member". This grounded me. We are clinical psychologists in our professional roles - but we never stop being a family member, a sister, a mother, a child...This participant is in a very senior role....her honesty about how her brother near suicide shook her practice was interesting to hear. As was her experience of losing a client to suicide when she was newly qualified. She holds onto the memory of the client (i.e. the way she looked, talked etc) in such a way that was heart-warming. It reminded me of how I choose to remember the client I worked with who took his life, a kind soul, he always offered me tea and always tried to ensure others were okay. A lovely man who was living with alot of pain....

6.2.   Appendix 2: Quality of the Qualitative Research using CASP checklist (CASP, 2017)

	Q1: Was there a clear statement of the aims of the research?	Q2: Is a qualitative methodology appropriate?	Q3: Was the research design appropriate to address the aims of the research?	Q4: Was the recruitment strategy appropriate to the aims of the research?	Q5: Was the data collected in a way that addressed the research issue?	Q6: Has the relationship between researcher and participants been adequately considered?	Q7: Have ethical issues been taken into consideration?	Q8: Was the data analysis sufficiently rigorous?	Q9: Is there a clear statement of findings?	Q10: How valuable is the research?
Veilleux, J. (2011).	Yes	Yes	Not applicable	Not applicable	Yes	Not applicable	No	Not applicable	No	Limited contribution.
Darden, A. J. & Rutter., P. A. (2011).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution to the field.
Murray-Swank., A. B. (2019).	Yes	Yes	Yes	Yes – first person account	Yes	Yes	Yes	Unclear	Yes	Valuable contribution to the field.
Clark (2009).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution to the field.
Tillman., J. G. (2006).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution to the field.

6.3. Appendix 3: Quality Appraisal of Quantitative research: Mixed Methods Appraisal Tool: Quantitative Descriptive Studies (Hong et al, 2018)

	Q1: Is the sampling strategy relevant to address the research question?	Q2: Is the sample representative of the target population?	Q3: Are the measurements appropriate?	Q4: Is the risk of non response bias low?	Q5: Is the statistical analysis appropriate to answer the research question?
Finlayson., M. & Simmonds., J. G. (2018).	Sample is relevant to the target population A clear justification of the sample frame used is provided The sampling procedure is adequate.	There is a clear description of the target population and of the sample (such as respective sizes and inclusion and exclusion criteria) Reasons why certain eligible individuals chose not to participate are offered.	Variables are clearly defined and accurately measured The measurements are justified and appropriate for answering the research question The measurements reflect what they are supposed to measure	Not clear	The statistical analyses used is clearly stated and justified as appropriate for the design and research question Problems with data analysis is reported in the interpretation of the results.
Chemtob., C. M. Hamada., G. H. & Rodney., Y. T. (1988).	Sample is relevant to the target population A clear justification of the sample frame used is provided The sampling procedure is adequate.	There is a clear description of the target population and of the sample (such as respective sizes and inclusion and exclusion criteria) Reasons why certain eligible individuals chose not to participate are offered.	Variables are clearly defined and accurately measured The measurements are justified and appropriate for answering the research question The measurements reflect what they are supposed to measure	Not Clear	The statistical analyses used is clearly stated and justified as appropriate for the design and research question Problems with data analysis is reported in the interpretation of the results.

6.4.   Appendix 4: Advertisement for study

University of Hertfordshire UH

Researcher: Farah Dauhoo (Trainee Clinical Psychologist)

Invitation to take part in a doctoral research study

Talking through the silence:

How do Clinical Psychologists' make sense of suicide?

This study hopes to contribute to an important area where there is a gap in suicide bereavement research.

➢ Would you be interested in participating in a semi-structured interview?

➢ Are you working as a Clinical Psychologist?

➢ Do you have two or more years of post-qualification experience?

➢ Do you have experience (within a personal or working context) of losing someone to suicide?

If you are interested in participating in this doctoral research study, please contact me, **Farah Dauhoo** (Trainee Clinical Psychologist at the University of Hertfordshire) on:

fd17aah@herts.ac.uk

This project is being supervised by Dr Jacqui Gratton (Lecturer and Academic Tutor at the University of Hertfordshire).

6.5.   Appendix 5: Participant Information Sheet
_____

UNIVERSITY OF HERTFORDSHIRE

FORM EC6: PARTICIPANT INFORMATION SHEET

1   Title of study

Talking through the silence: How do Clinical Psychologists 'make sense' of suicide? – A Thematic Analysis

2   Introduction

Thank you for taking an interest in this research. This participation information sheet hopes to offer you an overview of the present research study by stating why this research is being conducted and what your participation would involve.

Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link: https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs

(after accessing this website, scroll down to Letter S where you will find the regulation)

About the researchers

My name is Farah Dauhoo and I am a Trainee Clinical Psychologist at the University of Hertfordshire. This research is being conducted as part of my Professional Doctorate in Clinical Psychology. I have had personal and work related experiences related to suicide bereavement, and I have always been interested in how suicide is conceptualised from a cross-cultural perspective and multi-faith lens. It is an area I am committed to exploring with a hope to contribute to the existing literature base.

This project is being supervised by Dr Jacqui Gratton (Lecturer and Academic Tutor at the University of Hertfordshire), Dr Jeannette Fuller (Clinical Psychologist at the Older Adults Mental Health Team – Luton). The project has also invited the expertise and experience of Dr Melanie Hodgkinson (Clinical Psychologist at Learning Disabilities in Southampton), who occupies a consultant position within this research.

3   **What is the purpose of this study?**

The research aims to develop an understanding of clinical psychologists' experiences of suicide; whether they identify as someone who is bereaved by suicide, whether they have worked with a client who took their life, or whether they are faced with these issues within a personal or professional context of people living with incurable and distressing conditions. The research also hopes to explore how they make sense of this experience and how this may shape or inform their clinical practice. Existing literature within the field of suicide bereavement and Psychology, focuses on the loss of a client who has taken their life. Currently, there are no known studies exploring the experiences of clinical psychologists who have experienced a personal loss through suicide, and how this may shape their relationship with suicide, their clinical practice, as well as their profession and personal ethics. Additionally, there are no

known studies exploring these experiences amongst clinical psychologists from various ethnic and diverse backgrounds.

4   Do I have to take part?

No. It is entirely your decision whether you would like to participate in this study. Should you accept to take part, you will be asked to sign a consent form. However, if you decide that you no longer wish to participate in the research study, you are free to withdraw at any time. In relation to your data, you can also request that it is destroyed and not included in the research for up to two weeks after the interview. You do not have to give a reason for any of these decisions.

5   Are there any age or other restrictions that may prevent me from participating?

The study is open to qualified clinical psychologists in the UK with two years or more post qualification experience who have experienced a personal loss of someone who took their own life, worked with a client who has taken their own life, or those who are working with or related to people with incurable distressing conditions. This study hopes to explore these experiences from diverse population, and therefore will be seeking to speak to clinical psychologists from a range of ethnic and diverse backgrounds. Factors that may prevent you from being eligible to participate are:

- Clinical Psychologists who are known personally known to the researcher.
- Clinical Psychologists who are newly qualified.
- Clinical Psychologists who have been bereaved by suicide within the last two years.

The level of vulnerability of participants will also be considered in relation to mental wellbeing. Participants will be offered the opportunity to see the questions prior to the interview itself. They will also be offered the opportunity to 'pass' on questions and will be offered the opportunity to withdraw from the interview at any time. Support numbers will also be offered to all participants.

6   How long will my part in the study take?

If you would like to participate, you will be asked to take part in one audio-recorded interview which will last around between 60 – 90 minutes.

7   What will happen to me if I take part?

This interview can take place at the University of Hertfordshire, or at a booked room at your preferred location/work base, alternatively the interview can take place over the telephone or Skype.

During the interview, you will be talking to the researcher about your relationship to suicide, how this may shaped or inform your clinical practice.

8   What are the possible disadvantages, risks or side effects of taking part?

Some potential disadvantages include:

- Talking about these experiences can be understandably difficult and has the potential to be distressing. If this is the case, you can opt out or stop the

interview, alternatively you can pass onto the next question. Information about sources of support will be offered after the interview.

- Duty of care – If any information is disclosed which highlights risk to self or others, the researcher has a duty of care to terminate the interview and support the interviewee to seek further help. Also, it may be necessary for the researcher to break confidentially to ensure the safety and wellbeing of the interviewee.

9   **What are the possible benefits of taking part?**

Some possible benefits include:

- An opportunity share your experience
- An opportunity to be part of a research study focusing on a topic which has an emerging research interest in Clinical Psychology.
- It is hoped that the research will enable training providers and psychologists to develop a greater understanding of the impact of experiencing a suicide, the sense-making process and the wider implications for clinical practice.
- This research may influence the support available for both qualified and trainee Clinical Psychologists.
- It may also inform teaching programmes.

10   **What will happen to the data collected within this study?**

The information collected about you alongside the interview will be kept strictly confidential. Any identifiable information will be anonymised and kept separately from the interview. Interview transcripts will also be anonymised during the data analysis and verbatim extracts used in the report will also be fully anonymised. Data will be stored electronically using password-protection for added security. This data will be

kept for 5 years post research project submission after which it will be destroyed by the principal investigator. The interview recording and interview transcript will be stored on a device which is encrypted for data protection purposes. Forms related to the research, such as consent forms and participant information forms, will be kept in a locked filing cabinet and transferred to the locked filing cabinet of the primary supervisor following the interview.

In the event that confidentiality needs to be breached, it will be managed in accordance with the regulations set out by the British Psychological Society code of conduct. If information is disclosed which indicates sufficient concern about your safety or the safety of others, it may be necessary to inform an appropriate third party without formal consent. The researcher may contact their principal supervisor discuss possible concerns. This may be overridden if it is deemed that the risk is imminent and requires immediate attention.

11   Will the data be required for use in further studies?

The data will not be used in any further studies.

12   Who has reviewed this study?

This study has been reviewed by:

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

The UH protocol number is *<enter>*

13   **Factors that might put others at risk**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

14   **Who can I contact if I have any questions?**

If you are interested in participating in this research study or if you have any questions, please feel free to contact me on fd17aah@herts.ac.uk to discuss your queries or to arrange an interview. If you would like to participate, you will be invited to sign a consent form prior to your participation. Please retain this invitation letter for reference.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

6.6. Appendix 6: Ethical Approval Confirmation

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Farahnaaz Dauhoo
CC	Dr Jacqui Gratton
FROM	Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chairman
DATE	26/09/2019

Protocol number: LMS/PGR/UH/03869

Title of study: Talking through the silence: How do Clinical Psychologists make sense of suicide?

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Jeanette Fuller (External Clinical Psychologist)
Dr Melanie Hodgkinson (Research Consultant)

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 26/09/2019

To: 01/05/2020

6.7. Appendix 7: Consent Form
_____

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

('ETHICS COMMITTEE')

"*Talking through the silence: How do Clinical Psychologists make sense of suicide? – A Thematic Analysis*

1. I have read and understood the participation information sheet for the above study.

2. I have had the opportunity to contact the researcher and ask questions relating to the study.

3. I have been informed that I am free to decline participation and I am able to leave the study without giving a reason before or during the interview.

4. I have been informed that my data will be anonymised and stored securely.

5. I consent to the audio recording of my interview.

6. I understand that if I disclose information which leads to sufficient concern about my safety or the safety of others it may be judged necessary to inform an appropriate third party without formal consent.

7. I consent to the use of quotes from my interview to be used as excerpts in the research reports and publications. I have been made aware that this data will be treated as anonymous and confidential.

8. I consent to taking part in the above study.

Signature of
participant………………………………...…Date…………………………

Signature of (principal)
investigator……………………………………………………Date………………………
…

UH FORM EC3

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here*, *in BLOCK CAPITALS]*

……………………………………………………………………………………………………
………………

of *[please give contact details here, sufficient to enable the investigator to get in
touch with you, such as a postal or email address]*

…..………………………………………………………………………………………………
………………

hereby freely agree to take part in the study entitled *[insert name of stu*dy *here]*

……………………………………………………………………………………………………
………………..

(UH Protocol number …………………………………………)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is
attached to this form) giving particulars of the study, including its aim(s), methods
and design, the names and contact details of key people and, as appropriate, the
risks and potential benefits, how the information collected will be stored and for how

long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that my participation in this study may reveal findings that could indicate that I may require medical advice. In that event, I will be informed and advised to consult my GP and I acknowledge that, following discussion, I may be required by the University to withdraw from the study. If, during the study, evidence comes to light that I may have a pre-existing medical condition that may put others at risk, I understand that the University will refer me to the appropriate authorities and that I will not be allowed to take any further part in the study.

6 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Name of (principal) investigator *[in BLOCK CAPITALS please]*
…………………………………………...

Signature of

participant……………………………….……….Date…………………………

Name of participant…………………………………..……

Signature of principal

investigator…………………………………Date…………………………

6.8.   Appendix 8: Interview Schedule

This interview schedule highlights the three main themes the interviews intend to cover and be developed further with a pilot interview.

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Thank you for agreeing to participate in this study. The focus of this study is on the topic of suicide and how we make sense and relate to such experiences. I appreciate that this can be a difficult topic to talk about, so please let me know if you wish to pause or stop altogether.

Theme A – Experience of suicide

- How long have worked as a Clinical Psychologist?
- What type of service do you work in currently?
- Within your role, what type of risk might you face?
- Can you tell me briefly about any experiences you have had where people have taken their own life or considered taking their own life?
- **Consider prompt**

If the participant knows someone who took their life:

- Can you tell me a breifly about your relation to them?
- Could you tell me about how (name/relation) died?
- **Consider prompt**

If the participant works with/is related to someone with an incurable condition:

- Could you me how you know this person?
- **Consider prompt**

Theme B – What sense do you make about suicide (prompt: spirituality)

- How has this experience shaped your own relationship to suicide? Or are there other experiences which have shaped it?
- How did you make sense of what happened/what is happening?
- What is your position in relation to people taking their own life?
- **Consider prompt**

Theme C – How does this relate to the role of a Clinical Psychologist?

- In what way has this experience affected you professionally?
- How does this experience impact your clinical practice?
- Does this sit with or against your professional ethics?
- Does this sit with or against the service policy?

How does this experience impact how you may respond to distress or people presenting with suicidality?

How do you manage the emotional impact of this?

How has it been talking about it today, is this way of talking about suicide something you have been able to talk about at work? Is it helpful, what has helped this, what has hindered this?

Finally, reflecting on this interview, how has this experience been for you?

Thank you for your time and thank you for sharing such a personal experience with me and this research.

6.9.   Appendix 9: Coding Development: Phase 2-5 of Thematic Analysis (Braun & Clarke, 2006).

Appendix 9 - Phase 2: Generating initial codes (codes into clusters)

Int 1 – 14/11/2019

Reflections	Transcript	Coding	Clustering
	Int: Yeah that would be absolutely fine, there are some questions later on that might repeat what you're about to say but yes now may be a good time to talk a little.		
Note: The pause before stating she'd ended her life	P1: Okay, she was someone who had a really extensive history of accessing mental health services and um there were numerous kind of suicide attempts, quite significant ones erm touch and go situations and erm she (pause) yeah ended her life erm and I hadn't necessarily rated her, she was definitely high risk in terms I knew she didn't want to be here, that was what she felt for a number of years if you like it wasn't a peaking attempt think, erm, I'm guessing you'll ask and I'm happy to talk about it a lot more, the thing I remember, the thing that kind of stood out and I still remember, was how many different emotions I went through because I was doing my main placement was a CMHT erm but I was doing a placement a day a week in a transplant unit, and I was there, and so this really odd kind of situation of being like "oh I'm in a place where people are fighting to live and want a chance to live" and at the same time someone has chosen to end their life, and I use the word choice loosely there because that's not really the sense I made	Extensive history of using MH services Numerous suicide attempts Client took own life Client didn't want to be here Felt this way for years The different emotions experienced Also on placement on transplant unit Place where people are fighting to live and people are choosing death Use of choice 'loosely'	 Suicide as not wanting to be here Connecting with the different emotions The juxtaposition between wanting to live and wanting to die

Appendix 9 - Phase 2: Generating initial codes (codes into clusters)

Int 1 – 14/11/2019

Reflections	Transcript	Coding	Clustering
I valued the honesty of sharing that she thought she could've done this in a way where organs would've been donated I wonder if CPs were better equipped could this help to manage the impact of suicide?	of it but in that moment what came up was this really bizarre juxtaposition of like… I don't quite know what to do with this, and she'd ended her life in a way that meant her organs definitely wouldn't have been able to be used and so again being in a situation where like at least you could've done it in a way that meant people could've benefitted…so all these really weird (pause) not weird, but all these thoughts run through, so it's a really bizarre situation really, and then I guess the other one that sticks in my mind was a soldier. And I think, I hadn't worked directly with him but he was under the service, and just kind of seeing I guess the impact that it had on everyone because it's quite a close community, um so even if they didn't directly know him, a lot of the other guys or the military they'd all heard about it or they know someone who knew him, there was a lot of anger where they felt they'd been kind of let down, and um, I guess seeing the ripple effects in a way that don't get to see in NHS because you're not in the community I suppose, and yeah seeing that effect and also knowing, there was a lot being written about it in terms of people being very angry of you why wasn't this there and why wasn't that there, and actually knowing from the inside the issue for me wasn't that the support wasn't there it was	The bizarre juxtaposition The not knowing what to do The thoughts of how she ended her life The "weird" thoughts that surfaced A bizarre situation Solder suicide Observing the impact Close knit military community Anger from community Ripple effect Community felt let down Anger from community Community response – why wasn't things in place?	The juxtaposition between wanting to live and wanting to die An unexpected response Observing the wider impact/The ripple effect Observing the wider impact/The ripple effect Anger as a response

Appendix 9 - Phase 2: Generating initial codes (codes into clusters)

Int 1 – 14/11/2019

Reflections	Transcript	Coding	Clustering

| | something we could've done better, maybe sometimes actually everybody did everything they could and it still was the outcome, and so I think that's the thing that kind of, it's always stuck with me, in terms of, that idea of that feeling around who are we to force people to stay in a life that is making them miserable?

Int: Mmm-m

P1: Erm, and, so when other things have happened, like when the soldier took his life, it felt very different um, so it was much more of a crisis kind of, he was really young, erm, he, had a young family, kind of I guess I know he's been exposed to quite significant traumas, and I guess the different was that kind of hope piece? In that, I would always, hope to have hope, and um, but I think with some people feeling like actually maybe the kindest most compassionate things is to allow a checking out, erm, whereas him, it felt really... I guess it felt much more, um, (pause) again frustrated but around the lack of services,

Int: Yeah | Sometimes people do all they could and that's still the outcome

Sense that who are we to force people to stay in a life that is making them miserable?

Who are we?

Different sense when solder died
Young age
Young family
Crisis situation

Always hope to have hope
Sometimes for some people, the kind compassionate thing to do is allow to check out

Felt frustrated at lack of services | Who are we?

Considering the life span?

Hope and kindness
Hope and kindness

Barrier to providing access support |

Appendix 9 - Phase 2: Generating initial codes (codes into clusters)

Int 1 – 14/11/2019

Reflections	Transcript	Coding	Clustering
Noticing that participant felt need to justify reflections	P1: Or the lack of him being able to access services, or feeling able to, because for him I think it could've been different? And so I guess that, in terms of your question how does it shape my relationship with it, I think, it kind of, it feels like its developing a much more nuanced maybe relationship with it, so… rather than maybe when I was younger um, it was kind of, um suicide bad, erm, and it kind of still feels like something we don't talk about as, you know erm, even things like Dignitas I guess, you know assisted suicide, it still feels like such a erm taboo kind of topic if you like, that we, we're not allowed to share thoughts of, like maybe that was the best thing, you know that, even as I say it I can feel that need to justify it like don't worry I am compassionate (laugh), yeah um, I guess that something that builds in me everytime there are experiences where kind of completion of suicide or attempted of, god this is such a complex issue if you like, and, I think we are quite good t reducing it to…one thing? Erm, or just to a 'it mustn't happen', and then it's like we should ban dialogue around it…so I think, yea I guess my relationship with it has become much more um, I don't know if accepting is the right word really? But more kind of, curious maybe or	Sense that it could've been different if he'd accessed services Relationship as nuanced When younger, suicide seen as bad Sense that we don't talk enough about assisted suicide Suicide as taboo topic Sense that we aren't allowed to share thoughts Feeling the need to justify compassionate quality Overwhelming sense Awareness that it's a complex issue Services at reducing suicide to one thing Reducing it to it mustn't happen Relationship more accepting More curious	 A shift in relationship A shift in relationship A lack of conversation A lack of conversation A lack of conversation Acknowledging the complexity Acknowledging the complexity A shift in relationship

Appendix 9 - Phase 2: Generating initial codes (codes into clusters)
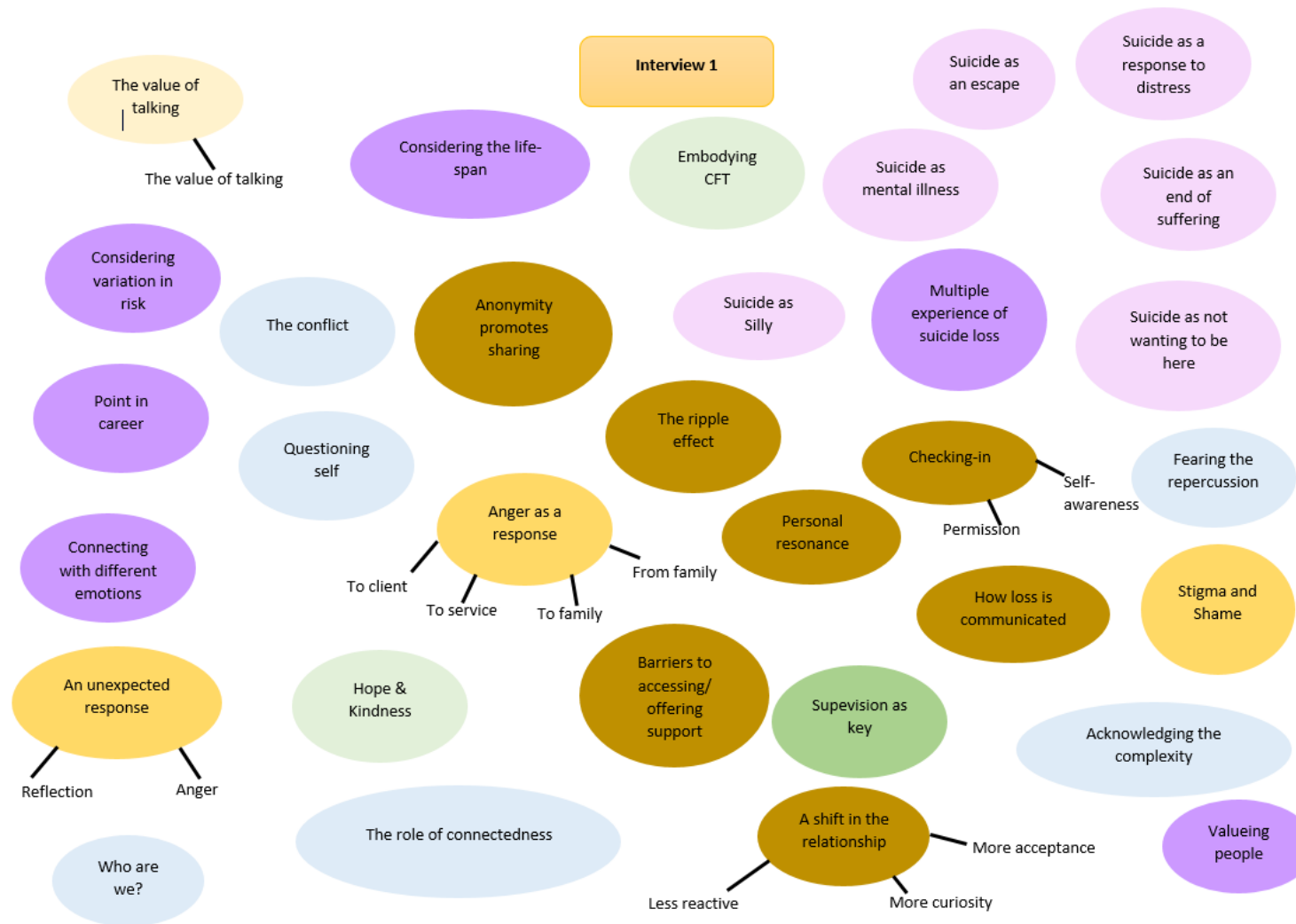
Int 1 – 14/11/2019

Reflections	Transcript	Coding	Clustering
	more kind of, erm, I guess trying to enable those conversations that aren't, oh my god you've had thoughts of suicide we must end that thought, like get rid of them or, you know instantly kind of panic I suppose, that sort of reactive um, process where, I guess I kind of think actually if you're in a lot of distress, I guess I use a lot of erm, CFT.. Int: Yes... P1: So I would think a lot about people being in kind of 'threat' system, erm, and that if you're in threat, then your brain is designed to go into fight or flight, so it's a really logical thought I think how, it is a way of ending or escaping my distress is to end my life, it's a very, yeah its actually quite a rational logical thought process, and... I just think being able to have those conversations with people sometimes, without the panic of, what does this mean? What sense are you making of it? Kind of is that a, there's just nothing to kind of be around for anymore, is it I can't handle the distress? Is it just that I am having a thought because that's quite natural for my brain to go well, you could end it...erm... and almost it's important that you have that knowledge as an option? It's	More curious about suicide More able to have conversations Less include to get rid of thoughts of panic Less reactive Use of CFT as a model Suicide as people in 'threat' system Logical to think of escaping distress by suicide – sense making Rational logical thought process The ability to have these conversations without panic Curiosity about how clients make sense of this experience.	A shift in relationship A shift in relationship Embodying CFT Embodying CFT Suicide as escape A shift in the relationship A shift in the relationship

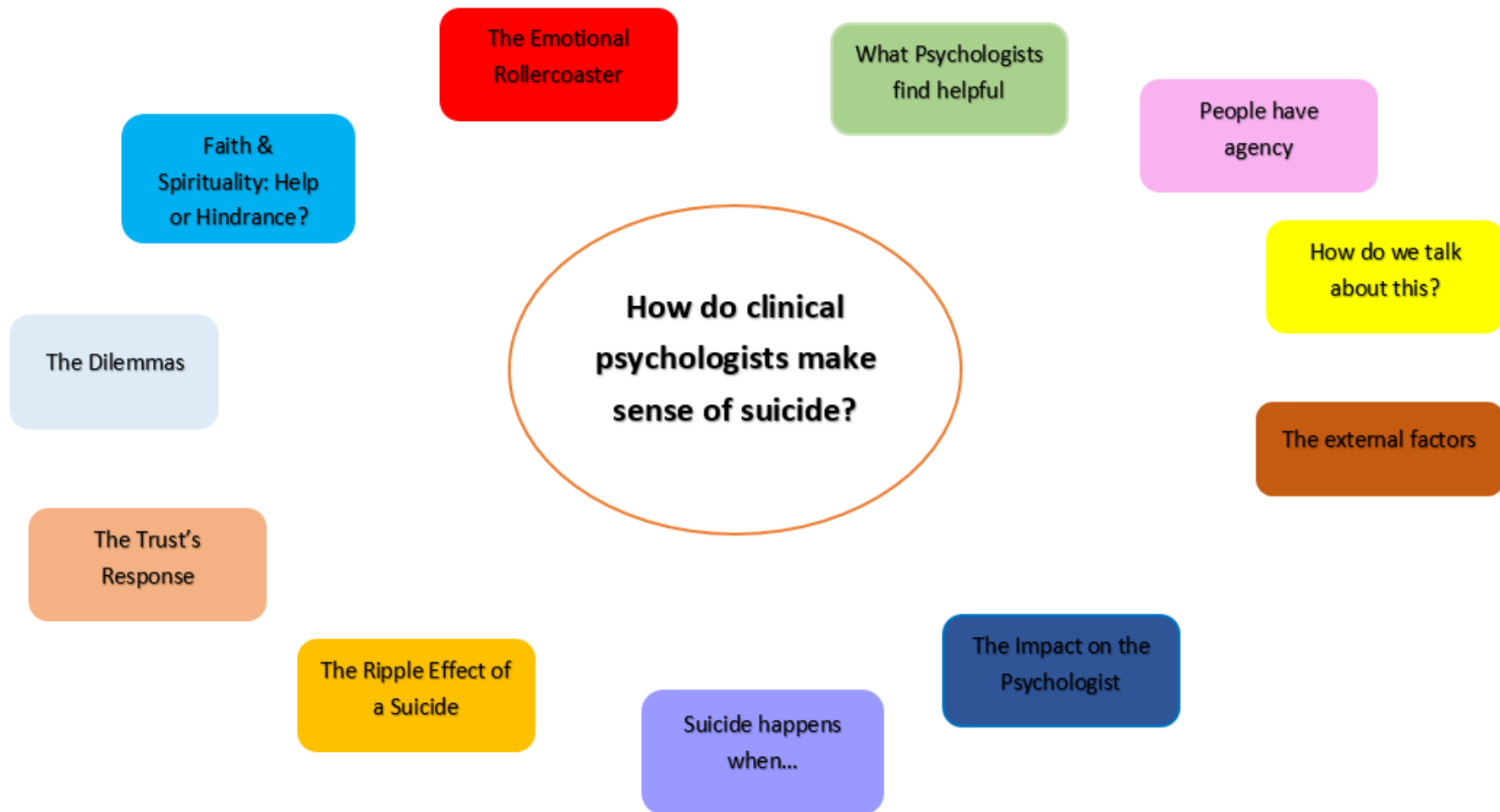*Appendix 9 - Phase 2: Generating initial codes (codes into clusters)*

Int 1 – 14/11/2019

Reflections	Transcript	Coding	Clustering

Reflections	Transcript	Coding	Clustering
	not one that we'd hope for but one that is there, and I don't know if that's even answering the question anymore so I'm just going to stop talking… (laughs)	Acknowledging that ending life is an option – not one we'd hope for	Acceptance
	Int: (laughs) It's really interesting to hear some of your thoughts, you've started to answer some of the questions arounds how you make sense of what happened – I was wondering what influenced how you make sense of the experience of suicide?		
	P1: Yeah um, so I guess my first, I have quite a…well… I'm thinking how far back do I go? So… my family are all medics, so I guess I grew up with things like death being open conversations, um…there wasn't anyone, I don't remember anyway, who committed suicide or experiences as a young person, but just I guess that idea of mortality and health and death were, we lived next to a graveyard… and then I had quite a number of friends, erm as a teenager who self-harmed, I think that was sort of a first exposure to distress if you like, in that way, psychological distress… um but I then kind of, had a baptism of fire, when working in forensics, forensic mental health, in a women's unit,	Family are medics Death openly talked about Mortality and health awareness growing up Lived next to a graveyard First exposed to distress by friends who self-harm Forensic job exposing to psychological distress as baptism of fire	Talking about death

Appendix 9 - Phase 3: Searching for themes

Appendix 9 - Phase 3: Searching for themes

The Emotional Rollercoaster

What Psychologists find helpful

People have agency

Faith & Spirituality: Help or Hindrance?

How do we talk about this?

The Dilemmas

How do clinical psychologists make sense of suicide?

The external factors

The Trust's Response

The Ripple Effect of a Suicide

Suicide happens when...

The Impact on the Psychologist

Appendix 9 - Phase 4: Reviewing potential themes – data after reconsidering themes

Appendix 9 - Phase 5: Defining and naming themes

Theme 1: "The messiness of being human" (Dilemmas)

Walking in the family's shoes

"What could I have said or done?"- Self-doubt/sense of failure

When views are not aligned

The duty of care vs personal beliefs

Suicide reduction initiatives as unrealistic

Who are we?

The right to live, the right to die

"A multidimensional response"

Suicide as an active choice

Suicide as response to unsurmountable pain

Suicide as an active choice

Theme 2: How is talk used as a way of making sense of suicide?

Talk as inhibited...

The discomfort

Fear of judgement

An invasion of privacy

Talk as blasé

Talk as clinical

Connect with how suicide is talked about in Trust

Talking as valuable

To colleagues, family, supervision

Case discussions/ Personal Therapy

Feeling triggered – separation between people mentioning it and feeling it

How suicide is talked about as an issue of faith?

Faith and religion as comforting disclose

Theme 3: An experience that shapes Psychologists

Resilience in the face of risk

Less afraid of showing humanity

Less fear when faced with risk

Surviving the worst case scenario

Searching for meaning in the method

More curious, more acceptance

Aware of blind spots

Experience shaped career choice

"The mask of professionalism is off" – Supervision as open & honest – how it is views

The link to theory - Compassion Focused Therapy – "The light within the dark clouds" – the way it is views

6.10. Appendix 10: Thematic Map
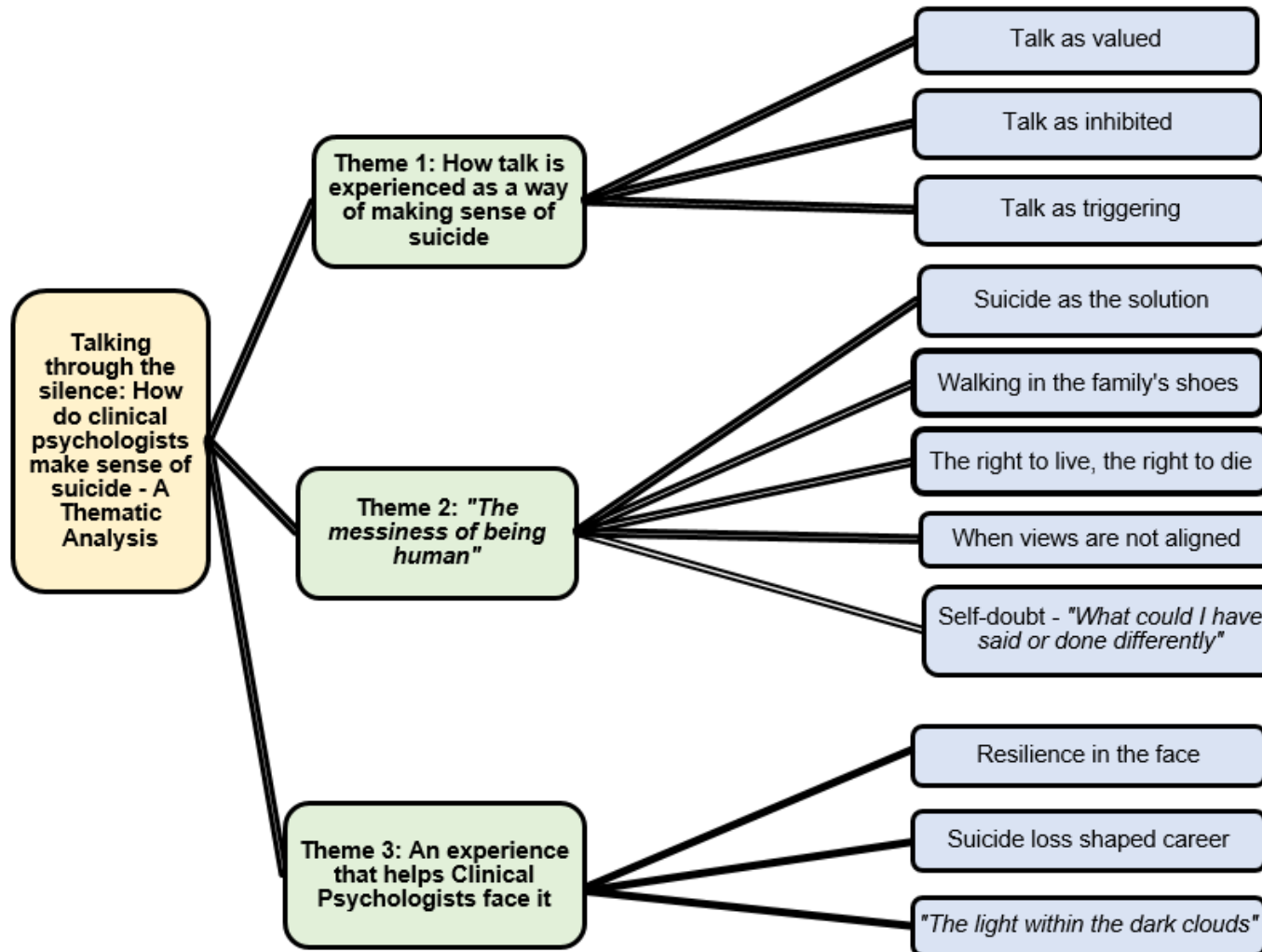
6.11. Appendix 11: Debrief sheet
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DEBRIEFING INFORMATION SHEET

Thank you very much for participating and making this study possible.

This study aimed to explore the experiences of Clinical Psychologists who have lost a loved one to suicide or worked with someone who took their own life.

I was interested in exploring:
- Your understanding of what happened.
- How you made sense of it and what shaped this.
- How this experience may have shaped your clinical practice.

The field of suicide bereavement research and research into the different types of reactions to traumatic grief has evolved over the last decade. Historically, research into suicide bereavement has not received the financial or human investment it needs (WHO, 2014). However, it is an emerging field in the UK and Psychologists have made significant contributions to the understanding of the causes and impact of suicidal behaviour.

This study hopes to:

- Gain a deeper insight and understanding into these experiences from the perspectives of Clinical Psychologists.
- Contribute to the existing research base.
- Develop conversations around this topic.

Services offering support
There are a number of local sources of support which may already be familiar to you if you find that taking part in this study and talking about your experiences has left you distressed. Whilst this is quite understandable and normal, if these feelings persist you may find the following services useful:

The Samaritans:
http://www.samaritans.org
Helpline telephone Number: **08457 90 90 90**
The Samaritans is a helpline which is open 24 hours a day for anyone in need. It is staffed by trained volunteers who will listen sympathetically. Alternatively you can send them an email them at jo@samaritans.org *and they will try their hardest to respond within 12 hours.*

Facing the Future:
www.facingthefuturegroups.org

Facing the future offers support groups for people bereaved by suicide run by Samaritans and Cruse Bereavement Care.

If U Care Share Foundation:
www.ifucareshare.co.uk
This service provides timely practical and emotional support to people touched by a suicide and deliver training on suicide prevention, intervention and postvention.

Suicide Bereavement Network:
www.sbnwk.org.uk
This organisation provides face-to-face and online support for anyone who is coping with the suicide of someone close.

The Compassionate Friends (TCF):
www.tcf.org.uk
A UK-wide organisation where local volunteers provide support to parents who have lost a child, and siblings. Their Shadow of Suicide (SoS) groups support families where a child has taken their own life.

Survivors of Bereavement by Suicide (SOBS):
http://www.uk-sobs.org.uk
National helpline telephone number: **0844 561 68 55** (9am to 9pm every day)
Survivors of Bereavement by Suicide are a self-help organisation, and many of their volunteers have themselves been bereaved by suicide. They offer a confidential telephone helpline, support information and group meetings. You can contact them by email on sobs.support@hotmail.com

Cruse Bereavement Care:
http://www.crusebereavementcare.org.uk
Helpline telephone number: **0844 477 9400**
Cruse is a national charity offering free support to anyone who has been bereaved. Cruse volunteers, who are trained and live locally, can visit you in your home or talk to you over the telephone. If you call the national telephone number they will put you in touch with your local branch. You can contact them by email on helpline@cruse.org.uk.

Alternatively, your GP may be able to refer you to more specialised local support services.