Volume One

THERAPISTS' EXPERIENCES OF THERAPY ENDINGS WITH MENTAL HEALTH PATIENTS.

by

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Thesis Overview

This thesis consists of two volumes submitted as part of the Doctorate in Clinical Psychology training program.

Volume I contains three research chapters. The first is of a systematic meta-synthesis which reviews fourteen qualitative research articles pertaining to mental health professionals' experience of patient suicide. Five themes and seven subthemes are identified; they illustrate an underlying sense of bereavement, fear and transformation. The second chapter is an empirical research paper which explores eight psychodynamic psychotherapists' experiences of therapy endings in time limited NHS psychodynamic psychotherapy. The analysis suggests therapists and patients can have an intimate professional relationship which can be differentially affecting for both after the therapy ends. The third chapter is a public dissemination document which gives an accessible overview of chapters one and two.

Volume II contains five clinical practice reports. The first report details the case of Katie, a 38 year old woman experiencing Anxiety, Depression and suicidal ideation; formulated from two psychological models. The second report presents a service evaluation assessing non attendance rates of psychological services assessment appointments and ways of improving engagement in adult secondary community mental health teams (CMHT's). The third report presents a psychological consultancy led case of Tahmina, a 69 year old woman with challenging behaviour. The fifth report details a single-case experimental design of Mary, a 35 year old woman with a mild learning difficulty and re-current stress induced vomiting. The fifth presents an abstract of an oral presentation about a case study of Louise, a 36 year old woman who experienced low mood and binge eating following a history of trauma.

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CHAPTER I

Research Component: Systematic Meta-synthesis Review

A meta-synthesis of mental health professionals' experiences of patient suicide.

Abstract

Aim: The review aimed to produce a new and integrative interpretation of qualitative research exploring mental health professionals' experiences of patient suicide. It intended to highlight key recommendations and the implications of this.

Method: A systematic literature search found 14 relevant articles. A meta-ethnography was carried out in accordance with Noblit and Hare's (1988) seven steps approach. The analysis resulted in five themes and seven subthemes.

Results: The themes reflect mental health professionals' experiences of patient suicide. 'Grief, loss and trauma: An emotional endeavour' suggests that mental health professionals tend to be emotionally affected by patient suicide. 'An existential shake up' suggests that they can experience intense feelings of guilt, incompetence and failure, and sometimes an increased sense of responsibility; these can affect their perceptions of their professional identity. 'Encounters with blame' indicates that mental health professionals can experience self-blame, blame from employers (including bureaucratic blame), peers and the deceased family. 'Support seeking' reflects that mental health professionals can seek support from others. This can have a positive or negative effect on them, depending on how others respond. Finally, 'A changed person' suggests that patient suicide can have a long standing and transformational impact on mental health professionals.

Conclusions: Mental health professionals' experiences of patient suicide are complex. The review suggests that mental health professionals experience an 'emotional regulation' and 'bereavement' process which can be complicated by a number of factors (e.g. the 'out of the ordinary' nature of suicide).

Introduction

Aim

This paper aims to provide a meta-synthetic review of qualitative research into mental health professionals' experiences of patient suicide.

Suicide (prevalence and context)

Suicide can be defined as an intentional act carried out by an individual (aged 10 and over) in an attempt to end their life, resulting in their death (Office of National Statistics, 2017).

The World Health Organisation (2017) revealed that approximately 788 000 people of all ages committed suicide in 2015. This was simplified to a suicide rate of 10.7 per 100 000 in the general population. In the United Kingdom, 5, 668 suicides were registered in 2016 (Office of National Statistics, 2017). Whilst there has been a slight decrease in suicide rates in the UK over the last 3 years, it is a great public concern and continues to have wide spread effects on all those involved (Office of National Statistics, 2017).

Over the years, there has been a strong body of evidence outlining that suicide is related to poor mental health (Goodwin, Kroenke, Hoven & Spitzer, 2003). This is particularly reflected in mental health research which suggests more than 90% of suicides and suicidal attempts are associated with having a mental health disorder (Mental Health Foundation, 2018). This includes psychiatric problems like depression (Goodwin, Kroenke, Hoven & Spitzer, 2003), schizophrenia (Hor & Taylor, 2010) and personality disorders (Pompili, Girardi, Ruberto & Tatarelli, 2005).

Suicide prevention has become a key government priority and a number of strategies and policies have been put in place to reduce the number of suicides and provide support for

those bereaved or affected by the suicide (DoH, 2012). More recently, a policy called 'Zero suicide policy' (NHS, 2016) has been published and adopted by a number of NHS trusts. The policy proposes that a "suicide is an avoidable death" and thus that suicide can be eliminated (NHS, 2016, p.5). This view is likely to pose many challenges and pressures for mental health professions who work with variable levels of risk on a daily basis.

Mental health professionals

Mental health professionals support people who experience mental health problems. They can include psychiatrists, general practitioners (GPs), psychologists, therapists, nurses and social workers. A part of their role is to help identify and manage patient risk, and particularly risk of suicide. However due to the nature of patients' difficulties and the complexity of mental health issues, mental health professionals can be faced with patient suicide (DoH, 2012). Appleby et al (2001) found that a quarter of people that had committed suicide had been in contact with mental health services within a year of their demise. Similarly, it is expected that one in five psychologists experience a patient suicide during their career (Bersoff, 1999; Kleespies et al, 1993). Other studies have estimated that between 20-60% of psychiatrists will have a patient commit suicide (Pilkinton & Etkin, 2003; Yousaf, Hawthorne & Sedgwick, 2002). This was similar to the number of patient suicides reported by mental health social workers (33%) (Jacobson, Ting, Sanders & Harrington, 2004).

Mental health professionals experience of patient suicide

Over the years, there have been a number of studies looking at the prevalence (Puttagunta, Lomax, McGuinness & Coverdale, 2014) and impact of patient suicide on mental health professionals (Seguin et al (2014). Whilst there have been some qualitative (Ting, 2006; Doyle, 2008; Hagen, 2017) and reflective papers (Grad & Michel, 2005; Valentine, 2006), the majority have been quantitative research studies (Dewar et al, 2000;

Courtenay & Stephens, 2001; Thomyangkoon & Leenaars, 2008; Gitlin, 1999; Menninger, 1991). These have highlighted that the effects of patient suicide can be long, enduring and markedly distressing. For instance, they indicate that mental health professionals can experience guilt (Dewar et al, 2000; Courtenay & Stephens, 2001; Thomyangkoon & Leenaars, 2008), stress (Gitlin, 1999), low self esteem (Dewar et al, 2000), self condemnation (Dewar et al, 2002; Courtenay & Stephens, 2001), anger (Thomyangkoon & Leenaars, 2008), shame (Thomyangkoon & Leenaars, 2008), damage to their identity (Brown, 1987) and trauma symptoms (Menninger, 1991) following a patient suicide.

A selective number of literature reviews have been conducted in this area, but they have tended to focus on a single type of mental health profession, such as therapists (Horn, 1994), or nurses (Anne-Grethe & Gilje, Fredricka, 2011). In recent years, there have been three published literature reviews (Kouriatis, & Brown, 2011; Ellis & Patel, 2012; Seguin et al, 2014) pertaining to this area of research. They form the rationale and importance for carrying out this further systematic literature review; they will now be explored in more depth.

Kouriatis and Brown (2011) carried out a review on how therapists' experiences of loss can affect them personally and professionally. Whilst this review gave some useful insights into this area, it had a particularly heavy theoretical focus on more reflective research and bereavement theories, rather than on participants' actual experiences from empirical research studies. Furthermore, it was not a systematic review and only presented research which had been published up until 2009. Shortly after this review, Ellis and Patel (2012) conducted a brief review looking at the impact of client suicide on clinicians, factors which can moderate the impact (e.g. professional experience) and ways of coping. However, like Kouriatis and Brown (2011), this review was not systematic and only presented literature up to year 2009. Furthermore, it did not include the experiences of nurses or psychiatrists, who

are two of the crucial mental health professional groups working with suicidal patients. Finally, the most recent review in this area is by Seguin et al (2014). Seguin et al (2014) completed a very comprehensive review of research focused on mental health professionals' reactions after a patient carries out suicide. The authors carried out a systematic search (from years 1980 to 2012) and included reflective papers, case studies, qualitative and quantitative research (n=37). Their paper provided an overview of the research, but tended to focus more on the methodology of the research outlined and related the outcomes in a very descriptive and medicalised manner (i.e. reporting on 'affect-related symtomatology' and 'stress-related symptomatology'). The authors did not talk about the findings in a detailed or psychologically meaningful way, which otherwise could have allowed an understanding of the relationship between the different highlighted areas (i.e. post psychological and behavioural functioning and adaptation). Additionally, they did not discuss the implications of these findings for mental health professionals. The present review intends to add to the research review base by presenting an experiential narrative of mental health professionals' experiences of patient suicide. It will review up to date qualitative research which is inclusive of all mental health professional groups.

Qualitative research

According to Lyons and Coyle (2007), qualitative research is concerned with gaining an in-depth and rich understanding of experiences, beliefs and processes. Thorne (2000) outlines that there are no particular restrictions on what can be defined as an 'appropriate' qualitative method; providing the method gives some insight into the phenomenon and does not reduce it to numerical values. The most frequently used data collection methods are interviews, focus groups, written accounts and observations. These methods generally allow a research study to qualify as qualitative research (Lyons & Coyle, 2007). Accordingly, the author welcomes all qualitative data collection methods in this systematic review.

Meta-synthesis

Meta-synthesis is an approach which aims to aggregate, examine, pinpoint key features and interpret the findings of a number of qualitative research studies in order to give a more holistic overview of a given topic area. This method of reviewing research can increase the strength and transferability of research findings (Noblit & Hare, 1988). A search into the topic area indicated that to date, a systematic meta-synthesis looking at mental health professionals' experiences of patient suicide has not been conducted.

The present systematic meta-synthesis literature review

The aim of this systematic meta-synthesis review is to produce a new and integrative interpretation of the qualitative research which informs us about mental health professionals' experiences of patient suicide. It is hoped that this will give a more detailed and relational account of their experiences, an understanding of the need for future research and the potential implications of these. A systematic search will be conducted to ensure that all the relevant articles are included. It is anticipated that this will enable a more thorough account of the most pertinent literature in the area.

Method

Review

There are various ways of undergoing a meta-synthesis. Noblit and Hare (1988) offer an approach called meta-ethnography. This involves summarising, integrating and interpreting a number of qualitative research studies. The aim of this method is to ensure that the essence of the research findings are kept intact by retaining crucial metaphors and themes, whilst interpreting them in the context of other research findings. It is imperative to identify how the research findings relate together. This is achieved by 'translating' the underlying concepts in the studies, and comparing them. If they are aligned well, then, they are termed 'reciprocal translations'. However, if they are oppositional they are called 'refutational translations,' and if they create a more holistic understanding of a concept from studies of its parts they are called 'lines of argument translations' (Noblit & Hare, 1988). The Noblit and Hare's (1988) seven stages approach (see Table 1) was used. As the research data aligned together, a 'reciprocal translation' approach was taken.

Table 1: The seven stages of the meta-ethnography (Adapted from Noblit & Hare, 1988).

Stage 1: Identify mental health professionals' thoughts and experiences of patient/s committing suicide.
Stage 2: A systematic search for research articles pertaining to the topic area.
Stage 3: Read the articles thoroughly (note key features pertaining to topic e.g. metaphors, themes and concepts).
Stage 4: Compute a cross tabulation table of the research studies (including key features).
Stage 5: Compare the key features and how they interact with one another.
Stage 6: Synthesise the translations (consider whether the findings can be translated into one another i.e. reciprocal translations).
Stage 7: Communicate and present the synthesis.

Systematic literature search strategy

A systematic search of the literature was carried out using a number of databases, namely PsychINFO, Web of Science and EMBASE via the search engine 'OVID'. The search focused on obtaining research specific to mental health professionals working with adults, which had been published between 1967 and 2017. The search strategy incorporated the three elements of the review by applying key words used in the field (see Table 2).

Table 2: Systematic literature search strategy terms.

1) Mental health professionals (search terms "Therapist* OR Psychologist* OR Counsel* OR *therapist OR Clinician OR Practitioner OR professional OR *worker OR Occupational OR Psychiatrist OR Nurs*")
AND
2) Research methodology which pertains to gauging individuals' experiences and internal world (search terms "qualitative OR interview*")
AND
3) Individuals purposive end of life experience (search terms "suicide adj2 (patient OR client OR service user OR consumer)"

The three elements were combined by using the 'AND' function. The search strategy was then applied across the title, abstract, subject headings (including table of contents, key concepts, test and measures) of the research literature. An inclusion criterion was used to filter through the mass of literature, leaving only the most relevant articles. The research articles used in the review met the criteria outlined in Table 3.

Table 3: Review inclusion criteria.

1. Qualitative research study
2. Published in a peer-review journal
3. Written in the English language
4. The research study recruited a minimum of six participants

5. Only reflected mental health professionals' experiential accounts following the suicide/s of individuals who were receiving care from them.
6. Patients who committed suicide must have been of a working age

The systematic search resulted in 72 research studies being generated. 25 duplicate articles were removed, leaving 47 articles. The titles (47) and abstracts (19) of these research articles were visually screened for their relevance to the topic area, leaving 11 articles for further examination. The articles were read in full to gage whether they met the aims of the review and 9 were retained for the review. Accordingly, 2 research articles were excluded from the review. The reasons for the research articles being excluded are indicated in Table 4. Figure 1 gives a visual representation of the attrition process. The articles' reference sections were examined for other relevant research, resulting in 2 studies being added to the research review pool. A search in 'Google scholar' was carried out and yielded 3 more relevant articles. A total of 14 studies were reviewed.

A number of research articles (3, 10-13) focused on mental health professionals' experiences of patient suicide, amongst other suicide related experiences (i.e. suicidal attempts and violent acts). These were discussed with Dr Michael Larkin (research supervisor) and it was agreed that only clearly defined data which corresponded with actual suicide would be analysed, whilst unrelated and/or ambiguous data would be excluded.

Table 4: Rationale for the attrition of research studies for the review.

No. of studies excluded	**Reason for exclusion**	**Exclusion details**
2	irrelevant to the topic under investigation	1 explored GPs' perspectives on primary care consultations for suicidal patients 1 was unobtainable in full text (Saito, Nakao, Takeda, Fujioka, Kimura, Wakimoto, Moriyama, Saito & Seishin, 2001 – 'The impact of patients' suicides on their therapists')

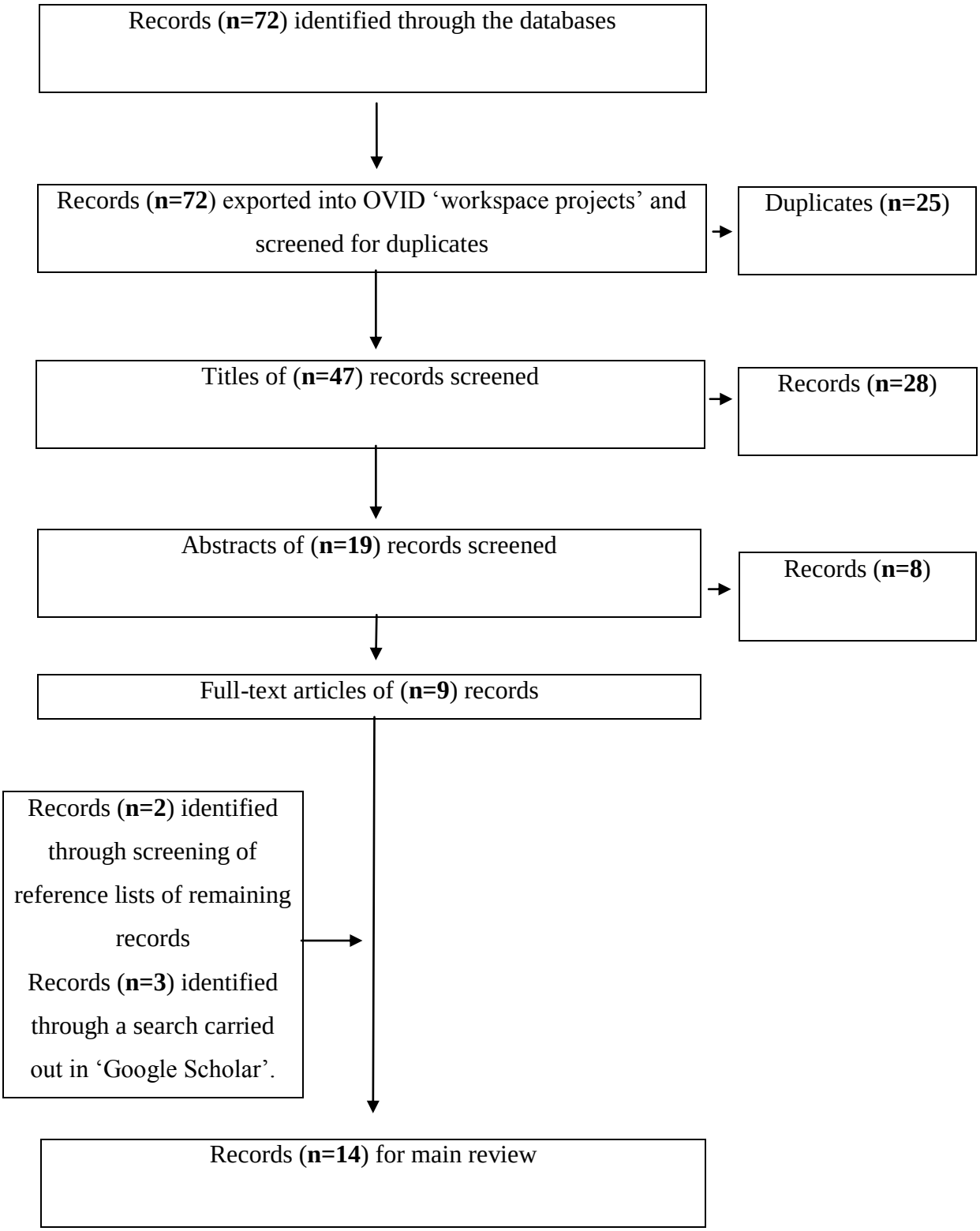

Figure 1: Visual representation of attrition.

The 14 articles were read thoroughly and their main features were noted (see Appendix 1).

Appendix 1 shows that all of the studies were carried out in Western countries. The majority of the studies had a relatively small sample size (n = range 6 to 21), as expected for qualitative research studies, except for two, which had relatively large samples of 145 and 198. The number of participants who took part in research across the studies was 516. The age range of the participants across the research studies was between 30 and 69 years. Surprisingly, 6 studies did not mention the age of their participants. The research studies varied in the occupation of the participants (27 psychiatrists, 24 mental health nurses, 21 psychologists, 228 GP's, 172 social workers, 12 trainee psychologists, 10 trainee nurses, 1 trainee counsellor, 21 trainee psychiatrists). All of the studies except two (Sanders, Jacobson & Ting, 2005; Hendin, Lipschitz & Maltsberger, 2000) obtained their data from conducting interviews. A number of data analysis methods were used by the authors; these included grounded theory (2), Phenomenological analysis methods (3), Consensual qualitative research methods (1), Thematic analysis (5) and systematic text condensation (1). However, one did not use a formal analysis method (Deringer & Caligor, 2014) and another was not stated (Hendin, Lipschitz & Maltsberger, 2000)

Quality assessment of the research articles

Qualitative research is based on the principle that there are no absolute universal truths. Instead, it believes there are an array of 'versions of truth' which are held by individuals, these may or may not resemble those of others (Lyons & Coyle, 2007). Thus, qualitative research aims to develop a rich experiential understanding of the individuals involved. This differs from quantitative research which assumes there are absolute truths, which can be measured and presented statistically. It is arguably easier to assess the validity

and reliability of quantitative research compared to qualitative research (Lyons & Coyle, 2007). Quality appraisal tools can assist with this process. Accordingly, a methodological checklist by the National Institute of Clinical Excellence (2009) (see Table 6) was used to assess the quality and credibility of the research articles in this review.

Table 5: NICE (2009) Methodological checklist for qualitative studies.

Section 1: Theoretical approach
1.1 Is a qualitative approach appropriate?
1.2 Is the study clear in what it seeks to do?
Section 2: Study design
2.1 How defensible/rigorous is the research design/methodology?
Section 3: Data collection
3.1 How well was the data collection carried out?
Section 4: Validity
4.1 Is the role of the researcher clearly described?
4.2 Is the context clearly described?
4.3 Were the methods reliable?
Section 5: Analysis
5.1 Is the data analysis sufficiently rigorous?
5.2 Are the data 'rich'?
5.3 Is the analysis reliable?
5.4 Are the findings convincing?
5.5 Are the findings relevant to the aims of the study?
5.6 Are the conclusions adequate?
Section 6: Ethics
6.1 How clear and coherent is the reporting of ethical considerations?

The marking criteria recommends marking each section based on whether the criterion was met ("Yes"), was not met ("No") or it was unclear ("Unclear") e.g. due to a lack of information. The author and a co-rater appraised the articles independently to reduce the likelihood of subjective marking. An overall rating was compiled based on these markings; these were called "no weaknesses", "few weaknesses" and "some weaknesses". Appendix 2 shows the overall ratings for the research articles included in the review.

Appendix 2 shows that the overall quality of the studies was 'fair.' Three of the studies were deemed to have 'no weaknesses' (5-7), one appeared to have a 'few weaknesses' (5) and nine had 'some weaknesses' (1-3, 8-9 and 10-13). The majority of the research studies were appraised as having weaknesses due to insufficient details or a lack of reporting. As a whole, the studies gave a sufficient level of insight into the theoretical approach, aims, study design and data collection; these appeared feasible. A number of the studies obtained an 'unclear' rating for validity due to a lack of detail regarding the role of the researcher (2-4, 8, 10, 12-13) and the context of the research (2-4, 8-12). This made it very difficult to ascertain whether the findings were valid. The studies appeared mixed in their analysis of the data findings, however overall it seemed the data analysis was generally fair and trustworthy. Finally, a number of research studies presented a fair appreciation of ethics (1, 3, 5-7, 10-11 and 13), whilst others lacked brevity (2, 4, 8-9 12 and 14). As mentioned, the lack of sufficient detail in these areas made it really hard to report on their feasibility.

Data extraction, analysis and synthesis

The research articles were read thoroughly on several occasions. A particular focus was placed on the research studies' results sections. Key features (i.e. metaphors, themes and concepts) pertaining to the topic area were highlighted and entered into a cross tabulation table. A significant amount of time was spent studying the table; this involved looking,

comparing and contrasting the key features of the studies. I noted down my initial impressions of what the data suggested (see Appendix 3) and started a reciprocal translation process. This involved clustering similar themes together (see Appendix 4) and grouping them into one another. This eventually led to creating overarching themes for the clustering and groups.

The synthesis resulted in five themes and seven sub-themes evolving from the data. To ensure the validity of these themes, I returned to the original quotes and results sections of the corresponding research articles and made several cross reference checks. A number of other similar quotes and references were collected to ensure the themes were plausible. A number of consultations with Dr Michael Larkin were undergone to ensure the credibility of the data handling process.

The researcher as a person in context

A.H is a trainee clinical psychologist who has experienced a number of planned and unplanned endings (e.g. patients leaving therapy prematurely). Over the years, she has become interested in the concept of endings, particularly in healthcare settings. More specifically, she has worked with a number of mental health professionals who have had patients commit suicide. Through conversations and personal observations, she has noticed that this can be a very challenging experience for them and all those involved. Therefore, her research position is one of great curiosity so that she can enhance knowledge in this topic area and make recommendations accordingly.

Results

The analysis resulted in five themes and seven subthemes (see Table 7; these represent the findings of the review articles).

Table 6: Themes and sub-themes.

Themes	Sub-themes
Grief, loss and trauma: An emotional endeavour	Grief and loss Trauma: An emotional storm
An existential shake up	None
Encounters with blame	Self blame Peers and Family: blame and reprisal Bureaucracy: blame and reprisal
Support seeking	Internal support seeking External support seeking
A changed person	None

The themes project mental health professionals' experiences of patients committing suicide. The various themes are presented with quotes from the original texts. The themes demonstrate that professionals often experience strong emotions throughout this endeavour. In my synthesis of the papers' findings, I suggest that these emotions appear to form a developmental story. This story appears to have clear episodes, or stages, and so these are used to structure the findings, below. The use of these stages does not mean that there is 'A Process' which all professionals will, or must, go through in response to patient suicide. Instead, these stages capture recurrent themes and associations within the studies I have reviewed. The reader will note that there is a cyclical or iterative quality to some of these stages: some feelings reappear and/or overlap. The narrative described in the studies under review begins with an initial response of shock and grief, which is often followed by trauma-

like responses (e.g. fearful dreams related to the incident). Some professionals then describe taking up a more removed stance and contemplating what this experience means for them professionally (e.g. their professional identity). It appears that this can lead to experiencing guilt and isolation; it can also affect support-seeking during the different stages. In the studies, this tends to change over time, with guilt and grief becoming less evident, and fears of its re-occurrence becoming more prominent. The themes seem to illustrate an underlying sense of loss, fear and transformation; alongside interesting (potential) parallels between mental health professionals and their patients, which will be explored below and further in the discussion section.

Grief, loss and trauma: An emotional endeavour

"Not him, it's got to be a mistake, it must be another with a very common, last name—not first name, must be a mistake"? But, of course, at the same time we knew this was not something that one makes mistakes about." – (Darden & Rutter, 2011, p. 331)

"I was absolutely shocked and it's a thing that affected me for a long time and I still think about it."- (Kendall & Wiles, 2010, p. 1718)

"And the thing is when they actually do it [suicide]. You feel a bit guilty, guilty conscious and ... That you actually didn't see the person enough or did enough..." – (Hagen, Knizek & Hjelmeland, 2017, p.33)

"Quite angry and particularly with the patient that died because we had put so much effort into her." – (Bohan & Doyle, 2008, p. 14)

"I could not control my crying. I mean, I was grief-stricken. When I say I came undone that's when I really let myself open up and sob and cry." – (Ting, Sanders, Jacobson & Power, 2006, pg. 332)

Figure 2: Key quotes pertaining to the theme 'Grief, loss and trauma: An emotional endeavour'.

The quotes in Figure 2 illustrate that mental health professionals can experience a sense of grief, loss and trauma when a patient commits suicide; this reaction is multi faceted, overwhelming and involves a range of emotional experiences i.e. shock, denial, guilt, anger, fear and intrusive thoughts. These experiences are broken down under two headings, namely 'Grief and loss' and 'Trauma: An emotional storm' to ease comprehension and allow a deeper exploration of these.

Grief and loss

This theme describes the professional's initial response to news of the suicide. It includes evidence that mental health professionals often experience grief and a sense of genuine loss when a patient commits suicide. It seems the experience also frequently involves feelings like shock, denial, anger, guilt and sadness.

Two key elements of the grief reaction, which were common across the articles, were shock and denial. This related to the mental health professional being unaware that the patient was acutely suicidal (1, 2, 5, and 9). Darden and Rutter (2011, p.331) illustrate this in the participant quote (see Figure 2), alongside the intensity of the shock and denial that can occur. It appears, shock and denial can complicate the acute grief reaction. However, several studies described how, after a period, mental health professionals were able to digest the news and reflect on the intensity of their response at the time of the incident.

Another prominent emotion which could be experienced as part of the grief and loss reaction was anger (2, 3, 4, 5, and 12). It seems that the anger was either directed at the self, the deceased or the agency/health care provider. For instance, Bohan and Doyle (2008) (see Figure 2) and Hendin, Lipschitz and Maltsberger (2000) suggested that professionals were angry with the deceased because they had invested so much energy into the patient and felt 'rejected' by him/her. Other reasons for the professionals being angry with the deceased patient included them giving up on life and being inconsiderate of the people they had left

behind to mourn them (e.g. children; studies 1, 6). Mental health professionals were also angry with the institution for not making more intensive support accessible (e.g. hospitalisation): "...[these are] chronic suicidal patients, but hospitals wouldn't admit them without being actively suicidal. Yet they could become active anytime and commit suicide. But at the time I send them to the ER, they get sent home and then commit suicide a week later." (Participant in Ting, Sanders, Jacobson & Power , 2006, p.333) and "I was angry . . . at the psychiatrist and our clinic for not doing more." (Participant in Sanders, Jacobson & Ting, 2005, p.204). It is possible that their anger was also due to the perception that the institution impinged their ability to help suicidal patients and the institutional restrictions evoked a sense of powerlessness and helplessness, which was difficult to tolerate. It was evident that mental health professionals also felt angry at themselves because they perceived they were somewhat incompetent and had failed the patient and their family.

It was apparent that for some, the grief involved a level of uncontrollability (1, 3, 5, and 7); Ting, Sanders, Jacobson and Power present an example of this (see Figure 2). This level of grief can arguably be comparable to the loss of someone close (e.g. a friend or family member), indicating the relationship between a mental health professional and patient can be a powerfully affecting one. The uncontrollability element seems to be related to the sudden and unexpected nature of suicide. It is likely that this may re-evoke other traumas or sudden losses, such as death. For example, "I think that it probably just brought back some other experiences, where I lost a friend traumatically in a car accident—it was really sudden. And so, its just sad and a lot of thinking about the whole situation and you know going to the hospital and actually seeing his body is not something that I've ever done before. So that was hard." (Participant in Darden & Rutter, 2011, p.331). Furthermore, in a theme titled 'Grief and loss', Ting, Sanders, Jacobson and Power (2006, p.332) presented a number of statements which suggest this: "[I] couldn't calm down and be professional." , "the night he died, I got

deathly ill; I had to go to the emergency room. I thought I was having a heart attack." and "[The patient suicide] brought up feelings of when my father died when I was five...triggered this fear from when he died".

To summarise, it was clear from the studies that mental health professionals reported experiences of grief when a patient committed suicide, and that this could include shock, denial, anger (at patient, self and institution), uncontrollability, and other losses. These intense experiences were perceived to complicate the grief response.

Over half the clinicians reported dreaming about the patient, some reporting dreams of dismemberment, violent death, gruesome death scenes, and other nightmare phenomena. – (Tillman, 2006, p.167)

Social workers indicated that in the days immediately following the suicide completion they experienced intrusive reactions, such as "memories of the event," "visualized what she may have looked like," "visualized the suicidal act," "visualized the hanging and how he looked," and "thought I could hear him talking to me." – (Sanders, Jacobson & Ting, 2005, p.203)

"I've been here for 18 years and during that time I've had three. All three depressed patients. Two of them are very far back. But still it's – something you – well – you remember. It was an appalling experience." – (Davidsen, 2011, p.115)

"It really was quite bizarre...this was a year later. I had brought a brand of shampoo at the store, and I was taking a shower. And just the smell of the shampoo made me feel nauseous, and I just couldn't figure out why and just felt so sick that I rinsed it out. And when I finished the shower I went, and I threw the shampoo in the trash can outside. I couldn't even stand having it in the house. I thought, "I just can't stand it; that smell makes me sick." And as I was driving to work that day, it dawned on me that it was the smell my client had." - (Ting, Sanders, Jacobson and Power , 2006, p.336)

Figure 3: Key quotes pertaining to the sub-theme 'Trauma: An emotional storm'.

Trauma: An emotional storm

Figure 3 demonstrates that mental health professionals can become overcome with experiences indicative of trauma, following the loss of a patient to suicide. This sub-theme conjures up an imagery of an emotional storm, which can typically be fear inducing, devastating, intrusive and evoke a bid to avoid it.

The intrusive elements of the trauma came across more strongly and frequently in comparison to the others (1, 4, 5 and 7), for example see Ting, Sanders, Jacobson and Power (2006, p.336) in Figure 3. It manifested itself as intrusive thoughts, dreams and flashbacks; all which were unwanted by the individuals. For instance, Tillman (2006, p.167) (see Figure 3) illustrate that social workers can experience gruesome dreams. The nature of the dreams seemed to be fear induced and devastating for those experiencing them. The trauma experienced also involved reactions which are commonly associated with extreme trauma: "Clinicians reporting dissociative phenomena were also those who experienced more isolation from colleague support, feeling alone with the trauma of their patient's suicide and cut off not only from others, but also, in the dissociative experience, from themselves" (Author in Tillman, 2006, p.167) and "Social workers indicated that in the days immediately following the suicide completion they experienced intrusive reactions, such as "memories of the event," "visualized what she may have looked like," "visualized the suicidal act," "visualized the hanging and how he looked" (see Figure 3) and "thought I could hear him talking to me." (Author/s in Sanders, Jacobson & Ting, 2005, p.203). Similar to devastation, sometimes left in the wake of a storm, it seemed that mental health professionals were bothered by memories of the suicide even years after it had occurred. Davidsen (2011, p.115) provides an example of this (see Figure 3). This suggests that the trauma associated with this event can have a long and enduring effect on individuals. Like a storm, the traumatic event can have the potential to intrude into mental health professionals personal lives by causing a

great pre-occupation with the deceased, affecting their capacity to engage with their friends and family (1).

Mental health professionals attempted to cope with the emotional storm by trying to avoid it (1 and 7): “tried to push it out of my mind” (Participant in Sanders, Jacobson & Ting, 2005, p.203) and reassure themselves they did all that they could (7).

This sub-theme suggests that mental health professionals can become traumatised by the patient completing suicide; the longevity of this can be considerably long for some.

Overall, this theme suggests that mental health professionals tend to be emotionally affected by patient suicide. Whilst some experiences resemble a trauma response; other elements of the emotional experience can involve a grief and loss reaction. These emotional experiences overlap and are interchangeable and vary in durability.

An existential shake up

“The first thing you think is was it my fault, could I have prevented it, should I have referred him to someone sooner, should I have picked up warning signs, was he on the right medication, did he take an overdose of his medication or did I give him the medication he then killed himself with? There is a whole host of things.” - (Saini, Chantler, While & Kapur, 2016, p. 418)

After a patient suicide one of the nurses had wondered whether some of the patient's activities that day (e.g. doing the laundry) could be a sign of her suicide, as if she could have prevented the suicide if she had only been more alert. - (Hagen, Knizek & Hjelmeland, 2017, p. 33)

“It makes me question being in the field when that [a suicide] happens. It makes me feel like I don't know what the hell I'm doing and that I have no business being a therapist.” - (Ting, Sanders, Jacobson & Power , 2006, p. 333)

“If you look at your role you are supposed to talk people off that bridge in a moment of

crisis and almost heal them. That is what people expect of you; to prevent people from going to their death by whatever means." – (Rossouw, Smythe & Greener, 2011, p. 6)

"I was so shocked and felt a high degree of responsibility for a while because I was working on a contract basis and had neglected to have the client sign consent, outline the laws regarding sexual abuse. After he disclosed his molestation, I consulted with my employer and was urged to report him. Right after that I saw him and he reported being "relieved" and agreed to cooperate with children's services. Approximately one week after, he shot himself on his ex-wife's lawn." - (Sanders, Jacobson & Ting, 2005, p. 205)

Figure 4: Key quotes pertaining to the theme 'An existential shake up'.

All of the articles gave a strong sense of mental health professionals experiencing an existential 'shake-up' following patient suicide, as illustrated by the quotes in Figure 4. This was imbued with guilt, self examination (including responsibility and control) and feelings of incompetence, loss of faith in one's own professional identity and abilities, and thus it can be understood as an existential upheaval creating inner turmoil.

The existential shake up involved guilt related to not being able to predict or prevent the suicide. For the most part, this was attached to feeling incompetent. For instance, professionals wondered whether they had failed to apply their skill set effectively (see quotes by Saini, Chantler, While & Kapur, 2016, p. 418 and Hagen, Knizek & Hjelmeland, 2017, p. 33 in Figure 4)

For many, these wonderings became ruminations, which involved the mental health professionals investing their energy in examining their actions, judging their performance and thinking of alternative things they could have done to prevent it. Ting, Sanders, Jacobson and Power (2006, p. 333) (see Figure 4) illustrate an example of a participant engaging in self examination and professional scrutiny. It suggests that after a patient suicide, mental health professionals can question their professional identity and experience feelings of despondence.

A number of the articles suggest that mental health professionals tended to experience a heightened sense of responsibility, which resulted in more mental and emotional tumult. Rossouw, Smythe and Greener (2011, p.6) and Sanders, Jacobson and Ting (2005, p. 205) (see Figure 4) exemplify this using participant quotes (see Figure 4). In a theme titled 'Responsibility, fear and guilt', Rossouw, Smythe and Greener (2011, p. 6) suggested that clinicians that experienced an increased sense of professional responsibility tended to think they were required to go beyond their capabilities to achieve a professional ideal. They proposed that patient suicide threatened their hopes of becoming that professional ideal because they were unable to prevent the suicide from occurring. This suggests that patient suicide can challenge mental health professionals' perceptions of their own professional identity, which may exacerbate their turmoil.

However, an analysis of the articles also suggests that some mental health professionals feel a lack of control in relation to whether patients commit suicide and think that the ultimate responsibility lies with the patient (5 and 7). On one hand it seems this view can somewhat alleviate the existential feelings, however, on another it generates further worry about the implications of this on their professional identity and a deterioration in their professional self worth.

It is evident from this theme that mental health professionals can experience intense feelings of guilt, an increased sense of responsibility and feelings of incompetence and failure. This can create inner turmoil during which mental health professionals can grow dubious about their professional identity and capabilities.

Encounters with blame

"I was so shocked and felt a high degree of responsibility for a while because I was working on a contract basis and had neglected to have the client sign consent, outline the laws regarding sexual abuse. After he disclosed his molestation, I consulted with my employer and was urged to report him. Right after that I saw him and he reported being "relieved" and agreed to cooperate with children's services. Approximately one week after, he shot himself on his ex-wife's lawn." – (Sanders, Jacobson & Ting, 2005, p. 205)

"There is always, there's that blame culture and I think [with] something as barn door as a suicide, there is a blame culture that comes back to the doctor. I think we all feel a bit threatened. We are trying to give perfection at the coalface. And then as soon as anything goes wrong we're responsible. It is very difficult to keep up that energy and that politeness and that open friendliness if you feel that as soon as there is any little glitch then actually they're going to blame you." – (Kendall & Wiles, 2010, p. 1716)

"I had the clinical director, and during the staff meeting when we were talking about what happened, he made a comment in front of the whole entire staff, sort of blaming me, saying "I wouldn't want to have his blood on my hands if I were you". And that really upset me as I looked back on it was nobody in the whole room reacted to the fact that this was blatantly inappropriate and mean. He was intending to cause me pain; I would have thought my supervisor, I would have thought both of them would have encouraged me to talk about it and help me work through it. Nobody did, and that was it. So I never really talked to anyone about it." – (Ting, Sanders, Jacobson & Power , 2006, p. 334)

"Shit what now? Is my neck on the line here? And I had these bureaucratic concerns about how responsible I have been as a clinician, appropriateness of treatment, etc. It brings an added pressure and I see this in all the District Health Boards, they are risk averse and you should protect yourself. The question of how to open myself up to hearing the person without [institutional investigation] creates conflict for me. It interferes with spontaneous practice. That need to feel safe steers you in the direction of being prescriptive and covering your arse; and that is not care." – (Rossouw, Smythe & Greener, 2011, p. 5)

Figure 5: Key quotes pertaining to the theme 'Encounters with blame'.

Blame was a popular theme that emerged across the articles; however, the mental health professionals' encountered many different facets of blame throughout their experience e.g. self blame, fear of blame, institutional blame and reprisal (see Figure 5). These are captured within 3 subthemes.

Self blame

It seems that when a patient committed suicide, mental health professionals had the potential to blame and criticise themselves (1 and 7). In large, this was attached to a heightened sense of responsibility and feelings of incompetence (as discussed in 'the existential shake up'). This appeared to evoke feelings of guilt and affect their professional confidence and self esteem.

Peers and Family: blame and reprisal

There appears to be a theme of mental health professionals stating that they experienced blame and reprisal from their peers and the deceased patient's family, running through the articles. A facet of this involved mental health professionals fearing their peers would blame them for the suicide (1, 7) and worrying they were being perceived negatively by them (4). It seems that mental health professionals can have the expectation that others will blame them; a participant (in Kendall and Wiles, 2010, p. 1716) (see Figure 5) described this as 'blame culture', owing to the public becoming increasingly dependent on healthcare professionals to 'fix them' and readily blaming them when an unfavourable outcome occurs. For some, fears of being blamed became a reality as they were faced with scrutiny by others; this perpetuated their distress (1 and 7). For instance, Ting, Sanders, Jacobson and Power's (2006, p.334) participant quote (see Figure 5) illustrates that mental health professionals can feel blamed and singled out by peers. It also suggests that they may become discouraged from accessing support and become isolated as a repercussion of blame.

It seems that over the years, mental health professionals had formed a relationship with the patient's families and sometimes made contact with them following the suicide (1, and 4). This either resulted in the families absolving the professionals of any blame (2) or the families directed their rage towards the professional and suing them for the death of the patient (4).

Bureaucracy: blame and reprisal

A number of articles revealed that professionals feared they would face reprisal from legal bodies (3, 4 and 5), particularly if they had not complied with risk averse bureaucracy (7 and 9). Over the years there has been a recognisable increase in paperwork related to suicide management (5). It appears that mental health professionals were troubled by having to adopt a more bureaucratic risk aversive practice, which appeared to be in conflict with their professional identity; which hinged on being competent, dedicated, person centred and caring (3, 4 and 9). Rossouw, Smythe and Greener's (2011, p.5) example of a participant account (see Figure 5) highlighted that in a bid to avoid litigation, mental health professionals had to carry out potentially time consuming bureaucratic obligations which could clash with a more person centred care approach. Never the less, in the event of patient suicide, mental health professionals worried about getting sued or losing their licence to practice (3, 4, 5, and 9). However, on occasions when legal reviews denoted that the practitioner/s were not to blame for the suicide, it alleviated their distress as they felt reassured that they were not at fault (9).

In summary, it seems that mental health professionals can have various encounters with blame; these can include self blame and the view that others perceive them negatively, which can have a negative effect on their professional identity. It can also include blame from peers and the deceased's family which can relate to a 'blame culture' and a growing dependency on health care professionals. It can also include bureaucratic blame, which

suggests that mental health professional can be reprimanded for the suicide or absolved of all blame.

Support seeking

"You almost transcend yourself and when something like this happens you realise that you are only human. It [supervision] was a release and I felt more comfortable with myself. It is part of the process of letting go; I remember asking myself what is it that I am trying to control here? What was I holding on to? And I think it was the thought that in this job I am not supposed to make mistakes." - (Rossouw, Smythe & Greener, 2011, p.8)

"I felt isolated from my supervisor, surprised at how [she] didn't know what to say, didn't debrief I was on my own. I called my supervisor...and her response was simply, "Why don't you just go home?" and I said, "I don't want to go home. I'll just sit there at home by myself and think about it. I need some help here." She just didn't know what to say to me. I felt the most alone I have ever felt in my career. I was very surprised by her reaction actually. It was almost as though she just didn't really have the time to debrief with me, so she wanted to get me off the phone and wanted to send me home." – (Ting, Sanders, Jacobson & Power, 2006, p.334)

"My boss and I went through the file and we could see that the risk assessments were done and that I had gone through the whole process [paper trail of mental health assessment] and that he was safe and sound." – (Rossouw, Smythe & Greener, 2011, p.8)

"The biggest help for me was kind of talking to my peers on the ward. I think that's the biggest help really, you know that you have the support from other nurses and they are going through a similar experience." – (Bohan & Doyle, 2008, p.14)

"Instead of calling my friends, I went back to find this article I had read in the newspaper [about an expert who started a suicide prevention center]. I found out where he [was]...what college he was associated [with] and went online. Got the phone number for him. Called him and left a message, thinking his secretary would call me back and say, "he's not available, here's a letter" or something...and then one day I got a phone call and

it was him. And he called, and he said, "I understand you're struggling"... Actually, I didn't talk to him; he left a message. He said, "I understand you're struggling and I'll talk to you." He left me his phone number, and that was it. When I got that message I just started crying." – (Ting, Sanders, Jacobson & Power, 2006, p.335)

Figure 6: Key quotes pertaining to the theme 'Support seeking'.

Support seeking is a predominant theme within the articles; it has two sub-themes, namely internal support seeking (e.g. organisation based support systems like supervisors, managers and peers) and external support seeking (e.g. external bodies like friends, family and personal therapy).

Internal support seeking

It seems that in the first instance, mental health professionals expected support from their supervisors (3, 4, 6, 8, 10, 11, and 12). In cases where the supervisors responded in a gentle and respectful manner (6), provided debriefing (12) and gave them the opportunity to talk (4); the professionals felt less responsible (3, 6 and 10) for the suicide and more realistic about their professional role (see Rossouw, Smythe & Greener (2011, p.8) in Figure 6). Furthermore, if the supervisors were well attuned to the needs of the professionals, it had a buffering effect (3, 4, 6, 10 and 12), particularly when professionals were going through an 'existential shake up' and were trying to process the suicide. It seemed that mental professionals deemed support as being crucial during this period. The following participant accounts are examples of this: **"**My supervisor met with me on Sunday and again on Monday, she was tremendous. I was devastated and my supervisor was a lifesaver for me during that time" (Participant in Tillman, 2006, p.169) and "If the supervisor had been less present, friendly or comforting, it would have been terrible" (Participant in Deringer & Caligor, 2014, p.763).

It is clear from the articles that gaining insight about the suicide was a key priority for the mental health professionals. This included wanting to be debriefed and informed about subsequent meetings related to the incident. However, it seemed that at times, the mental health professionals failed to gain further knowledge about the suicide because they felt they were being avoided and/or abandoned by their supervisors (1, 2, 4, 6, 10, and 11). This was evident in Ting, Sanders, Jacobson and Powers (2006, p.334) participant quote (see Figure 6) where the professional seemed to be preoccupied with the suicide and feared he/she would ruminate in isolation. This suggests that there can be a mismatch between the professionals' desire to gain information and remain connected to the working environment as a way of gaining some solace but is faced with alternate recommendations which can feel harrowing. When this occurred, there was evidence of the professionals feeling angry (4), self blaming (10) or thinking their supervisor was insensitive (6), callous (6) and uncaring (1, 11). Rossouw, Smythe and Greener's, (2011, p.8) participant quote (see Figure 6) highlighted that in cases where professionals have been debriefed; the focus was on ensuring the bureaucratic elements (i.e. paper trail) safeguarded the organisation so it would not be held liable for the suicide. In some cases, the service/s discouraged them from discussing the patient case, in case it led to them being held accountable for the suicide (1). In keeping with this, sometimes, mental health professionals felt the personal impact of the suicide was overlooked by the supervisor.

It is evident that some mental health professionals seek support from their peers and find it helpful (4, 5, 12, and 14). Bohan and Doyle's (2008, p.14) quote (see Figure 6) illustrates that they might find it easier to access peers who can empathise with them. Other articles (4 and 14) indicate that on some occasions, patient suicide had brought mental health professionals together and governed a sense of belonging ("special fraternity"; Tillman, 2006, p.169), particularly during a period which can feel isolating. Conversely, if mental health

professionals felt their peers would scrutinise them or their professional image will be tarnished, they avoided informing them of the suicide (4). The articles suggest that being isolated can hinder mental health professionals' recovery following patient suicide (3 and 5).

External support seeking

It is evident that at times, the professionals feel the need to source support from people who are unrelated to their employing body (see Ting, Sanders, Jacobson & Power (2006, p.335) in Figure 6). For instance, two studies (6 and 12) highlighted that whilst there were some reservations in how much information professionals shared with their respective families, they were able to access them for support (12). This appeared to have a cathartic effect (6 and 12). On some occasions, the professionals made contact with the deceased family to seek comfort. Hendin, Lipschitz and Maltsberger (2000) suggested that professionals felt relief when the deceased family stated that they did not blame them for the suicide and were grateful for their interventions. Similarly, they also sought help from friends, which could be experienced as beneficial (6 and 14). Interestingly, the articles showed that professionals appeared to be very vague and brief about the level and nature of the support they had received. For example, Saini, Chantler, While and Kapur (2016, p.418) presented the following participant quote, "So first of all I'd go to my colleagues and my friends a lot of whom are medical and I think that's quite a standard supportive system to have around you." but the details of the support remain unclear. Within this, Tillman (2006) highlighted a need for the professionals to seek psychological support to develop a greater understanding of the patient and their act of suicide. This indicates the nature of suicide can be very ambiguous and it is this ambiguity which can cause distress. Ting, Sanders, Jacobson and Power (2006) indicate that some individuals feel they have a lack of objective and non judgemental support and are motivated to seek support independently, which comes with the expectation of it being somewhat unavailable. They highlight that the support which is likely

to be instrumental in helping the professionals to process the suicide includes being heard, acknowledged and received by another.

In conclusion, the articles indicate support from supervisors can be beneficial, however when the support feels inadequate, mental health professionals can appear to lack knowledge about the suicide, which can hinder their recovery. In some cases, they can isolate themselves and become reluctant to access support from others. It is also possible that this is indicative of the professionals being reluctant to engage with bodies related to the organisation or there is a lack of extensive support systems available to them. As a subsequent, they can rely on external resources to help them process their emotion and make sense of the suicide e.g. family and friends.

A changed person

"I still feel sorry that she is gone. Still occasionally go over and over the events leading up to the suicide wondering if I could have done something different." – (Sanders, Jacobson and Ting, 2005,p. 206)

"Perhaps this was the most traumatizing experience in 20 years as a therapist and supervisor." - (Sanders, Jacobson and Ting, 2005, p. 206)

"I understood why the client did it. I felt like it wasn't a choice I would have made, but I think it was a choice he made. I had done everything clinically possible...but you know, it was almost like he was at the end of the rope. He could not tell another lie because everybody was in on him. He had no place to go...but you know on the other hand, I was relieved for him. Being out of his pain. It was a situation where I went to his funeral. I said goodbye to him." – (Ting, Sanders, Jacobson and Power, 2006, p.338)

Figure 7: Key quotes pertaining to the theme 'A changed person'.

This theme illustrates that mental health professionals are affected by patient suicide and subsequently undergo some transformational changes. These changes can either be a

continuation of a heightened emotional experience or a reduced grief, loss and trauma response or a positive development involving enhanced practice and acceptance; in either case, the professionals become different to how he/she was before the incident took place.

The articles consistently indicate that the changed person can continue to experience reactions commonly associated with an existential crisis (as described in the existential shake up theme) (e.g. participant in Sanders, Jacobson & Ting, 2005, p.206), grief, loss and trauma (as described in the grief, loss and trauma theme) (i.e. sadness (7), guilt (7) anger (6), hyper-vigilance (6 and 12), stressed and burnt out (11)). Participant accounts (Sanders, Jacobson & Ting, 2005, p.206) (see Figure 7) describe that in some cases, they continued to experience flashbacks and reminders of the event even years after it has occurred. In cases where a continuation of these responses were noted, mental health professionals appeared increasingly fearful of it re-occurring (1 and 4) and started declining referrals of those who were perceived to be at a risk of committing suicide (1 and 4).

The articles also suggest that in some cases, the changed person may become more sensitive in detecting other potential future suicides (2, 6, 7 and 9), more skilled in carrying out suicide risk assessments (1, 6 and 7), and had grown an appetite for learning more about suicide (e.g. "the suicide has spurred me on to always keep learning more."; participant in Sanders, Jacobson & Ting, 2005, p.207). For some, this change involved a shift from an existential position to one of acceptance (1 and 7). For instance, in a theme titled 'acceptance', Ting, Sanders, Jacobson and Power (2006, p.338) (see Figure 7) illustrated that in some participant cases, the professionals had become more forgiving and understanding of why the patient had committed suicide. This involved pursuing a path of acknowledging their own professional limitations (i.e. responsibility and control).

In some of the articles, descriptions like “a hard death” (6), “still is somewhat upsetting.” (7), “I’m almost more troubled about it now then I was then”(5) and “still hurt” (5) were used to illustrate the impact of the suicide, indicating that this incident can have a longstanding and deep seated effect on the professionals.

In summary, it is apparent from this theme that patient suicide can have a long standing and transformational impact on mental health professionals. Whilst, some individuals are able to use this experience to develop into more skilled professionals, others continue to struggle with existential, grief, loss and trauma elements of their experiences; both can influence on their practice for the better or the worse (respectively).

Discussion

The review presents a narrative of the complexity of mental health professionals' experiences of patient suicide. It can be an intense, challenging and emotionally destabilising experience which can be very affecting. It is clear that the themes demonstrate a strong sense of fear, a process of loss and bereavement (of the patient's life and the individual's perception of their professional identity); and finally, a transformation.

Emotional Regulation

What became apparent during the review was the overwhelming and complex nature of experiencing a patient suicide. It reveals an acute period of being in an emotionally heightened state which can make it difficult for mental health professionals to process loss and existential turmoil. In turn, if the emotional turmoil is not worked through sufficiently, it is likely to transpire and create further turmoil (e.g. flashbacks) and defensive practice (i.e. more risk averse).

Bion (1962) suggests that an event out of the ordinary can affect individuals' capacity to contain and process the distressing incident, leading to feeling overwhelmed. It is clear that this could be true for mental health professionals who experience emotional challenges following patient suicide (as described in the following themes: 'grief, loss and trauma' and 'existential shake-up'), particularly in the short term. Over the years, research has demonstrated that recovery styles can have an impact on how individuals regulate their emotions and recover (to a degree which allows individuals to engage in usual activities of daily living) following a traumatic event (Aldao, Nolen-Hoeksema & Schweizer, 2010; Garland, 1998). In particular, two distinct recovery styles, namely 'sealing over' and 'integration' are commonly used following trauma. They are not mutually exclusive of one

another and can be used interchangeably by the same individual (Lindbom-Jakobson & Lindgren, 2001). A sealing over recovery style can comprise of individuals avoiding coming into contact with thoughts and feelings related to the traumatic incident. Individuals may isolate the incident from their emotional life and view themselves as being separate to what has taken place (Lindbom-Jakobson & Lindgren, 2001). Where-as an integrative style refers to individuals being conscious of the continuity between the different phases of the event (i.e. before the traumatic incident, during the trauma and recovery) and a curiosity and willingness to explore intra-psychic elements of it in a useful way (trigger, behaviours and relationships) (Lindbom-Jakobson & Lindgren, 2001). The present review shows that in some cases, following patient suicide, mental health professionals engage in a defensive practice, such as avoiding accepting referrals for patients at a higher risk of suicide. This appears to be characteristic of a sealing over style and the present review findings suggest that it might be due to stigma, fears of litigation and a lack of appropriate and timely support from supervisors and peers. Research demonstrates that using this style can lead to difficulties in recovering from the trauma, experiencing an exacerbation of mental turmoil, which can sometimes develop into trauma symptoms (e.g. flashbacks) (Aldao, Nolen-Hoeksema & Schweizer, 2010). It can also endanger individuals' capacity to tolerate future difficulties, function (daily activities of living) effectively and develop their identities (e.g. ability to relate to the self and others in a constructive way) (Garnefski, Kommer, Kraaij, Teerds, J., Legerstee & Onstein, 2002). This may explain why even years after the suicide took place, a subset of mental health professionals continued to experience trauma like symptoms and fears of the event re-occurring.

Although the present review findings highlight that mental health professionals can be overcome with an array of emotions and internal battles; there is limited evidence to suggest they reach the threshold of a 'clinical population' which requires the ongoing support of

mental health services. This indicates that in large, they are able to work through their anxieties and are relatively robust individuals. It also suggests that the majority of mental health professionals use an integration recovery style which can enable them to engage in the bereavement process, work through their existential shake up and connect with support systems (e.g. personal therapy, colleagues, family and friends) in a meaningful way. However, it is important to note that having an available support network and an understanding and explorative culture in health settings is likely to provide the containment that is required to recover from patient suicide and restore mental health professionals' capacities. Conversely, a health setting which isolates mental health professionals (e.g. blame and lack of appropriate debriefing) is likely to foster an unhelpful environment which encourages a sealing over style.

Bereavement and loss

A bereavement process is a prominent feature of the themes. The present review reveals that mental health professionals can undergo a bereavement process which can be understood in the context of Kubler-Ross's (in Kubler-Ross & Kessler, 2005) stages of grief model. This generally begins with individuals feeling shocked and denying the reality of the loss, followed by anger, confusion, bargaining (trying to negate the death), depression, and eventually acceptance of the loss and a development of new ways of existing in the world. Although the present reviews analysis maps well onto this model and enables an understanding of mental health professionals' experiences of patient death, it does not suggest the bereavement process occurs in such a concrete and linear manner. Instead, it suggests, the bereavement process is highly complex and the stages may overlap and not necessarily result in the individual accepting the loss.

This complexity could be related to suicide being an event out of the ordinary, and the nature of mental health professionals' relationship and involvement with their patients. For instance, mental health professionals relate with patients on many levels, such as personally, as a care professional with responsibilities and legal obligations, and as an employee on behalf of an organisation. Thus it appears that this complexity could be understood in the context of disenfranchised grief. Disenfranchised grief refers to the grief an individual experiences following a loss that might not be socially sanctioned (e.g. if stigma is attached to it) (Worden, 2010). Due to the nature of the individuals relationship with the deceased, he/she might be excluded from the usual tasks of mourning (e.g. attending the funeral, talking about their feelings for the deceased and/or accessing social support) (Doka, 2002). It may also result in the individual being ostracized by the deceased family (Doka, 2002), which appears to be the case for some of the mental health professionals in this review. This could be problematic as research suggests that in order to process loss, individuals' needs to be able to talk and explore their thoughts and feelings about it (Worden, 2010). However, the present review suggests that this may not always be possible for mental health professionals as supervisors can be inaccessible, they can be excluded from meetings about the deceased and/or there might be concerns about liability. This suggests there are a number of additional factors which may affect their ability to engage with a bereavement process, which is already a complicated phenomenon in itself.

The present review findings also indicate that the complexity could be related to mental health professionals having to grieve pre conceived ideas about their professional identity. This is evident from all of the themes which reflect the cognitive and affect experiences (e.g. guilt, anger, heightened responsibility and blame) associated with the idea of a professional ego ideal. Thus, it is possible that mental health professionals mourn both

the loss of their patient, and beliefs about having the power to 'save the ailing' and preserve life; which of course are impossible and appear to be an unhelpful defence.

Psychodynamic literature can also help understand the complexities of loss and mourning as it focuses on both conscious and unconscious processes that affect responses to events. For instance, Klein (1940, 1952) felt that under stress, individuals tend to be more susceptible to being gripped by persecutory anxiety, which can colour how they experience events and peoples responses (e.g. as punishing, accusatory and/or benign). It can make it very difficult for them to experience people as possessing both good and bad aspects to them, tolerate destructive feelings, endure separations, and mourn losses. In considering the present reviews findings, it is possible that a parallel process may occur whereby mental health professionals are brought in close contact with their limited ability and feelings of considerable vulnerability, making the mourning process difficult. This vulnerability and difficulty with mourning the loss appears to create a temporary shift towards a persecutory frame of mind, making them more sensitive to feelings of being blamed, persecuted and/or isolated. This is reflected throughout the themes (i.e. 'grief, loss and trauma', 'existential shake-up' and 'encounters with blame') which also highlight that mental health professionals can experience anger towards their patient for committing suicide but are unable to express it to them. It is also evident in their anger towards organisational structures (supervisors, managers, investigators and bureaucratic procedures), and fears of being blamed and reprimanded by 'super ego' functioning figures (e.g. senior staff, peers and the patients family) who possess the power to persecute them; much like the internal persecution that patients were likely to have experienced whilst they were alive. In turn, the results also reflect that authority figures and service members can act in ways which identify with that of a persecuting figure (see 'encounters with blame'). Indeed, to an extent, mental health professionals' fears of persecution can be very real as they undergo bureaucratic

investigations where litigation and liability are readily brandished around and can result in the loss of their professional membership and job. However, the results indicate that for the most part, mental health professionals are able to move from a persecutory state to a frame of mind which is more robust and integrated.

A comparison with other meta-synthesis

The present review supports and supplements the findings of fellow literature reviews in this area (Kouriatis & Brown, 2011; Ellis & Patel, 2012 and Seguin et al (2014). Whilst these reviews gave some insight into the symptomology and moderating factors, like the effect of the number of years in professional practice has on the impact of patient suicide; the present study provides an arguably more recent, comprehensive and experiential narrative of mental health professionals experience of patient suicide.

Critique of the review

It is clear that meta-synthesis reviews have an element of subjectivity to them as they draw upon interpretations of the research data, as well as the research authors understanding of the participant's experiences. Triangulation is a method used in qualitative research which involves a number of individuals reviewing the data and discussing their understanding of them until a mutual consensus is achieved. The author used triangulation methods during consultations with her research supervisor to improve the credibility of the interpretations and prevent the likelihood of making unwarranted conclusions.

The review used a relatively robust approach to finding the relevant articles, however, it is important to note that the review was of a small scale and it is possible that it may not have captured other pertinent articles e.g. non-peer review articles like dissertations; which may have been useful.

Whilst the review has some limitations, it is important to consider that the conclusions are drawn from a number of articles which are appraised as being of a relatively good quality. Although the review does not suggest it presents the experiences of all mental health professionals following patient suicide, it does give some rich insights into a sensitive topic which has been relatively sparsely researched. Furthermore, the findings appear internally cohesive and are supported by a number of reputable theories which supports the credibility of the conclusions.

Implications of the review

The present review has identified that there are many facets to mental health professionals' experiences of losing a patient to suicide. It illustrates a narrative of a tumultuous journey, which is important for mental health professionals, mental health services and legislative bodies to be aware of. It is clear that the experience of a patient committing suicide is much more than an end of a life and its impact on the individual's family and friends. In particular, it is important for mental health professionals to be aware of the potential effects of patient suicide and help those who have had such an experience to recognise that they are not alone and others share their sentiments and struggles. Equally, it is important for supervisors and legislative bodies to be aware of the toll a patient suicide can have on mental health professionals and some of the barriers (e.g. blame and lack of sufficient debriefing) which can disrupt their recovery so that they can support them accordingly. Whilst it is important for critical incident investigations to take place, it is crucial for services to bear in mind the implications of the timings of these, as it appears there might be a conflict in how mental health professionals can be supported during this critical period whilst being able to use the event as a developmental milestone for others (i.e. 'lessons learned'). Accordingly, it is important for services to develop ways of obtaining information

from mental health professionals for incident reviews, without disrupting their mourning process.

It is hoped that readers can develop their understanding of the importance of grieving, become more curious and informed about the meaning of patient suicide in relation to mental health professionals identities and more attuned to the support they may require (e.g. empathic approach to prevent self reproach and ongoing fears of re-occurrence). Given that it is likely to be very difficult to deliver a zero suicide policy and maintain a commitment to human rights (United Nations Human Rights Council, 2017) the fantasy that *all* suicides can be prevented is likely to increase the burden and turmoil mental health professionals' experience. Similarly, the use of terminology which may have connotations related to super ego functioning (e.g. 'lessons to be learnt') and a 'blame culture' in healthcare settings is likely to reinforce feelings of being persecuted and hinder mental health professionals ability to engage with a constructive mourning process which will be developmentally useful. It is important to emphasise that there is a need to change the present health care culture to one which encourages talking non-judgementally about patient suicide in mental health services because this may reduce the stigma attached to having a patient commit suicide and make support more accessible and appropriate to mental health professionals needs. It also highlights the need for legislative bodies to develop training programs which enable supervisors and managers to aid mental health professionals' recovery after patient suicide. For instance, the review indicates a need for mental health professionals to have adjustment support, such as being kept informed about the case (e.g. in staff briefing) as it seems that ambiguity is a crucial part of the challenges associated with patient suicide. It appears from the present review that the turmoil they experience can be related to 'not knowing' or 'having gaps' in their knowledge of the incident; and the partial view they had of the patients' life. As described in the results section, most of the professionals were oblivious to the patient's

intentions and found some solace in obtaining more information about the incident. It seems 'knowing' is important in the healing process and supervisors should be sensitive to this need so that such incidents can be used as opportunities for professional development. Furthermore, the review indicates that some of the other challenges experienced by mental health professionals include difficulties having access to their supervisors and being responded to in a supportive manner. It is important for supervisors to be conscious of this need. It is strongly encouraged that mental health professionals are mindful of what is manageable and unmanageable as part of their job role, and access professional support during periods of turmoil so they can process their experiences in a safe and contained environment, particularly if they experience on-going trauma symptoms.

The present review intended to provide a collective overview of mental health professionals experiences as there were an insufficient number of qualitative articles to allow a more condensed understanding of experiences specific to the various mental health professions. This type of review would also allow a comparison of experiences which may provide further insight into the themes presented and how their relationship or training may influence their experiences of patient suicide. However, for such a systematic review to take place, it is important that researchers conduct more qualitative research in this area. It would also be useful for researchers to conduct different types of research (including quantitative and mixed methods) based on what has been found, for example 'what are the long term health implications for mental health professionals following patient suicide?' or 'what impact does mental health professionals' working during the acute phase following patient suicide have on patient outcomes'.

It is also worth considering that although this research area is so pertinent to the current climate and future of mental health care services, it is relatively under researched.

This might be indicative of the emotionally laden nature of the topic and fears surrounding the need to acknowledge the inevitability of patient suicide in health care settings.

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CHAPTER II

Empirical Paper

Therapists' experiences of therapy endings in time limited psychodynamic psychotherapy.

Abstract

Aim: In therapy conducted with people who struggle to manage experiences of loss and mourning, the careful negotiation of an ending is critical. This research study aimed to explore therapists' experience of therapy endings, in time-limited psychodynamic psychotherapy in the NHS with complex patients. It intended to give a sense of how therapists conceptualise endings and what influences the ending process.

Method: A qualitative research method design was used. 8 psychotherapists were interviewed; the interview data was transcribed in verbatim and analysed using an Interpretative Phenomenological Analysis (IPA) method. An IPA support group and triangulation methodology was employed to support the development of a credible analysis.

Results: The themes indicate that time looms over the therapy from the beginning to the end. During the ending phase, therapists' can draw on the therapeutic frame of psychodynamic therapy to anchor themselves so they can enable patients' to work through their previous and present issues. It is an emotionally involved process, where patient's and therapist's own history of loss can be evoked. Therapists develop an intense and affecting bond with patients through the therapeutic process and this connection can be maintained internally even after the therapy has ended.

Conclusion: Therapy endings are complex periods which are multi layered and have many facets that relate to the past, present, conscious and unconscious. The intensity of the therapists and patients bond can be used to enhance the work during the ending

period. It appears that therapists continue to maintain a connection with patients in the form of curiosities, emotions, gifts and memories.

Introduction

Psychodynamic Psychotherapy in context

Psychodynamic psychotherapy is a specialist branch of psychological therapy which focuses on the impact of early childhood experiences and attachments in the development of psychological disorders (Waddell, 2002).

Psychodynamic psychotherapy tends to be a longer term treatment compared to other psychological therapies. In the first instance, The National Institute of Clinical Excellence (NICE) (2009) guidelines recommend treating mental health difficulties with the use of medication, self-help guides and psychological therapies like Cognitive Behavioural Therapy (CBT). In the second instance, it recommends psychodynamic psychotherapy for individuals who continue to experience significantly complex mental health difficulties. Accordingly, the NHS offers a course of time limited psychodynamic psychotherapy (approximately two years) to patients with complex and pervasive difficulties like personality disorder.

Personality Disorder

Personality disorder is an umbrella term for a condition where individuals experience long standing emotional difficulties that significantly influence mood, identity formation and relationships. For instance, in Borderline Personality Disorder (BPD) individuals can struggle to regulate their emotions and have polarised positive or negative views of others. This can lead to impulsive behaviours (e.g. self harm) and unstable

relationships. Individuals tend to have maladaptive patterns of relating which can be received as dramatic, unpredictable and concerning (NICE, 2009).

The prevalence of people with personality disorders in England is 1 in 20. However, only people at the severe end of the personality disorder spectrum may require treatment (NHS, 2017). NICE (2009) guidelines recognise that due to the complex nature of Personality Disorders, they can be relatively difficult to treat and often require a longer term therapy.

Personality disorder and Psychodynamic Psychotherapy

The psychodynamic model understands personality disorder in the context of early childhood experiences and relationships with parental figures. The usefulness of psychodynamic psychotherapy for people with personality disorders has fared well in practice based research and in comparison to other psychological therapies. For instance, a randomized control trial (RCT) assessing the effectiveness of transference-focused psychotherapy (psychodynamic psychotherapy) with 42 patients with BPD from two community mental health centres (CMHT's) showed that there had been a reliable clinical improvement in patients quality of life, psychopathological dysfunction and BPD symptoms after three years of treatment (Giesen-Bloo et al, 2006). Furthermore, a recent systematic review investigating the effectiveness of psychological therapies for Personality disorders found positive outcomes for Psychodynamic based therapies (Haskayn, Hirschfeld & Larkin, 2014). In addition, Clarkin et al (2007) conducted a study into the effectiveness of dialectical behaviour therapy and transference-focused psychotherapy (with and without medication) treatment for 90 BPD patients. The researchers randomly assigned the patients to the treatment modalities and found that

both improved depression, anxiety, global functioning, suicidality and social adjustment. However, only transference-focused therapy was associated with improvements in anger and impulsivity and predictive of change in irritability and assault.

Time limited NHS psychodynamic psychotherapy has also appeared to be effective for intra psychic change (Harrist et al, 1994) as therapists can help patients acknowledge, express and assimilate difficult feelings and experiences (Travis, Binder, Bliwise & Horne-Moyer, 2001). It can help individuals develop an ambivalent state of mind which can lead them to being better at tolerating difficult feelings and maintaining relationships (Waddell, 2002).

Emotional development and containment

A person's emotional development and capacity to establish and maintain close relationships is rooted in their earliest experiences and reliant on a caregiver's responsiveness and capacity to digest and make bearable an infant's emotional distress (Waddell, 2002). Over time, the infant's growing mind can gradually learn that difficult situations can be tolerated and thought about in an organised and useful way. This can help the person stay open and connected to an array of feelings without needing to defend against them (Bion, 1962).

Personality disorder is understood from a psychodynamic perspective as reflecting disruption in these early experiences and that instead of being helped to assimilate and grow from experiences, people have had to employ defences that limit their awareness of painful or disturbing feelings (e.g. splitting, dissociative mechanisms and denial) (Waddell, 2002). The use of such defences, whilst protecting an individual from being overwhelmed, can maintain unhelpful patterns of relating and work against

the integration of experiences, including loss, which is necessary to form a secure sense of self (Waddell, 2002).

According to psychodynamic models (Davar, 2010), in healthy development, the infant can experience separations from the mother as frustrating and anxiety provoking. The absence of a mother can generate anxiety related to being scared and abandoned. If the anxiety is not too great and the separations are predictable the infant can take separations as an opportunity to explore and have fun. Over time, the infant is likely to develop into a more resilient person who learns to trust themselves and others. However, if the infants' anxiety levels are too great and/or separations are too unpredictable or long, the infant can develop unhelpful behaviours to defend against the anxiety in an attempt to cope. This can become problematic to individuals' psychological development and ability to relate to others (Davar, 2010). These sets of difficulties are recognised as being characteristic with the diagnosis of personality disorder.

The therapeutic approach

In psychodynamic therapy, there is an attempt to access and re-work some of the underlying feelings that stem from early experiences. This is made possible through establishing a therapeutic relationship whereby previously unprocessed emotional experiences, including those involving loss, can emerge and be re-worked. The therapeutic work is centred on the therapist being receptive to the patients' unconscious communications of more infantile or raw emotional states, trying to process these experiences and offer an interpretation or intervention that facilitates patients being able to think about and process the experiences too (Waddell, 2002). An important aspect of psychodynamic therapy is that therapists allow themselves to be emotionally stirred and

available to the patient's emotional experience, whilst being able to *think* about it (i.e. be a container). Furthermore, the work requires therapists to be able to separate out what the patient communicates, against what belongs to their own experience or history; this can be termed as working in the 'transference and counter transference' (Lemma, 2003). It is through these intricate processes that a patient's emotional experience is contained and his/her own capacity to tolerate, digest and integrate emotional experience develops (Bion, 1962; Lemma, 2003).

The importance of 'time and endings' in Psychodynamic Psychotherapy with BPD patients

Over the years, time and endings have received a considerable amount of attention in psychodynamic psychotherapy literature and work (Murdin, 2014). For instance, Williams (1997) suggests that time and endings are important because they tend to mark the transition a person makes from one psychological state to another. He states that endings are similar to other transitioning occasions like baptisms, weddings and funerals because they bring a close to an endeavour and are followed by the beginning of something new. Williams (1997) offers that ending periods can be critical because they may revive feelings associated with previous unresolved separations and losses. During this phase, individuals may become increasingly distressed and try to cope by trying to detach from the therapist by making this period as brief as possible, defend against feelings of loss and appear more future orientated (Williams, 1997). The ending phase gives an opportunity to reconnect with un-worked anxieties and engage with the process of mourning in a safe and contained manner (Williams, 1997). It can make the process of

ending more tolerable, which can then serve as an archetype for other transitions (Murdin, 2014).

The end phase of therapy can be characterised by a re-appearance of the client's symptoms which can disrupt the therapeutic work progress and outcomes (Holmes, 1997). Holmes (1997) suggests that this is due to the ending phase of psychodynamic therapy mimicking the process of adolescence and emotional development; whereby the client battles between the freedom and autonomy which follows the therapeutic end, against the loss of intimacy and security which was provided by the therapy. The therapeutic outcome is largely reliant on the attunement between the therapists and client's attachment styles and alliance. Thus Holmes (1997) recognises that there are differences in how therapists and clients conceptualise endings. Whilst some clients respond to therapy endings by replacing therapy with something else, others can deny the significance of it by viewing it as something they can return to (re-referral). In contrast, therapists can experience it as a burden which has been lifted as it re-evokes their own past losses.

Reworking patterns of relating and managing loss

The way separations and endings are negotiated and worked through is an important aspect of this work, both in terms of helping a patient make sense of and integrate the impact of past losses, but also in developing their capacity to tolerate and mourn losses more generally which in turn strengthens their capacity to maintain relationships. For instance, they may grow to not be as fearful of abandonment, needing to avoid loss and be reliant on the on-going presence of the other. Instead it is hoped that they are able to bear conflict and separations, which are commonly part of all

relationships. The ending of a therapeutic relationship can be a period where patients' feelings become more heightened and ways of relating become more visible (Lemma, 2003).

Therapy endings research

There has been some research which gives us insight into some of the factors which may influence therapy endings. In particular, it appears that therapists personal experiences of bereavement and loss can affect their personal and professional development (Kouriatis & Brown (2011) and how they facilitate the ending of therapy (Boyer & Hoffman, 1993).

In exploring this, Fragkiadaki and Strauss (2011) conducted a study of 10 psychodynamic psychotherapists' experiences of planned therapy endings using a grounded theory approach. The findings revealed that therapists' personal sense of loss and grief experiences shaped how they understood and facilitated therapy endings. For instance, the word 'termination' reminded them of their own personal therapy coming to an end. This helped them relate to their patients during the ending. Therapists stated that they anticipated the therapy ending from the onset. They alluded to two types of therapeutic endings, one being a 'good ending' in which they described their therapeutic bond with patients as intense and parental. In such instances, they made more self-disclosures and encouraged patients to be more independent near the end. The ending evoked feelings of intense sadness, pleasure and loss in the therapists. The second type of ending was a 'good enough' ending. This type of ending usually followed a treatment process where the therapists felt a sense of defeat, self doubt, burden and an erratic relationship. The therapists described that in 'good enough' endings they did not make

self-disclosures and felt relieved at the end of therapy. The ending phase usually involved a collaborative treatment review and supervisory support. The findings also revealed that therapists fantasised about contacting patients after they had been discharged from the service to enquire about their wellbeing.

Within this, it seems that therapist's personal relationships coming to an end can help them become more empathic, congruent, diverse and attune to the patients inner world (Sahpazi & Balamoutsou, 2015). Likewise, it appears that therapy endings can be influenced by therapist's attachment styles and level of narcissism. For instance, therapists with a dismissive-avoidant attachment style can be less likely to experience denial during the ending phase (Andrews, 2004). Furthermore, therapists who exercise a higher level of authority (construct of narcissism) tend to experience more anxiety at the ending (Andrews, 2004).

Research has also indicated that therapists' use a number of therapeutic skills (e.g. focus on helping patients process their feelings, discuss progress and newly acquired skills) during the ending phase (Norcross, Zimmerman, Greeberg and Swift (2017). Rabu, Binder and Haavind (2013) stated that therapeutic skills can determine whether a 'good enough ending' can be achieved in open ended therapy. They found that if therapists and patients were mindful of each other's feelings, had collaborative discussions for the need of an end and the client had the option of returning to therapy (future orientation) it helped achieve a more positive therapy ending. The findings propose that these key features helped the dyads manage feelings of rejection and abandonment. The research also highlighted that during the therapy, the therapists assessed the client's level of readiness to end (autonomy) by how they responded to

breaks in therapy (vacations), a reduction in therapy sessions and the offer to continue with therapy. The therapists also revealed that they prepared the client to be more autonomous by asking them to think about how they managed similar situations using their new skills.

In time limited NHS psychotherapy, issues of control can also complicate the endings phase (Haskayne, Larkin & Hirschfeld, 2014; Cowen, 2003). This is not often recognised by the therapist as they may view the ending as a collaborative decision. However, patient's views reveal that they can see the end as an imposition which brings up feelings of powerlessness (Cowen, 2003). Therapists have found that an effectively written discharge summary letter can have some therapeutic value and can aid this process (Ingrassia, 2003).

What we need to know and why

The literature gives some understanding of the difficulties that individuals can experience with loss, mourning and separations; especially in the end phase of psychodynamic psychotherapy. However a lot of the literature is based on the authors' personal reflections or selected case studies (Holmes, 1997; Bass, 2009; Mander, 2010; Williams, 1997; Salberg, 2009; Rabu & Haavind, 2012). Whilst the topic area has become increasingly active, a lot of the research has been conducted outside of the United Kingdom (Rabu, Binder & Haavind, 2013; Knox et al, 2011; Andrews, 2004; Norcross, Zimmerman, Greeberg & Swift, 2017) and/or based on client funded therapy (Rabu, Binder & Haavind, 2013; Knox et al, 2011). There is a notable gap in the research literature concerning therapists experiences of endings in NHS funded time limited psychodynamic psychotherapy with patients suffering with complex mental health issues

(typically BPD), who are likely to struggle with loss and separations. Whilst there are indications of patients 'acting out' (e.g. engaging in unhelpful behaviours like self harm), avoiding coming into contact with painful emotions or the therapist and/or their being a deterioration in their mental health during the ending phase (Lemma, 2003; Williams, 1997), little is known about how it affects therapists' personal and professional lives. Therefore, it is imperative to understand how therapists conceptualise, practice and manage during time limited psychodynamic psychotherapy endings with complex patients.

The research will give an insight into therapists' experiences and how endings are facilitated. It will help understand therapists' perspectives of loss, mourning and separations and how this might influence the therapy dynamics and progression. It will help understand the impact of such experiences on therapists' future development. It does not only intend to have beneficial outcomes for patients and therapists but other people and services that support people with personality disorder.

The research study

The research aims to explore therapists' experience of time limited psychodynamic psychotherapy endings with complex patients. It intends to give a sense of therapists' conceptualisation of endings and how these have changed or developed over time. It hopes to give some insight into therapists' expectations of therapy, what influences the ending phase, the therapeutic alliance and the experience of being in an ending phase. It also seeks to get a sense of how therapists' personal experiences may affect how they facilitate therapy endings and how therapy endings may affect their development.

The research has an experiential focus; therefore it intends to use a qualitative design with an interpretive phenomenological lens. Semi structured interviews are a useful qualitative data collection method because they give an opportunity to enter the participants world and enquire about their perspectives on given phenomenon (Smith, Flower & Larkin, 2009). This is compatible with the study's aims and interpretative phenomenological processes. Accordingly, the study will use semi structured conversational interviews to get a rich understanding of therapists' experiences.

Method

Design

The aim of this study was to explore therapists' experiences of therapeutic endings in time-limited psychodynamic psychotherapy. Qualitative research seeks to carry out an in depth exploration of participants' perspectives. The commitment to depth means that it requires fewer participants. Lyons and Coyle (2007) recommend a minimum of 6 participants to allow for a credible analysis. Accordingly, the present study recruited 8 participants.

Interpretative Phenomenological Analysis (IPA) was used to study the interview data. It is a qualitative analysis method which gives an understanding of how individuals make sense of their experiences (Lyons & Coyle, 2007). It was used to gain some insight into the therapist's responses and emotional meaning.

The service context

The service is a tertiary, outpatient psychotherapy service provided by the National Health Service (NHS). It delivers psychodynamic psychotherapy to individuals experiencing complex, severe and enduring mental health difficulties.

The researcher and supervisors as a person in context

The researcher Ayshah Hanif (A.H) is a British Pakistani who completed this research as part of her thesis project for the Clinical Psychology doctoral training program. As part of her clinical training, she has worked with a number of individuals who experience moderate to severe levels of mental health problems. During her practice she has noticed that patients can act in various ways leading up to the end of therapy (e.g.

deteriorate or disengage prematurely. This has been reflected in patients post therapy outcome measures, which may not truly represent the therapeutic advances they have made during the therapy. In addition, A.H has become intrigued by the lack of time clinicians can dedicate to thinking about and carrying out therapy endings, in contrast to patient assessments and during therapy interventions. A.H has researched the importance of endings, particularly in therapy and appreciates the implications of this on patient progress and hopes to learn more about this and contribute to improving clinical practice.

Michael Larkin (M.L) and Jill Rowbottom (J.R) supervised the project. M.L is a White British, senior university lecturer who contributes to clinical training and has a specialist interest in qualitative research, with a particular focus on IPA. J.R is a White British Clinical Psychologist who is experienced in working psychodynamically and is undertaking further psychoanalytic training.

A.H conducted the participant interviews and primary data analysis. The research supervisors were involved in discussing the interview data.

Procedure

Recruitment

The therapist participants were recruited using a purposive sampling method. A.H stopped recruiting participants when 8 therapists had taken part. In order to ensure therapists did not feel pressurised to take part, two recruitment methods were used. In the first, A.H and J.R presented the research idea at team meetings. The second involved outlining the research study in generic team emails. In both cases, invitation letters (see Appendix 5) and information sheets (see Appendix 6) were made available and therapists

were asked to contact A.H to discuss the research and implications of taking part. A.H met with each potential participant and explained the study. If the individual still wished to take part he/she gave written consent (see Appendix 7).

Interviews

A.H collected demographic and clinical experience information. She conducted semi-structured interviews (see Appendix 8) which lasted between 45 to 90 minutes. The interviews were all audio-recorded with a Dictaphone. In the interviews, the participants were invited to describe and reflect on their experiences of therapeutic endings in time limited psychodynamic psychotherapy. They were asked to reflect more deeply on their experience of working with patients' who had had therapy for at least a year, and worked through a planned ending. During the interview, the interviewer used prompts like "can you say what that was like for you", "can you elaborate on that?" and/or "can you give me an example?" to help develop the therapists accounts and yield an experiential output.

The interview questions were developed collaboratively by A.H and J.R. They were based on their experience of psychodynamic psychotherapy and literature which examines separation, loss and mourning processes (Williams, 1997; Holmes, 1997); and therapists and client's experiences of therapy endings (Fragkiadaki & Strauss, 2011). The interview questions were assessed by M.L, to ensure they were appropriately open and exploratory. The interview schedule began with general questions about endings then moved onto more specific questions in relation to a patient. It was hoped that this would allow a more in-depth exploration of therapists' experiences in relation to a therapy ending. The final segment of the interview explored therapists personal experiences of

endings (losses and separations), and how these influenced how they facilitate and experience therapy endings.

Ethical considerations and information storage

The research project gained ethical approval from the University of Birmingham and governance approval from the NHS Health Research Authority (NHS HRA) (see Appendix 9). The research data was anonymised to conceal the participants' identities. A.H did not give the research supervisors any details pertaining to the participants' identities and referred to them using randomly allocated pseudonyms. These have been maintained throughout the research. As J.R worked at the NHS site where the participants were recruited, she was not given any access to participant information or full transcript data. A.H explained J.R's role to the research participants and reassured them that she would not have access to identifiable information or complete transcript materials. The participants' wellbeing was paramount; therefore A.H enquired about participants' wellbeing before, during (if deemed necessary) and at the end of the interviews. The researcher only commenced and completed the interviews if she considered the participants were not unduly disturbed.

The research data were stored securely at the University of Birmingham and on a password protected encrypted device. Once the interviews were transcribed, the researcher offered the participants a copy of their transcription and gave them the opportunity to omit any data they did not want to be included in the research. The participants were satisfied with their contribution and did not ask for any of the data to be omitted from the research.

Participants

The study captured 8 therapist participants' experiences. The participants (Males = 3 and Females = 5) were aged between 37 and 52. They were from various mental health professional backgrounds (e.g. Clinical Psychologists, mental health therapists and specialist nurses) and had experience of working psychodynamically. The participants had been working in mental health services for a significant period (range = 8 to 23 years).

The participants provided therapies which typically lasted two years, during which they met with patients on a weekly basis, until they reached an agreed ending. The ending phase was considered as the last three months of therapy.

Grounding of Interpretations and reflexivity

The interview data was worked through using a systematic approach based on Smith, Flowers and Larkin's (2009) recommendations for IPA data analysis (Table 1). A.H kept a reflective log of her experience throughout so she could consider how her personal positioning may have affected the research. Triangulation is a method which helps ensure that interpretations are plausible and reflect the participant's perspective. One form of triangulation involves other analysts inspecting the data and providing feedback on the emerging themes (Smith, Flower & Larkin, 2009). During the analysis stage, triangulation was used on a regular basis to increase the credibility of the data analysis.

Table 1: Systematic data analysis approach (Adapted from Smith, Flowers & Larkin, 2009).

Step	Process	Credibility assurance checks
1	The initial reading of the transcript was done whilst listening to the audio recording to ensure the text was considered in the context of the lingual utterances (pitch, tone etc). This helped get a richer understanding of each account.	Iterative process involving triangulation with the research supervisors and peer support from an IPA group (the group members were also involved in IPA based projects).
2 (see Appendix 10)	Systematic line by line coding was done. Exploratory, linguistic and conceptual comments were noted in the right hand column.	
3 (see Appendix 10).	The transcript was re-read and further comments were made and/or changed (as appropriate).	
4 (see Appendix 10)	Emergent themes were noted in the left hand column.	
5(see Appendix 11)	A table was constructed for each participant. It listed all the emergent themes with corresponding codes and	

	quotes.	
6 (see Appendix 12)	The tables for each participant were considered in the context of the others and similarities and differences were noted.	
7 (see Appendix 13)	The tables were cut according to the themes. Common themes were clustered together to create super ordinate themes. Themes which were not pertinent to the research were excluded.	

Results

The analysis presents therapists' experiences in four overarching themes, within these, four sub-themes emerged.

Table 2: Themes and sub-themes.

Themes	Sub-themes
Time has a looming presence	None
Endings are relational, dynamic, and complex	Current separations Previous separations Endings are relationally emotive Revival and reworking of previous losses
Coping with the complexity of endings	None
Staying connected after the patient has moved on without the therapist alongside	None

The themes present a narrative of therapists' experiences of therapy endings in time limited psychodynamic psychotherapy in the NHS. It reflects a passing of time which leads up to a potentially complex and challenging period, the ending. The ending is multifaceted as it can involve separations, emotions, losses and reparation. It reflects a period during which issues of time, control and relational dynamics can become more prominent and therapists tend to draw on a number of sources (internally and externally) in order to cope with the complexity of the ending. This can entail therapists staying connected to patients after the therapy draws to a physical end. These themes will be explored below and further in the discussion section.

Through-out the therapists' narratives there are many references indicating that therapy is experienced as a journey. This can be understood as a shared endeavour, where the therapist and patient accompany each other through the evolving nature of their relationship and therapeutic trajectory. The following quotes are examples of this:

> *Blue: "if someone's really gone through a, (PAUSE), a significant journey with you, it (PAUSE), it's very (erm) (PAUSE) affecting"*

> *Alex: "there's a sense that we're both standing somewhere, looking back at some landscape which we've covered. We might be recognising there's a whole other journey to carry on"*

Time limit has a looming presence in the therapeutic journey

All the therapists described how, as part of the service requirement, they began the therapeutic journey by informing patients they were embarking upon a time limited therapy, which would typically last two years. The therapists' accounts indicated that the time limit had a looming presence during the work:

> *Alex: "It's always been around – the end, the time, as an external"*

The time limit conjured mixed feelings for the therapists, with some viewing it as a service imposition which impinged the work. In such cases, there was a strong discourse related to the impingement evoking frustrations, pressure and helplessness in the therapists. Winter described how it could hinder good progress:

> *Winter: "There were patients with, who I might have felt like we were making good progress and they could have benefitted from a longer period of therapy...*

the duration wasn't great from the start... and I felt like oh we are just getting somewhere so if we could have another six months – or a year (laughs) that would be good. So it felt like an imposed thing".

The allocated time limit was experienced as sparse, with a wish for it to have been longer. Winter's account indicates a frustration with not being able to reach a therapeutically viable place because of the externally set time constraints.

However, a number of therapists recognised the benefits of having a time-limited therapy. This included, reducing the patient's defensiveness and dependency on the therapist and making the patient more focused. There was a strong discourse about the time limit ensuring the therapy comes to an end, which can accelerate the work and prevent it from becoming 'stuck'. Sage describes the dangers of *not* having a time-limited therapy:

Sage: "I think it is difficult sometimes for people because we do need more time, but equally, there's always the danger of it rolling on for say 13 years or something because nobody wants to end it. Then that becomes a kind of fostering dependency where the person never really moves on from therapy. I think the two year boundary can actually be quite helpful. Anyway, I think what it does do is it makes us set a limit, which might not otherwise be there, or certainly in the past if it wasn't there".

This suggests there can be a clinical need for longer term therapy, but that not having a time limit may also be counterproductive as it can exacerbate the patients underlying problems, leading to a 'stuck-ness'. It may deter patients from developing their own sense of agency, whilst a time limit can prepare them to function more independently.

This theme suggests that therapists have mixed feelings about the looming presence of the set time limit. Whilst some therapists view it as a hindrance to the therapeutic work, others see it as a beneficial boundary, which has the potential to accelerate the work. It is noteworthy that the therapists describe therapeutic change as a movement in response to a difficulty, which otherwise could be stuck or fixed.

Endings are relational, dynamic, and complex

This theme looks at issues concerning the overwhelming complexity of endings, which appear multi layered. Therapists described how the complex nature of endings is underpinned by an iterative movement within the dyad. They reflected upon issues pertaining to the prospect of *separating*, which is particularly illuminated during the ending phase; and spoke of how historical experiences of loss could potentially be *revived*. There is also a 'to and fro' between issues of separation, historical issues and the therapists being affected on many levels of the self (e.g. personal and professional). These avenues will now be explored in more depth.

There has been a shared rhetoric about the ending phase being turbulent and intense for therapists and patients. Some therapists compared it with being on a roller coaster ride, in a battle or needing to 'hang onto their seat'. Frankie associates it with being a recipient of personal therapy.

> *Frankie: "The first thought I have is that it is an incredibly powerful time. What comes to mind was when my own analysis ended and we were talking about the run up, which was actually planned over a year, my therapist said something like*

'In the ending phase, everything gets quite large, and the main thing is to 'hang on to your seat'. That is what comes to mind and I think that is right".

This implies that endings can be a powerful and charged experience where everything becomes amplified. It also suggests that Frankie might be able to identify with how patients feel during this stage, which helps make sense of the ending and the complexity of the work. It also suggests that therapeutic endings can join up with and revive therapists' personal and historical experiences of endings and some of that might still be felt on some level when working with patients.

Current separations

There can be many levels to the separation that occurs at the ending, which can happen simultaneously. It appears this may contribute to the complexity of this period. The therapists suggest there are many facets to an ending i.e. emotional, psychological, physical and actual, which all need acknowledging during the end. Devon highlights the nature of this:

Devon: "Whether they're actual or psychological, or (PAUSE) physical sort of endings, the way the people are sitting. Faces they see. The patients that are in the waiting area [at the same time – as them (ermm) (PAUSE). The corridor down to my room, my room itself, the layout of the room. The things that are in the room. (PAUSE) they've all got to be said goodbye to"

They can also occur on different planes of consciousness, which can be known (conscious) or unknown (unconscious) to the individual:

Devon: "but once an ending is set, I think it does (errr) (PAUSE) consciously and unconsciously sort of trigger a whole load of previous losses and goodbyes, and endings."

Devon describes conscious and unconscious planes of thinking which are active during the therapeutic ending; these can connect with previous losses and endings that individuals have experienced. It suggests the ending can evoke a period of unsettlement that is not solely attributable to the fact that therapeutic contact is coming to an end.

This sub theme indicates that even current separations can be multi layered (psychological, physical, actual, conscious and unconscious), but the various aspects all need tending to during the ending. It suggests a process of mourning, which appears to be important for patients to undergo during the ending phase. The many facets add to the complex nature of the ending.

Previous separations

Some of the therapists spoke about their personal experiences of earlier losses and separations (e.g. death), which seemed to have influenced their career choice and development:

Frankie: "My own personal history absolutely fundamentally affects all my work. What brought me to psychotherapy was a history with some significant early loss. So endings are a massive issue, they have to be involving loss to some extent.

This can suggest that earlier experiences can underpin individuals' behaviour and have a significant, long term impact on their development.

In relation, all of the therapists narrated they were able to use their experiences in positive ways i.e. develop into being more attune to themselves and patients' feelings; and cultivate this as a therapeutic tool.

> *Devon: "I feel I've got more (PAUSE) obviously more experience of (PAUSE) for example, if, if, if a feeling is (ermm) evoked in me, then I can do a thing in my head of, well, how much of that belongs to me, myself, how much of that [is a – Projection from the patient. Is it appropriate, isn't it appropriate"*

Devon depicts becoming more skilful, particularly in developing a deeper understanding of the emotions that are being experienced and to whom they belong. It seems this has developed with experience, suggesting this may have been harder to do in the past.

It appears that therapists personal experiences of loss can have a strong and long lasting impact on their lives, in such cases these experiences can help develop their identity and career choices. Therapists can use their personal experiences to inform their work with this patient population, but this could risk misguiding the work if not carefully attended to in the way Devon describes.

Endings as relationally emotive

The therapy ending period encompasses a range of raw and tender emotions, as experienced by all of the therapists. These were verbalised as standalone words, followed by pauses. The words and utterances guide us into the potentially powerful and emotionally laden nature of their relational experience, which otherwise might be difficult to communicate in complete sentences. I present an example of this in the following quote:

Devon: "(Ermm) (PAUSE) repair. (Errr) loss. (Ermm) (PAUSE) sadness. Quality (PAUSE). (Errr) (PAUSE) healing really, yeah [healing –"

Devon lists an extensive range of powerful concepts which could potentially create a sequential map of what happens around the ending phase. It is possible that reparation during therapy is followed by the loss of the therapeutic relationship in the ending phase, which is accompanied by sadness. It is possible that the nature and quality of the therapeutic work can affect the healing process.

Relationships were described as pertinent to the work. All of the therapists alluded to different relationships being activated during the therapy, particularly in the ending phase, adding to the complexity. Therapists described patients as bringing primitive and vulnerable parts of themselves to therapy and according to their fantasies; they unconsciously cast the therapists into various roles. This included a parent, romantic partner or a sibling. Jesse illustrates an example of this:

Jesse: "She'd talked in terms of wanting to just come and sit in my lap and be held. (PAUSE) There's a very small child quality about it. And, in many ways, that's what she wanted from therapy. She wanted some, an adult to tell her how to be and to make it safe for her".

In all cases, there was a strong discourse about therapists taking on an enabling and facilitative role which sought to cater for what therapists deemed the patients actually needed, rather than desired. This often involved the therapist being in a range of relational interactions and personas, like being a 'withholder' (particularly of true

emotions about the patient), a parental figure and/or companion. Sam's quote gives an example of the therapist being an enabler by not acting out with the patient:

> *Sam: "To just allow her to be in the room, was a real challenge with her. Really challenging. Not to get very cross when she was using her psycho-babble and to, you know, sort of, putting me in my place or trying to put people in my place. I suppose what I learned from it, was to be very mindful of what it had took from me and how I might act out and behave equally badly as she had been behaving. As she'd reported people behave very badly with her in the world outside"*

Sam describes an experience of having a very strong emotional reaction in response to a patient, where it was difficult to even be in the room together. It illustrates frustrations and how uncomfortable it can be when patients invite them into unhelpful relational dynamics and the challenges of tolerating their emotional reactions for the sake of helping the patient.

During the interviews, the therapists spoke about their relational quality changing during the ending. For instance, if the therapists thought the patient had made some therapeutic progress in therapy, they were more inclined to share some of their personal selves during the ending phase. However, if the therapist felt the patient had made little progress or was struggling during the ending, they tended not to do this; instead, they continued to use the prescribed technique. An example of this can be seen in Alex discourse:

> *Alex: "The only thing that might be different – it didn't with her – is I might give a bit more of myself latterly. If I thought that we had done some good transference work and the person was going off with enough of that, I wouldn't be so guarded*

or stingy with personal information. I might give them more of a thought or a feeling".

Alex describes making a judgement about patients' progress during the end stage; if it feels sufficient then Alex is likely to share personal information which can encourage further reflection. This suggests, therapists may go through a decision making process which can change their relationship to a more interpersonal one during the ending phase.

The majority of therapists felt warmly about the patients by the end and felt upset during the separation. Sam, Blue and Jesse were a few of the many therapists who described the experience as 'moving' or 'being moved':

Sam: "I was aware of it being quite sad actually. Feeling quite moved by the ending with this woman. That it was (ermm), but again, not sad in a wasted time sort of a way. But sad in a, yeah, really quite, really quite like this woman. She's a really nice woman"

Sam discloses feeling sad about ending with the patient; this appeared to be specifically related to the patient as a person, rather than a service user or therapy outcome, per say. This again reflects the possibility of a personal element budding in the professional relationship during the end. It is possible that the term 'moved' or 'moving' in such a context reflects a passing of emotions, which are constant and affecting.

The therapists note that their patients can experience them in various ways (e.g. caring, dismissive or abandoning) during the ending, which can influence *how* he/she ends. Most of the therapists talked about anxieties related to how patients may act (e.g. not attending

or refusing to leave). Here, Jesse gives an example of his/her fears about how the patient may behave in the final session:

> *Jesse: "She could have left equally kicking and screaming and we'd have to open the door and shove her out sort of thing. Coz we've had that with a number of clients"*

Ultimately, it appears the patient is in control of the final meeting/s. This can be seen as almost paradoxical to how the therapy started where the service provider set the therapeutic frame (e.g. the treatment duration, the frequency, timing of sessions and self disclosures).

> *Sam: "You eventually hold people in your minds. And actually some patients may, they may not hold us in mind at all. They may just want to get us out and, I mean I had one guy left his, I think it was helpful to him. But he left his therapy (ermm) in an absolute triumph. And he drove off out of the, he wanted to tell me the car he'd driven. He'd just bought this beautiful new car and I could hear the exhaust as he was driving off out of the car park. And he was so proud. And I thought what a brilliant way to leave your therapy (PAUSE). In a high powered car (laughs)".*

Sam speaks about warming to patients and keeping them in mind, but also illuminates the possibility that patients may wish to leave in ways which are personally useful, which can sometimes be by putting the therapist out of mind. Sam describes the patient leaving in a way which indicated a sense of being proud of what had been accomplished by the end of therapy. The patient marked the end with the purchase of something which allowed a powerful and evident exit, which Sam was in agreement with. It indicates that the

patient's behaviour at the ending phase can affect how the therapist feels after he/she leaves.

This sub-theme supposes that patients bring their primitive feelings to the therapy which can evolve, just like their relationship with the therapist. However, the raw and tender nature of emotions can be overwhelming, even for therapists, which feeds the relational dynamics. Contrary to the therapy, which was led by the service and therapist, the end gives patients the opportunity to take back control and exit as they wish. This layers onto the therapeutic work and complicates the ending process for both, as the therapists feelings about the patients are also constantly changing during this period. Irrespective of the work sometimes arousing unfavourable feelings for the patients, even during the ending phase, it is clear that by the end, all of the therapists had a level of care, warmth and sympathy for the patient and how they left.

Revival and reworking of previous losses

The interviews suggest that although the ending can be an emotionally demanding and complex period, it can also present an opportunity to re-work past issues, strengthen the work done so far, and form a healthy archetype for future losses. An example of this is in Devon's narrative:

> *Devon: "An end, give an opportunity to experience an ending process as thoroughly as you can, then it kind of equips them with a set of experiences that can impact a lot in everyday life. So that's what I'd hope for in a therapeutic ending. It's not only just the ending of therapy, but the ending itself is a (PAUSE),*

a real (ermm) intervention, essentially it's an opportunity for clients to gain an experience of facing a loss in a, obviously, in a healthy way"

Devon suggests that a therapy ending can allow patients to process 'endings' as effectively as possible, which is likely to help them develop skills for managing daily life and other losses more productively.

The therapists' narratives also suggest that working in a psychodynamic way gives them the opportunity to think about and potentially develop their interests, and re work their personal experiences. Sage, Devon and Blue all make reference to this in their narratives.

Blue: "the ideas about you know, losses in my life or endings in my life (PAUSE), a, it hasn't sort of blasted me with a parallel it's a more a sort of pervasive thing where you get the luxury, being this kind of therapist to think about what life's all about quite a lot. And that interests me anyway. So I get to (PAUSE) munch it over on a daily basis and when ending material feeds in to that – It's just (PAUSE) all grist to the mill".

This sub-theme indicates endings can be an opportunity for therapists and patients to develop themselves and become more skilled at managing therapy endings.

As outlined in this super ordinate theme, endings are multi layered and interlinked, making them very complex and demanding. They are a powerfully turbulent period which activates many planes of being (i.e. conscious, unconscious, present and past). It can be an emotionally-charged period for both the therapist and patient and involves an evolution of relationships and interactions. Although it is a complex period, it offers an opportunity for personal and professional development.

Coping with the complexity of ending

As described, the ending is a complex period. Thus, it is not surprising that this theme is dominated by the therapists bid to cope with the complexity, which can involve trying to help the patients work through their difficulties, make sense of their experiences and being hopeful. These will now be explored in more depth.

The therapists expressed various ways of coping with the complexities of the ending phase; theory-driven sense-making was a unanimous component. The interviews highlighted that all of the therapists attempted to make sense of demanding concepts (e.g. loss and mourning), challenging aspects of the work (e.g. patient resistance to therapeutic advancements and therapists residual feelings), the patient's difficulties and therapeutic progress by using psychodynamic-based learning and supervision. The psychodynamic learning seemed to consist of theory and clinical applications. Devon's following quote illustrates the use of theory to make sense of loss:

> *Devon: "I think I always understood them theoretically....* b*ecause, using an analytic framework for the work that we do, or I do (ermm) there are, loads and loads of losses. Every day, tiny little losses. That have to be mourned and grieved"*

Devon seems to use theory to grapple with arguably complex and emotionally demanding concepts such as loss and mourning. This suggests therapists can use theory as an anchor for experiential sense making, particularly during the ending. It also indicates that psychodynamic theory can help therapists understand and work with very loaded material by noticing it on a very micro level, in an ordinary way.

At times, when the ending phase has become potentially too overwhelming for the patient to continue working, the interviews suggests that therapists can use theory to cope with losing the patient and the feelings associated with the work being left incomplete. Alex's account provides an example of this.

> *Alex: With him I don't know that I did get to properly work through the ending, because he took his leave. I suppose I thought about it in terms of a reactivation of his defences really. There was the part about getting the new job, getting the flat and going off. I felt like that was requiring him to be in a more defended place because actually, as much as he'd like to say that he's a kind of Machiavellian arch manipulator, I think he's terrified. What came through more in the material is there's a sort of terror that he's not wanted or he wouldn't do it right. So, the defences, I could see how that came"*

It appears that Alex uses theory to keep a non-judgemental stance towards the patient and understand why he may have left prematurely. It seems that psychodynamic working can help therapists by providing a framework to think about the patients actions in light of their difficulties. It is possible that thinking in this way may prevent them from attributing blame or failure onto themselves. This could have a protective function as it is less likely to damage the therapist's sense of identity (i.e. 'enabler and facilitator'), allowing them to cope with the demands of the work over a long term.

Similarly, therapists' accounts suggested that supervision could be used to make sense of the work. For instance, therapists shared their feelings about the work with the

supervisor, who tried to help them make sense of it. This seemed to have a grounding and developmental effect.

> *Sage: "You kind of think about it in supervisions and you're aware of something you weren't aware of before and then you can kind of think about what it means for you, but also what it means for the client. I think it is powerful".*

The accounts also reflected how therapists used supervision to recognise their own sensitivities, some stemming from personal difficulties, which could potentially hamper the work. An example of this can be found in Jesse's account who was struggling with a personal loss:

> *Jesse: " When we were going through that, having to be very aware in supervision that I was caught in my own stuff, and just checking out that it wasn't becoming, it wasn't having too significant an impact on the therapy – of course it was having an impact, of course it was gonna be present there".*

Jesse outlines receiving support from the supervisor in identifying that Jesse was being affected by a personal experience which was impacting the work and could be potentially detrimental to the work. It also illuminates a transparent and trustful way of working, where the therapists and supervisors can be quite intimately involved.

Most of the interviews harboured a hope that the work had been significant enough to produce long term, ongoing internal growth. It appeared that this hope helped them cope with the separation and uncertainty about the patient future. The following quote illustrates an example of this:

> *Alex: "I suppose my fantasy would be that she'd managed enough to keep it going, that she probably would drop off every now and then and fall back into smoking weed, or destructive relationships and stuff but that there might have been enough of a germ inside her that she'd managed to grow a little bit of possibility that she could do something else. I think that's my desire. I'm hoping it was her desire too. God, this must be 10 years ago that this person I worked with".*

Alex's narrative suggests that therapists can cope with the ending by having faith in the continuity of the work and the patient's ability to grow therapeutically. It also indicates that the therapist and patient relationship can be so profound and affecting, the individual may stay in the therapists mind for a significant length of time.

Some therapists acted in ways to almost cement the hope that they had for the continuity of the work by discussing further treatment (i.e. referrals or accessing private therapy). Blue's following quote highlights a hope for the patient to continue the work by accessing further therapy and taking ownership for her own wellbeing and future work.

> *Blue: "I think she would re-access therapy probably outside of the NHS. (Erm) coz we did talk about that in the ending phase as well, that she didn't need to be a mental health patient, you know that she could take responsibility for her own emotional wellbeing and that might include (PAUSE), if she needed to, working with a different therapist in the future".*

This theme suggests that the most predominate way that therapists coped with the complexities of an ending phase was by trying to make sense of it using the

psychodynamic model. This included using psychodynamic oriented theory and clinical supervision. Some of the therapists coped by fostering hope for the patient and the work they had done, particularly that it will continue. At times this involved discussing the patient's progress with them and encouraging them to access future work.

The followed theme outlines what happens next; particularly what remains after the patient has left.

Staying connected after the patient has moved on without the therapist alongside.

The period after the ending seems crucial to the therapeutic journey. This theme describes the various ways in which the therapists maintain a connection with the patients even after the therapy has ended. Therapists narrate a sense of maintaining a bond through curiosities, unfinished work, emotions, safe keeping of gifts and memories.

A number of therapists described a sense of being left with an uncertainty and curiosity about the patients' wellbeing and future.

> *Jesse: "There's something about (PAUSE) (errrr) reaching that point where I, I don't know they, they leave and that's it. I don't hear what happens, I don't know whether it's OK for them, I don't know what, what it's like".*

This evoked a number of reactions, depending on whether the therapy met the therapist's expectations. For instance, if the therapists felt the patient had made a significant 'shift' then they tended to be left feeling proud of the patient's accomplishments and work. During the interviews, therapists spoke of this in a very parental manner:

Blue: "Well sort of proud. You know, that she'd (PAUSE) proud of her. Like seeing someone off. Seeing a child off, to the next year of school or something.

Blue describes feeling very proud of the patient and likened it to the intimate nature of a parent and child relationship; and how a parent would feel in response to their child growing up. It suggests that patients develop during the therapy but they may still be very early on in their maturation. Additionally, it highlights that patients go through a transition which involves moving away from the therapist.

As mentioned, not all of the endings appeared to leave the therapists with a sense of accomplishment and celebration. Some therapists spoke about such endings evoking anxieties about the patient becoming poorly, returning for therapy or committing suicide:

Winter: "OK he's leaving us, is he going to survive or not (laughs). Like (errr) his, is he going to be like completely messed up after this, and will be completely difficult (laughs) experience"

The interviews suggested that this can leave therapists with a host of negative feelings. The following quote illustrates the tender and raw nature of such emotions:

Sage: "I was left with feelings of anger and distress really and confusion I suppose, in terms of wondering what had happened to him. Maybe that's what I needed to be left with"

This suggests that therapists may be left with a real intensity of raw emotions like anger and distress. It also indicates that therapist that these maintain a bond between the two, as possibly wished for by the patient. Furthermore, it may suggest that even though a physical end has taken place, the work can continue.

Irrespective of the outcome, all of the therapists referred to thinking about the patient in the context of there being some 'unfinished business'. It was clear that even after the therapy had ended, the therapists felt there was still some therapeutic work left to do:

> *Sam: "So we have a concrete ending. But actually there's still something that may remain unresolved that, the person may then want to return"*

Sam describes that even when the therapy comes to an end, there is some work pending, and it is unclear whether the patient will return.

Half of the therapists talked about safe keeping gifts that their patients had given them. The therapists tended to speak about the symbolism of the gifts in respect to their relationship and work. Jesse provides an account of how significant this can be in maintaining an ongoing presence of the patient:

> *Jesse: "she still has a presence in this room and I haven't ended that on her leaving. She went on holiday once and came back with two gifts of plants and they became very much part of the therapy. There's this child like plant, this more adult like plant, and she wanted me to be this... could she trust that I wouldn't forget her either? But I haven't, they've become part of this room.*

Jesse described experiencing the patients on-going presence in the room by the means of a gift which represented their relationship and the type of support the patients desired i.e. parent and child. It suggests that the patient wished for the therapist to keep her in mind, which the therapist has done by allowing her to remain as part of the room.

This indicates the therapist can maintain an internal link in the form of memories, which can stay with therapists:

Blue: "It just sort of leaves its imprint, a multi-coloured imprint really of different feelings and, (PAUSE) can sort of, appreciate the work you've done together".

It seems that after the therapy has ended, therapists can maintain a bond as above with their patients through curiosity, a sense of unfinished work which may or may not lead to further therapeutic work (uncertainties), emotions, safe keeping of gifts and memories.

In conclusion, it appears there has been a build up from the time the therapeutic journey began, with the time having a looming presence, until the ending point, which is multi-faceted. During the ending, the therapists draw on the therapeutic frame of psychodynamic therapy to anchor themselves so that they can help and enable patients to work through their issues. This involved therapists having an experience of the patient and their own personal histories. After the ending occurred and the patients had left, the therapists appeared to maintain a connection with them in the form of curiosities, emotions, gifts and memories.

Discussion

The research aimed to explore therapists' experiences of the ending phase of NHS time limited psychodynamic psychotherapy with complex patients. It was hoped that this would give us some understanding of how they think about endings, what occurs during this period and how they might be affected.

The present findings indicate that the time limit of therapy can provide a useful framework for promoting therapeutic change. However, at times, a longer duration might be required to reach a more therapeutically viable place. In considering this in the context of psychodynamic theories outlined by Davar (2010), it appears that the therapists in the present study may have been working with patients of a greater complexity; therefore required more time to help them develop a more robust sense of self. It also seems that the looming nature of time may characterise the ending as a challenging and unsettling period which can increase the emotional intensity of the therapist's and patient's connectedness. For instance, the present study's findings support and further Cowen's (2003) findings as it seems there are issues of control during and at the end of therapy. Whilst Cowen (2003) found that patients felt powerless during the end phase, the present study revealed that therapists could also experience a sense of powerlessness as they had to comply with the NHS's set time limit. Although the present study did not take patients perspectives into account, the therapists' narratives suggested that patients can attempt to re-gain control from the therapists (in the context of the NHS) by controlling how they exit.

The intensity of therapist's emotional involvement can be understood in the context of Bion's container containment theory (1962), as it seemed the therapists allowed themselves to be emotionally stirred and available to the patients' emotional experiences up until the very last session. This not only reinforces the complexity of patients' difficulties, but supports the notion that endings can be used as an opportunity to rework previous losses and separations.

The present findings suggest that during the ending phase, therapists may experience patients as reverting back to being more defensive (i.e. detaching from the therapist) in an attempt to cope with the ending. This can make it difficult for the therapists to help them work through their anxieties and mourn the loss of the therapeutic endeavour. This is supported by Williams (1997) who suggests that patients may behave in this way due to a re-experience of painful and highly emotive feelings, which can be both consciously and unconsciously associated with other unresolved losses and separations. However, irrespective of this, therapists seemed to be able to work through the complexities of the ending and keep the patients somewhat connected to the process and survive it. However, it is likely that these findings only reflect a patient population that had the ability to tolerate and complete the therapeutic journey and not of those who struggled and had an incomplete or unplanned therapy ending.

In line with Norcross, Zimmerman, Greenberg and Swift (2017), the present study found that therapists felt proud and delighted when the patient's progress was deemed satisfactory and frustrated when the desired outcomes were not achieved. The present study's findings indicate that it is likely that this could be due to the therapists wanting to keep their 'enabler role' intact, as it gives them a sense of fulfilment, gratification and it

is imperative to their professional identity. This is plausible, as research has recognised that therapist's personal histories, particularly of limited appropriate responses from caregivers, can lend them to becoming more attune to the needs of others and experiencing gratification through helping them (Glickauf-Hughes & Mehlman, 1995; Limor, 2016). This is further supported by literature suggesting that such early developmental histories can influence individual's career choices and make them more attracted to becoming therapists (Macdonald, 2014; Fragkiadaki & Strauss, 2011). This is supported by the present study and Fragkiadaki and Strauss (2011) findings which suggest that therapy endings are layered with therapists' personal experiences, particularly of hardship and loss. However, it is also possible that therapists' feelings could also be related to working in the NHS, which in the current climate places a great emphasis on professionals meeting target driven outcomes.

The present study's findings are very are consistent with those of Fragkiadaki and Strauss (2011). However, the present study furthers their findings by suggesting that a good connection is not necessarily that which has only been of a parental nature in the relationship, but that a range of relationships can evolve during the process. This could also indicate that therapists are required to work in a versatile manner to promote therapeutic progress and uphold their perception of themselves as enablers. Furthermore, whilst Fragkiadaki and Strauss (2011) suggest that after the ending, therapists can fantasise about making on-going contact with the patient; this study reveals that therapists continue to maintain a bond with them through reflective curiosities, cherished memories and gifts. This indicates that the therapeutic relationship can be intense, mutually affecting and of an enduring nature.

The present study's findings are in line with Sahpazi and Balamoutsou (2015), Boyer and Hoffman (1993) and Knox et al (2011) as it appears therapists' personal experiences influence their conceptualisation and practice of facilitating therapy endings. However, the present study furthers these findings by revealing that therapists recognise that this can be both useful and detrimental to the work. To aid with this, therapists can rely on their supervisors to help them manage their anxieties and think about their work during this delicate phase of the work. It also highlights that irrespective of their developments, therapists can still continue to struggle with the complexity of therapy endings and attempt to cope with this period by using psychodynamic based theory and working. This can give the therapists a fuller sense of the patient in the context of their difficulties; it may also serve as a protective layer which shields the therapists from attributing blame, helplessness or failure onto oneself when their expectations of the work are not met. The study also reveals that having hope for the patient's future and the longevity of the work can help therapists cope with the complexity of the end and the separation.

Interestingly, the present study found that therapists tended to describe therapeutic outcomes in a relational sense. For instance, terminology like 'movement', 'shift' and 'growth' was commonly employed by the therapists. This differs to the NHS culture which tends to use a symptom orientated language to define outcomes (e.g. 'moderate', 'severe' or 'reduction in impulsive behaviours'). This contradiction could be problematic as it can create a gap in professionals understanding of the patients' difficulties and how they can work with them (consistently) across the services. It may also pose difficulties for patients after therapy has come to an end. For instance, other health care professionals

may expect them to view and/or describe their difficulties in a quantifiable and concrete sense; where-as they may make sense of it in a relational or 'conscious and unconscious processes' type of manner. This may affect how patients can continue with the work of psychodynamic psychotherapy (without being in physical contact with the service), whilst being supported by mental health professionals in other areas of the NHS.

Implications of the research study

The present study has identified that therapy endings can be very complex and challenging. It illustrates a narrative of therapy endings being a tumultuous and delicate part of the therapeutic journey, which is important for therapists, other parts of the NHS mental health services (e.g. inpatient services) and legislative bodies to be aware of. It is clear that the experience of a care ending is much more than the patient being discharged from the service and/or being referred to other parts of the mental health system. In particular, it is important for mental health professionals to be aware of the implications a care ending can have on patient's difficulties and how they may behave during this period (i.e. an increase in the intensity of their difficulties and unhelpful behaviours like not attending meetings or complying with the recommended care regimes). Equally, it is important for mental health professionals to be aware of the toll a care ending can have on professionals if it is not understood in the context of the patient's difficulties (e.g. feeling burnt out or rejected by patients). It is hoped that readers can develop their understanding of endings in the context of loss and mourning in this patient population. Similarly, the findings highlight some of the potential implications of not using a common language to describe clinical changes across services in the NHS. It appears that

this disparity could have an impact on continuing care pathways for patients with personality disorders.

It also highlights the need for legislative bodies to develop training programs which enable mental health professionals in other areas of the service to develop skills in being able to think about, and work through the end phase of their contact with patients. It also emphasises the need for supervisors to help therapists' and other mental health professionals' to work through the end phase of their contact with patients' effectively.

Evaluation

It is important to view the findings in the context of the study's limitations. For instance, the participants were recruited from one site which can affect the study's generalisability. The interpretive nature of IPA makes the analysis vulnerable to analyst bias. However, this is unlikely as the author used a reflective diary and triangulation. It is hoped that this has secured the credibility of the findings. In addition, the study may have benefited from conducting follow up interviews. It is possible that this could have captured some insightful post interview reflections, adding to the existing findings. It may have also given the opportunity to verify whether the analysis accurately reflected their experiences.

The study has many strengths; one being the fair sample size and near equal gender representation. To date, the research in this area has tended to be more representative of female therapists than males. The present study has been able to capture a reasonable number of males and females experiences. In addition, although the therapists did not omit any parts of their accounts, they were given the opportunity to do

so in order to ensure they were absolutely satisfied with what the authors analysed and shared. Furthermore, this topic was very complex and hard to explore, however I think that it reflects something of the complex nature of endings which other studies may have struggled to do.

Future work

In developing this topic area, it would be useful if future research could explore both therapists and patients experiences of time limited psychodynamic therapy endings. This could enable a deeper and more holistic understanding of this critical and complex period. It could also allow some comparison of their experiences and how they may evolve. The present study touched on therapists experiences of unplanned endings. However due to the focus of the study this could not be drawn out extensively. It would be interesting to explore how these are characterised and experienced because it may give some insight into therapy which is experienced as particularly difficult or 'not good enough'. In either case, the present study's methodology could be used to carry out the research. Finally, this research poses the question of what are other mental health professionals experiences of working with complex patients in other areas of the NHS service (e.g. inpatient) where they may not have the in depth psychological training or privilege of having the time and resources to think about the patients and whether this may lead them to acting in more defensive ways to manage the emotional demands of therapeutic contact.

Conclusion

In conclusion, therapy endings are greatly complex periods which are multi layered with many facets related to the past, present, conscious and unconscious. They can revive feelings associated with previous losses and separations and can be worked through during this period. Therapists can use their relationship with the patient as a foundation for therapeutic change and their relational dynamics can change during the course of their meetings, particularly during the end when the patient might be struggling. Therapists are able to draw on psychodynamic working and hope for the patient's continual growth in order to help themselves, and the patients journey through the ending phase. However, the intensity of their bond can have a long standing impact on the therapists as they continue to maintain a bond with patients after the therapy draws to a close. The present study has attempted to further the area of research but more research is required to develop these findings and conclusions.

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CHAPTER III

PUBLIC DISSEMINATION DOCUMENT

This chapter gives an outline of the literature review and empirical paper carried out by Ayshah Hanif as part of the Doctorate in Clinical Psychology program at the University of Birmingham.

Systematic Meta-synthesis Review: A meta-synthesis of mental health professionals' experiences of patient suicide.

Introduction

It is suggestive that more than 90% of suicides and suicidal attempts are associated with having a mental health disorder (Mental Health Foundation, 2016). Suicide prevention has become a key government priority and a number of strategies and policies have been put in place to reduce the number of suicides and effect it has on others (DoH, 2012; NHS, 2016). Often, people who commit suicide are under the care of mental health professionals (Appleby et al, 2001), which can have a significant impact on them. This can include guilt (Dewar et al, 2000; Courtenay & Stephens, 2001; Thomyangkoon & Leenaars, 2008), stress (Gitlin, 1999), low self esteem (Dewar et al, 2000), self condemnation (Dewar et al, 2002; Courtenay & Stephens, 2001), anger (Thomyangkoon & Leenaars, 2008), shame (Thomyangkoon & Leenaars, 2008), trauma (Menninger, 1991) and damage to their identity (Brown, 1987).

Over the years, a number of reviews have attempted to investigate this topic area. However, these reviews have tended to be quantitative in nature and struggled to give a rich exploration and understanding of the research question. The aim of this systematic meta-synthesis review is to produce a new and integrative interpretation of the qualitative research which enables a more detailed and relational account of mental health

professionals' experiences of patient suicide. Additionally, it is hoped that this review will highlight areas which require further exploration (future research) and the potential implications of these.

Method

A systematic literature search found 14 relevant articles. A meta-ethnography was carried out in accordance with Noblit and Hare's (1988) seven steps approach; this involved using a 'reciprocal translation' method. The analysis resulted in five themes and seven subthemes.

Results

The themes reflected mental health professionals' experiences of patient suicide. 'Grief, loss and trauma: An emotional endeavour' suggested that mental health professionals tend to be emotionally affected by patient suicide. Whilst some experiences resembled a trauma response; other elements of the emotional experience involved a grief and loss reaction. 'An existential shake up' suggested that they can experience intense feelings of guilt, incompetence and failure, and sometimes an increased sense of responsibility. This appeared to be distressing and created self doubt regarding their capabilities and professional identity. 'Encounters with blame' indicated that mental health professionals can experience self blame, blame from employers (including bureaucratic blame), colleagues and the deceased family. 'Support seeking' reflected that mental health professionals can seek support from others. This can have a positive or negative effect on them, depending on how others respond. 'A changed person' suggested that patient suicide can have a long standing and transformational impact on mental health professionals. Whilst, some individuals were able to use this experience to develop

into more skilled professionals, others continued to struggle with existential, grief, loss and trauma elements of their experiences; both can influence their practice for the better or the worse (respectively).

Conclusion

Mental health professionals' experiences of patient suicide are complex. The review suggests that mental health professionals experience a bereavement process which can be complicated by the 'out of the ordinary' nature of suicide. The experience can make it hard for them to make sense of what has occurred and what this means for their professional identity and how others will perceive them. It is apparent that the experience is transformational and depends on the quality and nature of support systems. Therefore, it is important for mental health professionals, supervisors and legislative bodies to be aware of its impact and factors which may hinder their recovery (e.g. blame and lack of debriefing) following patient suicide in order for appropriate support to be put in place (e.g. staff training).

Empirical paper: Therapists experiences of therapy endings in NHS time limited psychodynamic psychotherapy.

Introduction

The NHS offers a course of time limited psychodynamic psychotherapy (approximately two years) to patients with complex and pervasive difficulties like personality disorder. The psychodynamic model understands personality disorder in the context of early childhood experiences and attachments where individuals may have struggled to process and mourn separations and losses (Williams, 1997). In such instances, ending periods can be critical because they can revive feelings associated with previous unresolved separations and losses. The ending phase of therapy can be an opportunity to reconnect with un-worked anxieties and engage with the process of mourning in a safe and contained manner. It can make the process of ending more wholesome, less painful and easier to bear; which can serve as an archetype for other transitions (Murdin, 2014).

There has been research which gives insight into some the factors which may influence therapy endings. In particular, it appears that therapist's personal experiences of bereavement and loss can affect their personal and professional development (Kouriatis & Brown (2011) and how they facilitate the ending of therapy (Boyer & Hoffman, 1993).

In time limited NHS psychotherapy, issues of control can also complicate the endings phase (Haskayne, Larkin & Hirschfeld, 2014; Cowen, 2003). This is not often recognised by the therapist as they may view the ending as a collaborative decision. However, patient's views reveal that they can see the end as an imposition which brings up feelings of powerlessness (Cowen, 2003).

There is a notable gap in the research literature concerning therapists experiences of endings in NHS funded time limited psychodynamic psychotherapy with patients suffering with complex mental health issues (typically BPD), who are likely to struggle with loss and separations. The research aims to explore therapists' experience of time limited psychodynamic psychotherapy endings with complex patients.

Method

A qualitative research method design was used. The researcher conducted semi structured interviews with 8 psychodynamic psychotherapists. The interview data was transcribed in verbatim and analysed using an Interpretative Phenomenological Analysis (IPA) method. An IPA support group and triangulation methodology was employed to support the development of a plausible analysis.

Results

The analysis presents therapists' experiences of therapy endings in four overarching themes and four sub-themes.

The first theme titled 'Time limit has a looming presence in the therapeutic journey' showed that therapists have mixed feelings about the looming presence of the set time limit. Whilst some therapists viewed it as a hindrance to the therapeutic work, others saw it as a beneficial boundary, which had the potential to accelerate the work. The second theme 'Endings are relational, dynamic, and complex' reflected the multi layered, turbulent and complex nature of this critical period. It included subordinate themes 'Current separations', 'Previous separations', 'Endings as relationally emotive' and 'Revival and reworking of previous losses'. The third theme 'Coping with the

complexity of ending' indicated that therapists attempt to cope with the ending period by using the psychodynamic model, fostering hope for the patient and the work, reviewing the patient progress and planning for the future. The final theme 'Staying connected after the patient has moved on without the therapist alongside' showed that after the ending, therapists tended to maintain a bond with their patients through curiosities, uncertainties about the unfinished work, emotions, safe keeping of gifts and memories.

Conclusion

In conclusion, it appeared that a time limit is significant to the therapeutic work. The ending period is very complex and therapists tend to employ a number of coping strategies to anchor themselves so they can continue working with the patients. This involved therapists having an experience of the patient and sometimes their own personal histories. The therapeutic relationship can leave a long standing impression on therapists and maintains an ongoing connection with the patients.

A crucial implication of the research is to raise awareness of the importance of therapy endings for therapists and patients and how this may affect staff that work with patients with severe and enduring difficulties. It also highlights the need for staff support with managing separations with patients and further research looking at different facets of the ending process.

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Appendices

Appendix 1: Details of the research articles selected for the review

Authors & year of publication	Study title	Aim (s) and objectives	Participants	Method and Analysis
1. Ting, Sanders, Jacobson and Power (2006)	Dealing with the aftermath: A qualitative analysis of mental health social workers reactions after a client suicide.	Assess the reactions experienced by social workers following a client suicide.	• n =25 (21 F, 4 M) • Age: Mean 53.25 (Range 37 to 69) • Origin: USA • Occupation: Social workers	• Telephone interviews • Grounded theory approach
2. Hendin, Lipschitz and Maltsberger (2000)	Therapists of patients who committed suicide reported a wide range of emotional responses.	Understand the emotional responses of therapists to the suicide of a patient.	• N = 26 (19% F, 81% M) • Age: Unknown • Origin: USA • Occupation: 21 Psychiatrist, 4 psychologists and 1 social worker.	• Narrative description, questionnaire and discussions during 1 day long workshop. • Unknown
3. Rossouw, Smythe and Greener	Therapists experience of working with suicidal clients	Experiences of therapists whose clients have committed suicide	• N = 13 (6 F, 7 M) • Age: Range 30 - 50	• Semi structured interviews • Hermeneuti

(2011)		• How does the news impact Therapists • What are therapists on-going experience of living through the aftermath	• Origin: New Zealand • Occupation: 5 Psychologists, 7 Psychiatric nurses and 1 Psychiatrist.	c-phenomenological method
4.Tillman (2006)	When a patient commits suicide: An empirical study of psychoanalytic clinicians	Gain a deeper understanding of the effects of patient suicide on the clinician	• N = 12 (7 F, 5 M) • Age: Unknown • Origin: USA • Occupation: Trainee and senior level psychoanalytic clinicians (5 psychiatrists, 6 psychologists and 1 social worker)	• Semi structured interviews • Thematic analysis
5.Darden and Rutter (2011)	Psychologist's experiences of grief after client suicide: A	In depth exploration of the phenomenological experience of	• N = 6 (2 F, 4 M) • Age: Mean 46 (Range 39 to	• Interviews • Phenomenological analysis

	qualitative study.	psychologists who navigated a client suicide	53) • Ethnicity: Caucasian • Origin: USE • Occupation: Psychologists	
6.Knox, Burkard, Jackson, Schaack and Hess (2006)	Therapists in training who experience a client suicide: Implications for supervision	Pre-licensure doctoral supervisees' experiences of client suicide • The role of supervision in coping • Beliefs about suicide and the preparation they received	• N = 13 (8 F, 5 M) • Age: Mean 33 • Ethnicity: 8 White, 2 African and 3 other • Origin: USA • Occupation: Trainees (12 clinical psychologists and 1 Counselling psychologist)	• Semi structured interviews • Consensual qualitative research methods.
7.Sanders, Jacobson and Ting (2005)	Reactions of mental health social workers following a client suicide completion: A qualitative investigation.	Social workers' experience of suicide • Short and long term impact • How duration relates to the	• N = 145 (106 F, 39 M) • Age: Mean 52 • Origin: USA • Occupation: Mental health social workers	• Self report questionnaire (close ended and open ended questions) • Coding and thematic analysis

		reactions		
8.Davidsen (2011)	'And the one day he'd shot himself. Then I was really shocked': General practitioners reaction to patient suicide.	Explore the emotional effect of patients' suicides on GP's • Whether this effect was linked to GPs' propensity to explore suicide risk	• N = 14 (6 F, 8 M) • Age: Mean 50 (Range 34 to 60) • Origin: Denmark Occupation: General practitioners (GPs)	• Semi structured interviews • Interpretative phenomenological Analysis (IPA)
9.Kendall and Wiles (2010)	Resisting blame and managing emotion in general practice: The case of patient suicide.	Ways in which GPs view, manage and experience CIRs for suicide in primary care. • how does Government-imposed regulation and target setting in relation to suicide prevention in primary care fit with GPs experiences of patient suicide	• N = 16 (5 F, 11 M) • Age: Unknown • Origin: UK • Occupation: GPs	• Semi structured Interviews • Features of grounded theorising, constant comparisons and themes

		• how does the context of medicine and generalpracti ce impact on GPs reactions and practice around suicide?		
10.Deringer and Caligor (2014)	Supervision and responses of psychiatry residents to adverse patient events*	Explore whether residents perceptions of the quality of supervision impacts their emotional reactions to adverse events	• N = 21 • Age: Unknown • Origin: USA • Occupation: Trainee psychiatrists	• Semi structured interviews • Cross tabulations and direct quotes
11.Phillips, Tannis-Ellick and Scott (2013)	Student nurses' experiences of support in relation to suicide or suicidal behaviours of mental health patients: an exploratory study	Explore student nurses' experiences of support in relation to suicidal incidents • Beneficial/ Non - beneficial support	• N = 10 • Age: Unknown • Origin: UK • Occupation: Student nurses	• Semi structured interviews • Thematic analysis

		• Make recommendations for education and support		
12.Bohan and Doyle (2008)	Nurses experiences of patient suicide and suicide attempts in an acute unit*	Explore psychiatric nurses' experiences of and reactions to a patient suicide or suicide attempt • Elicit their perceptions of the support they received after the incident	• N = 9 • Age: Unknown • Origin: UK • Occupation: Psychiatric nurses	• Semi structured interviews • Open coding and thematic analysis
13.Hagen, Knizek and Hjelmeland (2017)	Mental health nurses experiences of caring for suicidal patients in psychiatric wards: An emotional endeavour	Develop further knowledge of how mental health nurses deal with a variety of demands in the care of potentially suicidal patients in psychiatric	• N = 8 (7 F, 1 M) • Age: Range 43 to 60 • Origin: Norway • Occupation: Mental health nurses	• Interviews • Systematic text condensation

		wards*		
14.Saini, Chantler, While and Kapur (2016)	Do GPs' want or need formal support following a patient suicide?: a mixed methods study	Explore GPs' views on how they are affected by patient suicide and what support they receive.	• N =198 (54 F, 144) • Age: Range: 30 to 50+ • Origin: UK • Occupation: GPs	• Interviews • Thematic analysis framework

*Studies looked at other behaviours in addition to suicide, in such cases, only sections clearly pertaining to patient suicide were analysed.

Appendix 2: Quality appraisal table

		Research study (author & publication date)													
		Ting, Sanders, Jacobson & Power (2006)	Hendin, Lipschitz & Maltsberger (2000)	Rossouw, Smythe & Greener (2011)	Tillman (2006)	Darden & Rutter (2011)	Knox, Burkard, Jackson, Schaack & Hess (2006)	Sanders, Jacobson & Ting (2005)	Davidsen (2011)	Kendall & Wiles (2010)	Deringer & Caligor (2014)	Phillips, Tannis-Ellick & Scott (2013)	Bohan & Doyle (2008)	Hagen, Knizek & Hjelmeland (2017)	Saini, Chantle, While & Kapur (2016)
Theoretical approach	Is a qualitative approach appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Is the study clear in what it seeks to do?	Yes	Unclear	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Study Design	How defensible/rigorous is the research design/methodology?	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
Data collection	How well was the data collection carried out?	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes
Validity	Is the role of the researcher clearly described?	No	Unclear	Unclear	Unclear	Yes	Yes	Yes	Unclear	Unclear	Unclear	Yes	Unclear	Unclear	Yes
	Is the context clearly described?	Yes	Unclear	Unclear	Unclear	Yes	Yes	Yes	Unclear	Yes	Unclear	Unclear	Unclear	Yes	Yes
	Were the methods reliable?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	No	Unclear	No	Yes	Yes
Analysis	Is the data analysis sufficiently rigorous?	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	Are the data 'rich'?	No	Unclear	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Unclear	Yes	Yes	Yes
	Is the analysis reliable?	Unclear	Unclear	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Unclear	No	No	Unclear	Yes
	Are the findings convincing?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	Are the findings relevant to the aims of the study?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	Are the conclusions adequate?	No	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes
Ethics	How clear & coherent is the reporting of ethical considerations?	Yes	Unclear	Yes	Unclear	Yes	Yes	Yes	Unclear	Unclear	Yes	Yes	Unclear	Yes	Unclear
Overall method quality	Can you describe the details of the overall method quality?	**Some weaknesses** Generally, the study seems to be theoretically sound and has been designed appropriately. However, it the role of the researcher is unclear and the participants sample lacks diversity (e.g. gender and ethnicity). The analysis section lacks detail, although the findings seem relevant. The conclusion	**Some weaknesses** A qualitative approach was apt; however the study ultimate lacked a lot of information and was very brief.	**Some weaknesses** A qualitative approach was apt but it was unclear what the study sought to do. The study design, data collection and analysis appeared feasible. The validity was questionable in some places due to insufficient information about the role of the researchers. Context bias may have been	Few weaknesses A qualitative approach was apt. The study was of plausible theoretical underpinning, design and analysis. The validity was questionable in some places due to insufficient information.	No weaknesses A qualitative approach was feasible. The study was generally a well designed and executed. The findings were relevant to the aims and were discussed and concluded in a fair manner	No weaknesses A qualitative approach was feasible. The study was generally a well designed and executed. The findings were relevant to the aims and were discussed and concluded in a fair manner	No weaknesses A qualitative approach was feasible. The study was generally a well designed and executed. The findings were relevant to the aims and were discussed and concluded in a fair manner	**Some weaknesses** A qualitative approach was apt. Underpinning values, assumptions and theory not described. The study design and data collection were feasible. The analysis and validity lacked information. The implications f the study and alternative explanations for the findings were not explored.	**Some weaknesses** The theoretical approach, analysis, design and data collection were apt. The validity and ethical basis are questionable due to a lack of information.	**Some weaknesses** Qualitative approach was apt. The study design, validity and analysis was largely questionable (e.g. recruited via email and experiential richness loss due to analysis method)	**Some weaknesses** The theoretical approach, design and data collection were apt. However, the validity and analysis are questionable e.g. lack of co-coder for analysis. A lack of information makes it difficult to determine the richness of the data.	**Some weaknesses** Qualitative approach, design and data collection were apt. The validity and conclusions were largely questionable (i.e. context and analysis sections lacked significant details e.g. coders)	**Some weaknesses** The theoretical approach and analysis were apt. However, the study design, data collection and parts of the validity are questionable.	Few weaknesses A qualitative approach, design, data collection, analysis and validity were apt. The ethical basis was questionable due a lack of information.

		section lacks an exploration of alternative explanation for findings and does describe any limitations.		an issue but this was addressed..										

Appendix 3: An example of initial impressions about the research data

	Theme: Guilt	Theme: Shock	Theme: Unexpected/sudden	Theme: Denial and disbelief	Theme: Professional failure and incompetance	Theme: Anger	Theme: Grief and loss	Theme: Responsibility
1) Ting 2006 American	Self blame and guilt. "I felt the whole would've, could've, should've thing." . "should have seen it coming" or "should have done something different. **Guilt about incompetance**. "What did I miss? How did I not see this? And just feeling devastated by it.. . I was feeling that the client had said something that I missed".	in the denial and disbelief theme	"I had no warning about this"	Denial and disbelief because it was a **shock and unexpected**. Denied the idea of it being intended "My reaction was...this was an accident...What turned out [the suicide] was not what [she] meant; she did so many bizarre thing. **Took days to recover from the impact**. "I had no warning about this," or "I had seen him that day, and he denied being suicidal".	Feeling **incompetent and doubtful** in one's ability as a clinician along a sense of "professional failure." "I was questioning my competancy". **Feeling judged** by colleagues and clients family.	with client: angry feelings regarding the client's **lack of trust**, feeling anger at being **rejected** by client. Angry for **giving up on life, being self ish and inconsiderate of impact** on others. Anger at it being **manipulative and havign to pick up the pieces**. "It was very clear to me that he killed himself to punish her [his wife], leaving behind a son to deal with it". Angry at **agency and society:** macro-level structures were insufficient to help the clients. agency for not taking **responsibility** and toward the "lack of insti tutional response...there were all the opportuni ties	**Loss of control**, over taken by emotional and physiological reactions (depressed, traumatised, sleep and crying) . Memories of **previous losses** (personal) "[The client suicide] brought up feelings of when my father died when I was five...triggered this fear from when he died." Along with grief, feeling a sense of loss for the client was reported,"It was such a waste;" the"whole thing's a tragedy. So many, many good points to	feeling personally responsible and liable, regardless of work setting (private practice or agency):"I felt really alone, not part of a team". Concerns about being **liable** for making decisions; "It's your responsibility; this could go the wrong way, and it's a lot of pressure. There's a very **helpless** feeling too because there's only so much you can do". "There were risks and liability, and I bear the weight".
Aims: Describe the lived experience" of a group of individuals regarding a particular phenomenon								

Appendix 4: An example of clustering similar themes together (using colour codes)

Theme: Professional failure and incompetance	Theme: Anger	Theme: Grief and loss	Theme: Responsibility	Theme: Avoidant behaviours	Theme:Intrusion	Theme: changes in professional behaviour
Feeling **incompetent and doubtful** in one's ability as a clinician along a sense of "professional failure." "I was questioning my competancy". **Feeling judged** by colleagues and clients family.	with client: angry feelings regarding the client's **lack of trust**, feeling anger at being **rejected** by client. Angry for **giving up on life, being self ish and inconsiderate of impact** on others. Anger at it being **manipulative and havign to pick up the pieces**. "It was very clear to me that he killed himself to punish her [his wife], leaving behind a son to deal with it". Angry at **agency and society:** macro-level structures were insufficient to help the clients. agency for not taking **responsibility** and toward the "lack of insti tutional response...there were all the opportuni ties	**Loss of control**, over taken by emotional and physiological reactions (depressed, traumatised, sleep and crying) . Memories of **previous losses** (personal) "[The client suicide] brought up feelings of when my father died when I was five...triggered this fear from when he died." Along with grief, feeling a sense of loss for the client was reported,"It was such a waste;" the"whole thing's a tragedy. So many, many good points to	feeling personally responsible and liable, regardless of work setting (private practice or agency):"I felt really alone, not part of a team". Concerns about being **liable** for making decisions; "It's your responsibility; this could go the wrong way, and it's a lot of pressure. There's a very **helpless** feeling too because there's only so much you can do". "There were risks and liability, and I bear the weight".	Avoidant behaviors toward other potential suicidal clients as well as avoidant thoughts and reminders. Many reported they would rather not see clients who were suicidal and would "transfer clients to others if suicidal". Personal avoidant decisions were reported, indicating social workers left their jobs or were in the midst of leaving.	reported intrusive reactions, feelings of anxiety and fear for the well-being of other clients, and of another suicide occurring while in their care. Some reported becoming "fearful of clients," that clients became a threat, spilling over and af fecting their personal and professional equilibrium. Intrudes in personal relationships (partner and kids). and mental health. Memories of suicidal clients stay.	Changes in Practice. Reported changes in individual practice behaviors included increased awareness of possible suicidal ideation, not making assumptions of what suicidal people are like, and conducting more detailed screening and lethality assessments. Changes in prof environment - team working and openeness, more postventions, educating others.

Appendix 5: Participant invitation letter

Version 3 (29.06.2016)

Title of Project: Therapists' and clients' experiences of therapeutic endings in long-term psychodynamic psychotherapy.

Researcher: Ayshah Hanif

Dear potential participants,

I am Ayshah Hanif and I am currently studying for a doctorate in Clinical Psychology at the University of Birmingham. I would like to invite you to take part in a research study. Before you decide whether you are interested in taking part, included with this letter is more information about why this research is being done and what it would involve for you. Please take the time to read the information sheet carefully and feel free to discuss any aspects of it.

What will happen to me if I agree to take part?

If you decide that you would like to take part, please tear off the 'permission to be contacted' slip below and put it in the research box at the reception desk. I will contact you and we can either arrange to have a discussion over the telephone or meet in person to talk about the research and whether you would like to take part.

Ayshah Hanif

Researcher/University Student

Email: axh079@bham.ac.uk

Dr Michael Larkin,

Research Supervisor

Senior Academic Tutor/Lecturer, School of Psychology, University of Birmingham
Email: m.larkin@bham.ac.uk

Dr Jill Rowbottom,

Research Supervisor

Clinical Psychologist and Psychodynamic Psychotherapist (BSMHFT).

Telephone: 0121 301 3800

Thank you for taking the time to read this letter and the information sheet.

Kind regards,

Ayshah Hanif

Researcher

Appendix 6: Therapist Participant Information Sheet

IRAS: 195257. Version 4 (17.08.2016)

PARTICIPANT INFORMATION SHEET

Title of Project: Therapists' and clients' experiences of therapeutic endings in long-term psychodynamic psychotherapy.

Researchers: Ayshah Hanif (Principle Investigator) and Jill Rowbottom (Research supervisor)

Ayshah Hanif is a Trainee Clinical Psychologist with the University of Birmingham. She will be working within Birmingham and Solihull Mental Health Trust as part of her clinical psychology training as well as carrying out research within the trust.

Jill Rowbottom is a Clinical Psychologist working within the Birmingham and Solihull Mental Health trust. Jill will be assisting and supervising Ayshah Hanif in the research project.

Michael Larkin is a Senior Research Tutor and Lecturer working within the University of Birmingham. Michael will be assisting and supervising Ayshah Hanif in the research project.

What is the purpose of this research?

This research is being conducted for three main purposes:

- To find out more about how therapists think and experience therapy, when it is coming to an end.
- To find out more about how clients think and experience therapy, when it is coming to an end.
- To find out more about the ending stage of therapy.

The research aims to understand how therapists and clients experience the end of a time limited therapy. We are interested in what they think about the ending process, the difficulties they may have experienced and how they attempted to work through these. We would like to explore how such experiences might help us understand what an agreed therapy ending looks like. Additionally, how therapy endings may have changed or developed over the years.

The therapeutic ending phase potentially provides another opportunity to work through difficulties, consolidate and expand on the work that has been done. Therefore, having a better understanding of their experiences is particularly vital to psychodynamic services as it can help improve how they manage endings and maximise client's wellbeing and healthcare provision.

What will taking part involve?

In this study you will be asked to partake in a one to one interview with myself (Ayshah Hanif). I will ask you to choose a case to base the majority of their reflections on, with the option of deviating and talking about your experience of working with others clients (as appropriate). I will ask you questions about your experience of therapeutic endings. I may also ask you to reflect on how you felt about yourself, client and their difficulties, therapy, any changes in mood and behaviour that you noticed during this phase. I may also ask you to describe how you think and feel about the therapeutic process now that therapy has come to an end, and whether it has affected your personal or professional development.

Why have I been invited to take part?

You have been invited to take part in this research study because you are a therapist working at [site name omitted for confidentiality purposes].

Do I have to take part?

This is entirely your decision and will not affect your employment in any way. If you agree to take part, you can change your mind and withdraw at any time up until the end of a three week reflection period after the interview, without giving a reason.

What will happen to me if I agree to take part?

If you decide to participate you can notify the research supervisor (Jill Rowbottom) who will inform myself. I will contact you and arrange a meeting for the research interview. The interview will take place at a local NHS trust site. The interview will take no more than 90 minutes, during which I will ask a number of questions in relation to the research topic (see above). The interview will be audio-recorded and transcribed for analysis. You will not have to answer any questions which feel uncomfortable or distressing and can withdraw at any point during the interview.

Once the interview is complete, the researcher will ask you a few questions to assess whether you are experiencing any distress. The researcher will arrange a time you can review your interview transcript to discuss any quotes or passages you would like the researcher to omit from the research.

In order to get a better understanding of the participant population, the researcher would like to collect your demographic data.

What are the disadvantages of taking part?

The study is not intended to cause you distress. However, when deciding if you would like to take part, it is important that you consider whether you would be willing to talk about such topics without it having a negative impact on you. Your wellbeing is paramount, therefore at the end of the interview I will check how you are feeling and set aside time to discuss any concerns.

During the interview, if you tell me something that indicates malpractice, confidentiality may need to be broken. If there is such a concern, I will try to discuss this with you and

encourage you to speak with your supervisor and/or team manager. Health and Safety Procedures will be followed.

The study will take a maximum of 135 minutes of your time. The service will take this into consideration and allow you to complete this within your working hours.

What if I become upset or distressed during the interview?

If you become upset or distressed I will ask you to pause and enquire whether you would like to continue. If you or I feel that you are unduly distressed and it is unhelpful for you to proceed, the interview will be terminated and you will be encouraged to contact your supervisor or therapy network.

What if something goes wrong?

If you become concerned with any aspect of your participation then you can contact me (Ayshah Hanif) on axh079@bham.ac.uk or supervisors Michael Larkin (m.larkin@bham.ac.uk) and/or Jill Rowbottom (0121 301 3800) who will try and address your concerns. If you remain dissatisfied or have issues with how you were treated during the research you can make a formal complaint to Birmingham and Solihull Mental Health Foundation Trust complaints department on 0121 301 2000.

What are the benefits of participating?

The research provides an opportunity for you to reflect on your therapeutic experience and possibly add to your understanding of therapeutic endings and how you facilitate them. We are aware that although endings are an emotionally powerful experience, and can have a significant impact on therapy, there is a limited amount of research literature which informs us of this particular topic area. We hope that this research project will increase peoples understanding of this process and will contribute to education, policy making, healthcare services and those involved with individuals who have mental health difficulties.

Is the information I give confidential?

The interview audio recording will be transcribed in full and anonymised. The transcript will help identify patterns and themes. Your name will not be used on your transcript; it will be replaced with a pseudonym (false name) and only I (Ayshah Hanif) and Michael Larkin will have access to these. Electronic copies of your audio recording will be stored in a password protected computer and/or password protected encrypted memory stick. Only I (Ayshah Hanif) will have the password to these.

In order to protect your identity, I will provide you with a copy of your transcript and within 10 working days I will ask you whether you would like me to omit any identifiable quotes before the analysis begins. During the analysis stage, it is likely that I will discuss connections, potentially with references to quotes with research supervisors (Jill Rowbottom and Michael Larkin). However, they will not have access to your entire transcript or know that it belongs to you. Irrespectively, they are both bound to abiding confidentiality guidelines and respecting your information.

The anonymised interview transcripts will be stored for 10 years as this is a University of Birmingham requirement. Audio-recordings will be destroyed when the project is complete. All of the research data will be stored securely.

During the interview, if you tell me something that indicates that you or someone else is at serious risk or harm or a misconduct of care has occurred, I would try to discuss this with you. I would either encourage you or act on your behalf and disclose the information to the relevant bodies. The research supervisor (Jill Rowbottom) will be informed and I would be required to follow Health and Safety Procedures.

What will happen to the results of the research study?

I will present the results with a short paper outlying the research to the psychology department at [site name omitted for confidentiality purposes] and as part of my (Ayshah Hanif) academic requirements for the University of Birmingham's Clinical Psychology Doctoral thesis. The research may be submitted for publication in an academic journal and conference. None of the participants in the study will be identified in any of these, but some anonymised quotations will appear in the outputs.

Who is organising and funding the research?

Birmingham University is organising the research and the study is self-funded. The researcher is not being paid to carry out the research.

Who has reviewed this research?

All research in the NHS is assessed by an independent group of people in a research ethics committee. This study has also been passed by the University of Birmingham's ethics committee. These bodies have been assigned to protect your safety, rights, wellbeing and dignity.

If you would like to discuss any aspect of this research please contact myself (Ayshah Hanif). Tel: 0121 301 3800 Email: axh079@bham.ac.uk

Appendix 7: Participant consent form

IRAS: 195257. Version 4 (17.08.2016)

Research site: [Site name omitted for confidentiality purposes]

Study Title: Therapists' and clients' experiences of therapeutic endings in long-term psychodynamic psychotherapy

Researcher: Ayshah Hanif

Participant Identification Number:.....

Please initial box

1. I confirm that I have understood the information sheet dated 17.08.2016 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my employment or legal rights being affected. ☐

3. I understand that the research interview will be audio-recorded ☐

4. I understand that following the research interview I will have a 10 working days period for reflection. The researcher will then contact me at which point I may withdraw my interview entirely or in part, without giving any reason, without my employment or legal rights being affected. ☐

5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the NHS team. ☐

6. I understand that direct quotes from my interview may be published in any write-up of the data, and used for training purposes, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments. ☐

7. I agree to take part in the above study. ☐

N.B: Once you have completed this consent form, you will be given the original and the researcher will keep a copy for her records.

.....	.....	.....
Name of participant	Date	Signature
.....	.....	.....
Name of researcher	Date	Signature

Appendix 8: Indicative Topic Guide (Therapist Participant) for interviews

Version 2 (7.04.2016)

Start section

General:

Q1) When you think about therapeutic endings in general what words, associations come to mind?

Q2) How do you think about therapeutic endings in your work generally?

Q3) Has your view and engagement with endings changed overtime? Can you elaborate on this?

Q4) What factors influence the therapeutic value that might be gained from working through an ending phase?

(Prompts: Can you elaborate on these? Can you describe what that is like for you as the therapist?)

Specific:

**We are going to talk about endings; In doing this, I would like you to have a particular client that you have worked with in mind. I do not mind who you pick, for example it could be someone with whom you had a 'powerful' ending, recent ending, typical/atypical ending; but if you could just tell me a bit about why you have chosen the particular client. If as we go through, other clients come to mind then feel free to use them as an example to describe your views.*

Middle section

Q5) Can you briefly tell me about your initial thoughts and feelings on meeting the client and the expectations that you had for the therapy? *(Prompt: how did you work with this client?)*

Q6) When did you first start thinking about the ending, how was it spoken about? *Prompt question: what do you think influenced how you thought about and facilitated this ending? ..*

Q7) When you reflect on the ending process with this client, what comes to mind? e.g. Where there any changes in the intensity of the work and expressed feelings, changes in the therapeutic relationship, emergent themes or an increase in acting out?

Prompts: can you elaborate on these? Particularly the nature of feelings being expressed?

Q8) Can you describe how you felt in response? (i.e. to his or her engagement and reaction to the ending)

(Prompt questions: How did you feel about yourself /the work/ the client at the time.

Q9) Can you say something about how your client had responded to holiday breaks or changes to appointment times during the therapy? *Prompt question how do you relate this to their responses to an anticipated ending.*

<u>End section</u>

Q10) Can you briefly describe how you worked through the ending and the issues you have described with him or her? *Prompt: Can you describe what might have been the therapeutic effect of this…?*

Q11) Can you describe how it felt to say goodbye to your client?

Q12) Since the therapy has ended have you had any further reflections on your work with this client or the ending? *Prompt: what impact will this have on your future work?*

Q13) We have talked about understanding the experience of ending in the context of a client's history but could you say something about how you think your own experiences or therapists personal experiences in general, might influence the ending process? *Prompt: Do you think feelings during the ending process in therapy were related to your own experiences of losses or difficulties?)*

Q14) What is your understanding now of what happened in the therapy and has it brought about any changes in the way you think or practice?

Q15) Has this changed over the succession of years through working with others? and if yes then how so?

Appendix 9: Confirmation of ethical approval

Dear Dr Larkin

Re: **IRAS ID: 195257: Therapists' and clients' experiences of therapeutic endings in long-term psychodynamic psychotherapy**

Confirmation of Local Capacity and Capability at Birmingham and Solihull Mental Health NHS Foundation Trust

This email confirms that Birmingham and Solihull Mental Health NHS Foundation Trust has the capacity and capability to deliver the above referenced study. Please find attached the agreed Statement of Activities as confirmation.

'Please note, formal confirmation of capacity and capability from Birmingham and Solihull Mental Health NHS Foundation Trust began on 17/05/2017, upon receipt of clarifications from the researcher to queries raised during the R&I Assess, Arrange, Confirm review'.

Delivery teams – please note that you have now been added to the study record on EDGE, the Trusts local information management system used to record all research at the Trust, including real time recruitment input by yourselves. EDGE can be accessed at www.edge.nhs.uk. Recruitment information should be entered as per the EDGE Clinical Delivery User Guide. All queries should be directed to Katie Williams, local EDGE Administrator at katie.williams@nihr.ac.uk.

Please refer to the HRA Approval letter dated 27 September 2016 for latest versions of approved documentation.

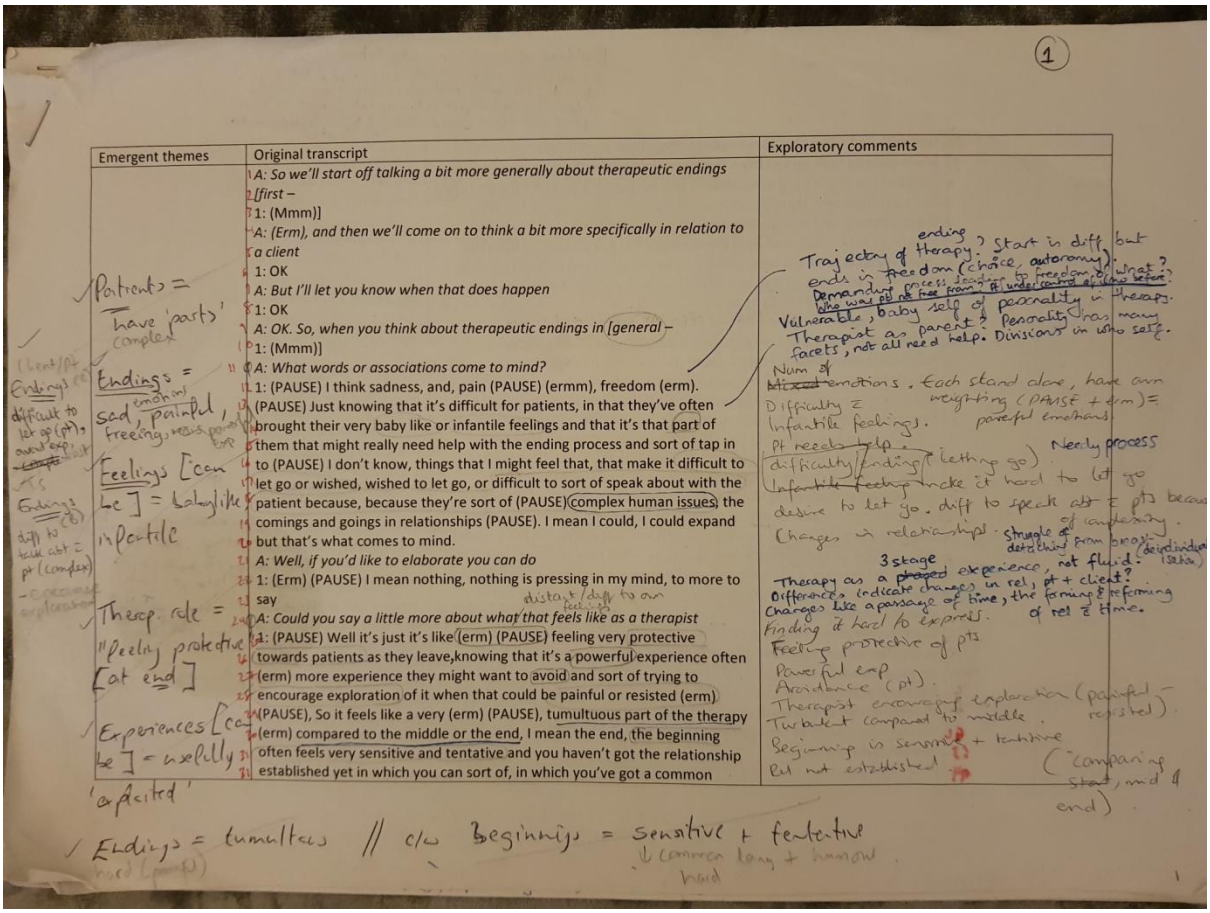
If you wish to discuss further please do not hesitate to contact us.

Best wishes

R&I

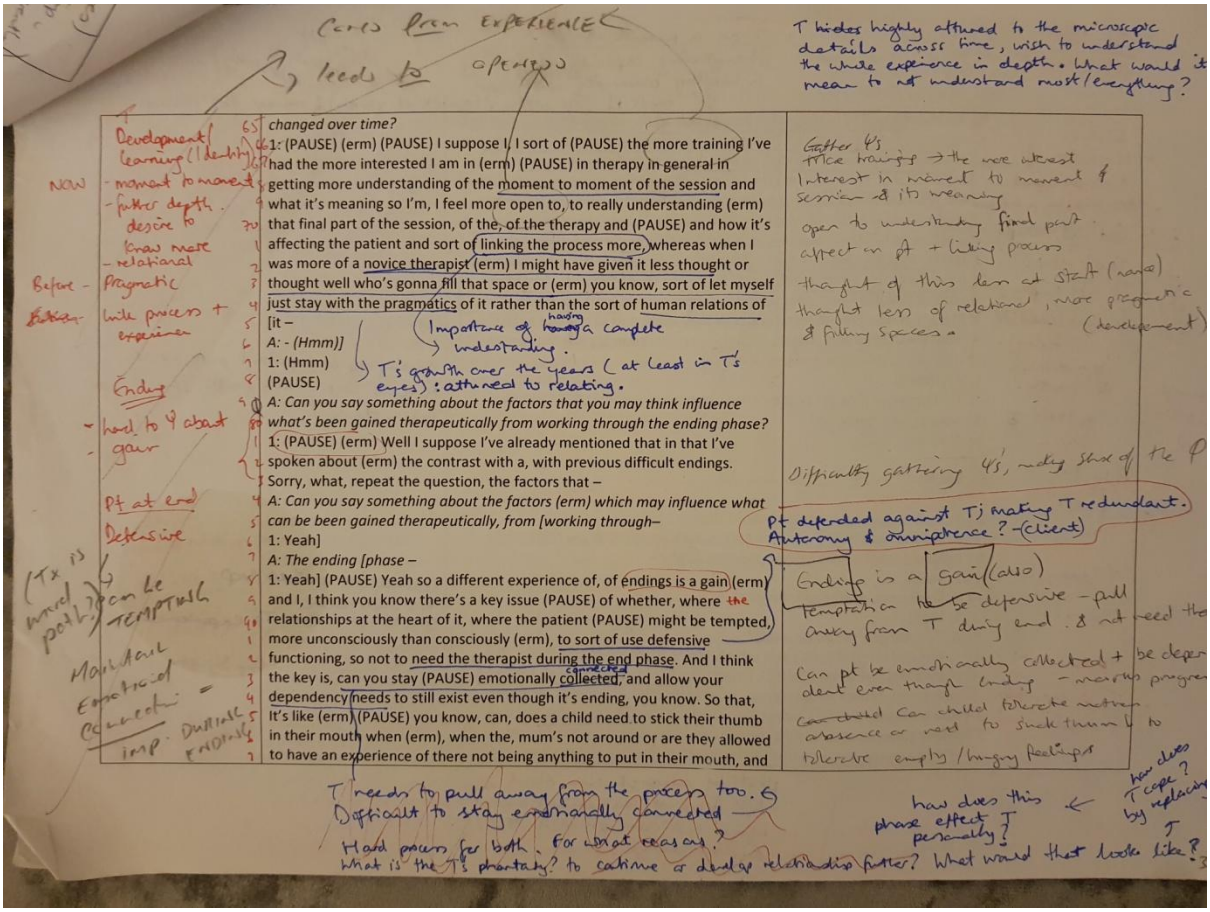
Appendix 10: Initial coding of a transcript (step 2, 3 and 4)

Example 1



Emergent themes	Original transcript	Exploratory comments
	A: So we'll start off talking a bit more generally about therapeutic endings	
	[first –	
	1: (Mmm)]	
	A: (Erm), and then we'll come on to think a bit more specifically in relation to a client	
	1: OK	
	A: But I'll let you know when that does happen	
	1: OK	
	A: OK. So, when you think about therapeutic endings in [general –	
	1: (Mmm)]	
	A: What words or associations come to mind?	
	1: (PAUSE) I think sadness, and, pain (PAUSE) (ermm), freedom (erm). (PAUSE) Just knowing that it's difficult for patients, in that they've often brought their very baby like or infantile feelings and that it's that part of them that might really need help with the ending process and sort of tap in to (PAUSE) I don't know, things that I might feel that, that make it difficult to let go or wished, wished to let go, or difficult to sort of speak about with the patient because, because they're sort of (PAUSE) complex human issues, the comings and goings in relationships (PAUSE). I mean I could, I could expand but that's what comes to mind.	
	A: Well, if you'd like to elaborate you can do	
	1: (Erm) (PAUSE) I mean nothing, nothing is pressing in my mind, to more to say	
	A: Could you say a little more about what that feels like as a therapist	
	1: (PAUSE) Well it's just it's like (erm) (PAUSE) feeling very protective towards patients as they leave,knowing that it's a powerful experience often (erm) more experience they might want to avoid and sort of trying to encourage exploration of it when that could be painful or resisted (erm) (PAUSE), So it feels like a very (erm) (PAUSE), tumultuous part of the therapy (erm) compared to the middle or the end, I mean the end, the beginning often feels very sensitive and tentative and you haven't got the relationship established yet in which you can sort of, in which you've got a common	

Example 2



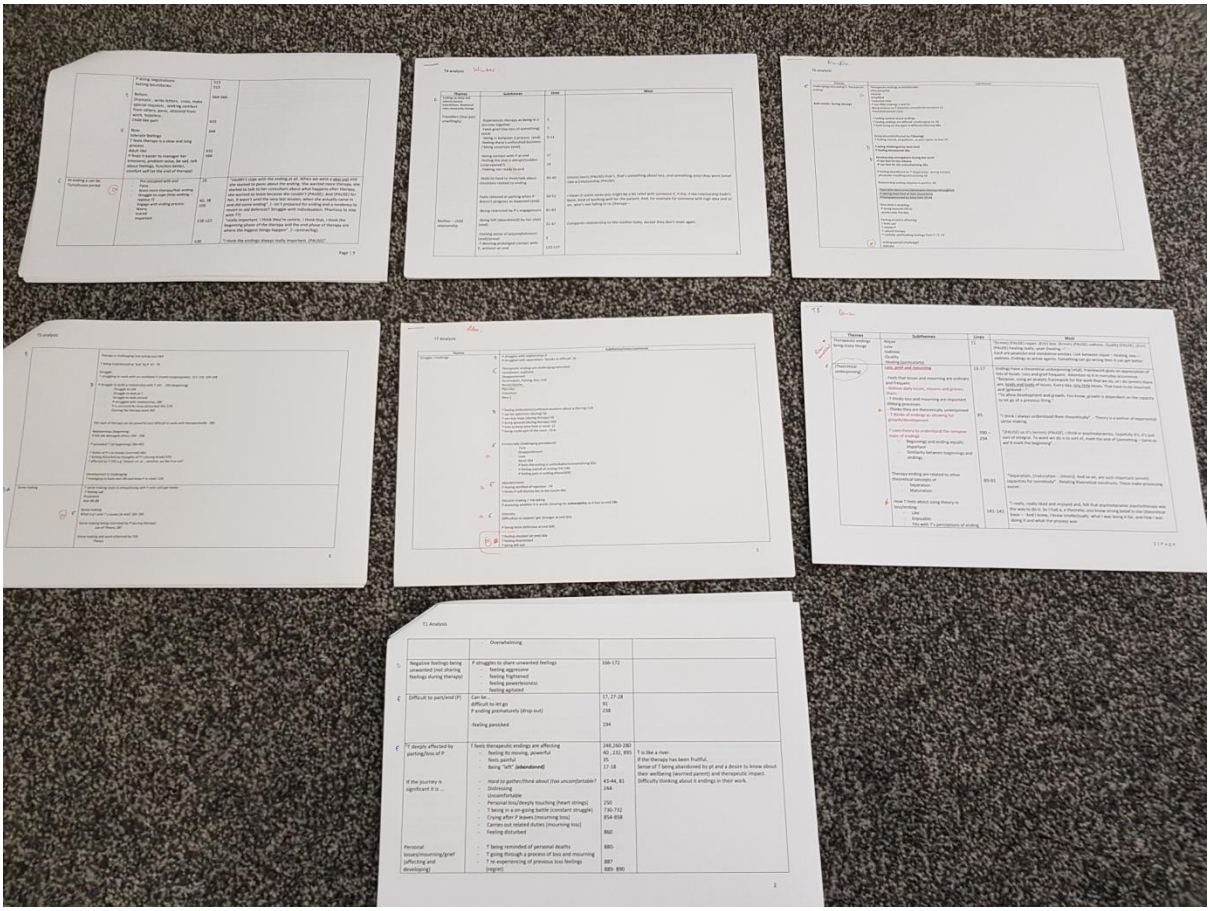
changed over time?
1: (PAUSE) (erm) (PAUSE) I suppose I, I sort of (PAUSE) the more training I've had the more interested I am in (erm) (PAUSE) in therapy in general in getting more understanding of the moment to moment of the session and what it's meaning so I'm, I feel more open to, to really understanding (erm) that final part of the session, of the, of the therapy and (PAUSE) and how it's affecting the patient and sort of linking the process more, whereas when I was more of a novice therapist (erm) I might have given it less thought or thought well who's gonna fill that space or (erm) you know, sort of let myself just stay with the pragmatics of it rather than the sort of human relations of [it –
A: - (Hmm)]
1: (Hmm)
(PAUSE)
A: Can you say something about the factors that you may think influence what's been gained therapeutically from working through the ending phase?
1: (PAUSE) (erm) Well I suppose I've already mentioned that in that I've spoken about (erm) the contrast with a, with previous difficult endings. Sorry, what, repeat the question, the factors that –
A: Can you say something about the factors (erm) which may influence what can be been gained therapeutically, from [working through–
1: Yeah]
A: The ending [phase –
1: Yeah] (PAUSE) Yeah so a different experience of, of endings is a gain (erm) and I, I think you know there's a key issue (PAUSE) of whether, where the relationships at the heart of it, where the patient (PAUSE) might be tempted, more unconsciously than consciously (erm), to sort of use defensive functioning, so not to need the therapist during the end phase. And I think the key is, can you stay (PAUSE) emotionally collected, and allow your dependency needs to still exist even though it's ending, you know. So that, It's like (erm) (PAUSE) you know, can, does a child need to stick their thumb in their mouth when (erm), when the, mum's not around or are they allowed to have an experience of there not being anything to put in their mouth, and

Appendix 11: An example of emergent themes for a participant (step 5)

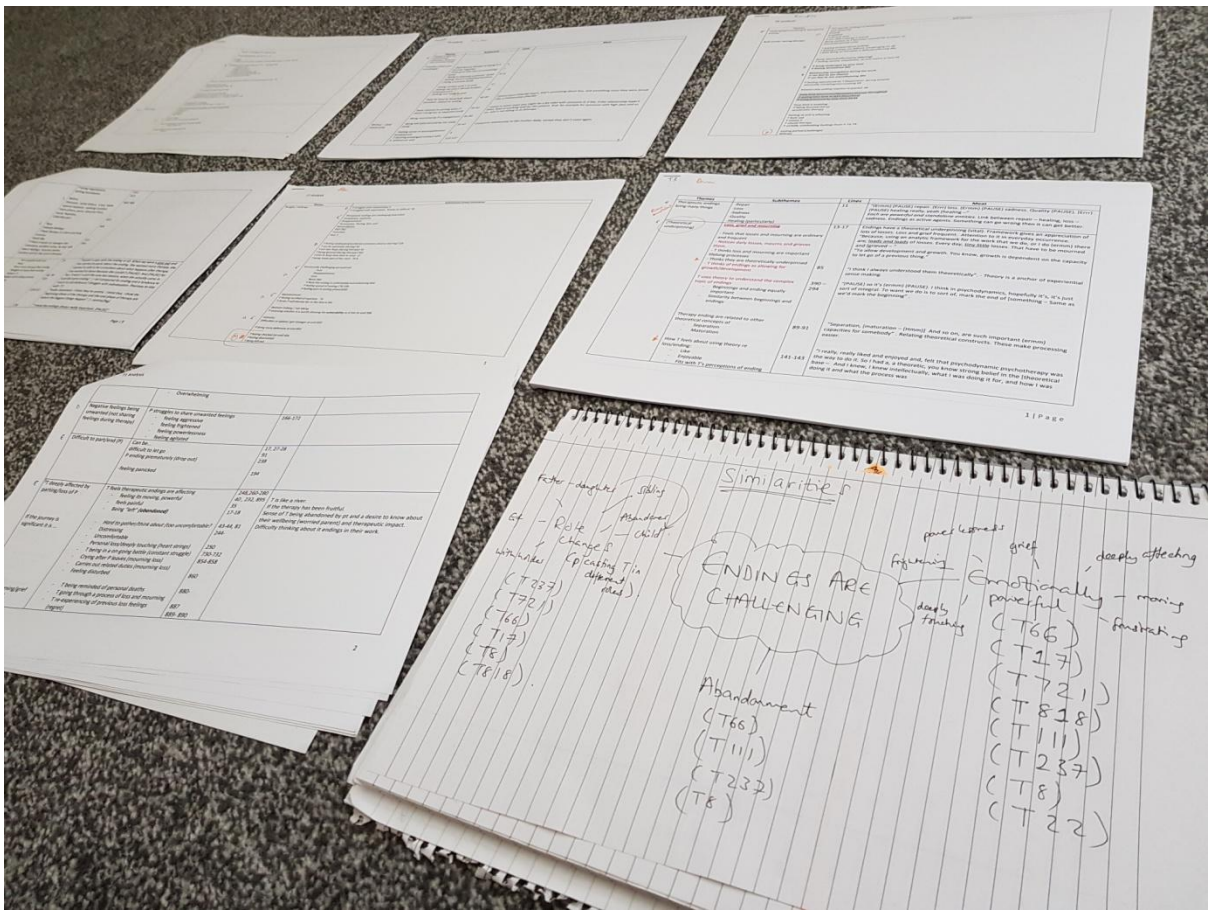
Themes	Subthemes	Lines	Quotes/concepts/notes
Therapeutic endings bring many things	-Repair -Loss -Sadness -Quality -Healing (particularly)	11	"(Ermm) (PAUSE) repair. (Errr) loss. (Ermm) (PAUSE) sadness. Quality (PAUSE). (Errr) (PAUSE) healing really, yeah [healing –" *Each are powerful and standalone entities.* Link between repair – healing, loss – sadness. Endings as active agents. Something can go wrong then it can get better.
[Theoretical underpinning]	**Loss, grief and mourning** - Feels that losses and mourning are ordinary and frequent - Notices daily losses, mourns and grieves them. - T thinks loss and mourning are important lifelong processes - Thinks they are theoretically underpinned - T thinks of endings as allowing for growth/development	13-17 85	Endings have a theoretical underpinning (vital). Framework gives an appreciation of lots of losses. Loss and grief frequent. Attention to it in everyday occurrence. "Because, using an analytic framework for the work that we do, or I do (ermm) there are, loads and loads of losses. Every day, tiny little losses. That have to be mourned and [grieved – " "To allow development and growth. You know, growth is dependent on the capacity to let go of a previous thing." "I think I always understood them theoretically". - Theory is a anchor of experiential sense making.
	T uses theory to understand the complex topic of endings - Beginnings and ending equally important - Similarity between beginnings and endings	390 – 294	"(PAUSE) so it's (ermm) (PAUSE). I think in psychodynamics, hopefully it's, it's just sort of integral. To want we do is to sort of, mark the end of [something – Same as we'd mark the beginning".
	Therapy ending are related to other theoretical concepts of - Separation - Maturation	89-91	"Separation, [maturation – (Hmm)]. And so on, are such important (ermm) capacities for somebody" . Relating theoretical constructs. These make processing easier.
	How T feels about using theory re loss/ending: - Like - Enjoyable - Fits with T's perceptions of ending	141-143	"I really, really liked and enjoyed and, felt that psychodynamic psychotherapy was the way to do it. So I had a, a theoretic, you know strong belief in the [theoretical base – And I knew, I knew intellectually, what I was doing it for, and how I was doing it and what the process was

Appendix 12: Participant theme contrasting (step 6)

Example 1

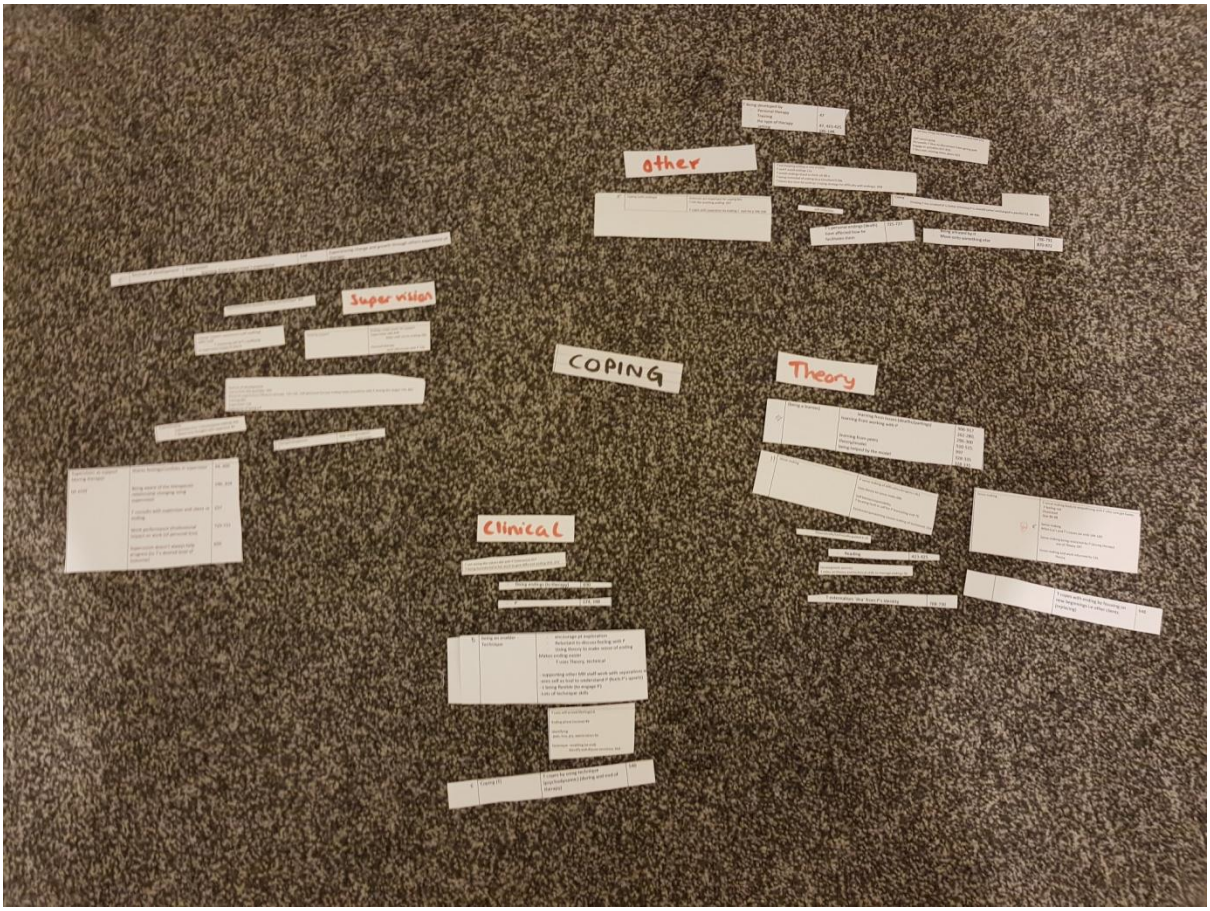


Example 2

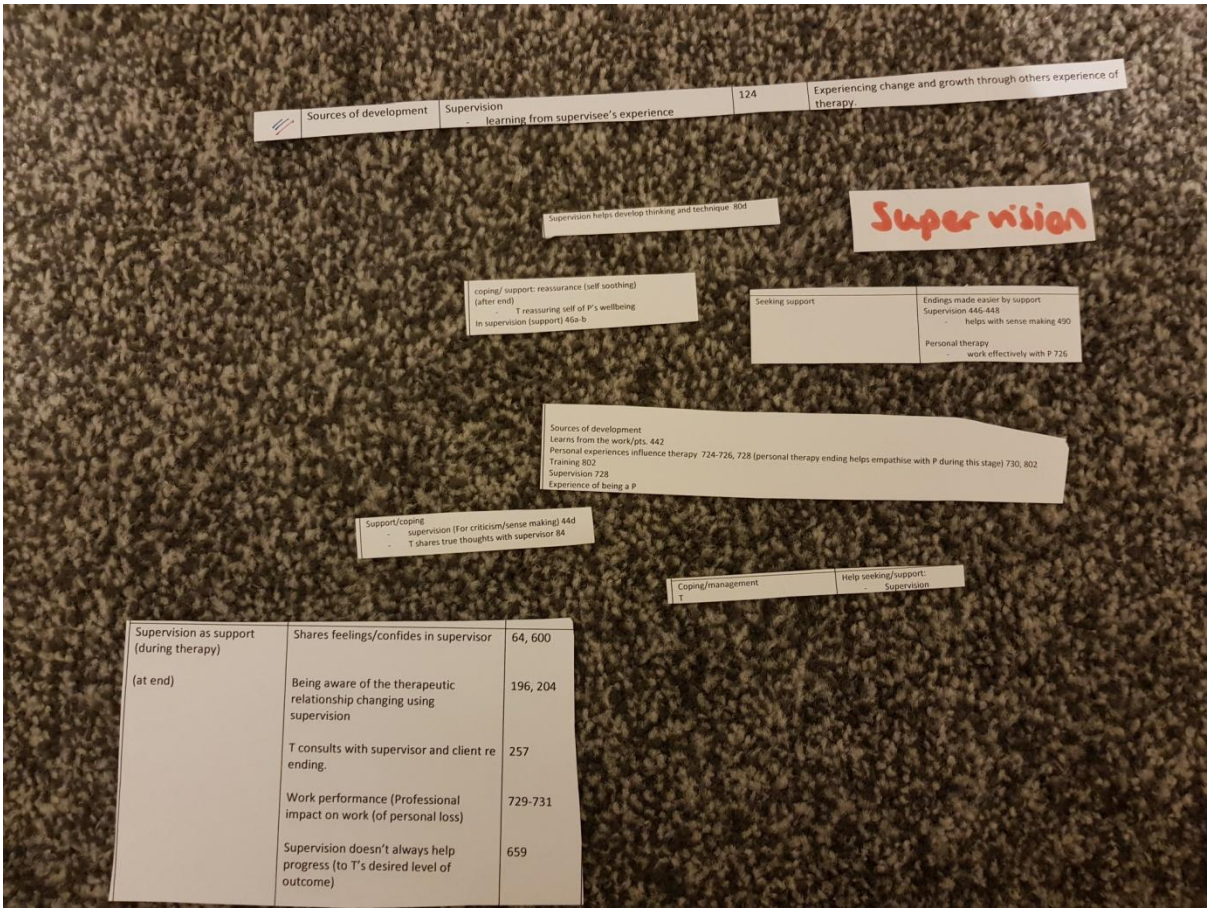

Similarities
ENDINGS ARE CHALLENGING
Abandonment
(T66)
(T111)
(T237)
(T8)
(T66)
(T17)
(T721)
(T818)
(T111)
(T237)
(T8)
(T22)
(T737)
(T721)
(T66)
(T17)
(T8)
(T818)

Appendix 13: The process of forming super ordinate themes (step 7)

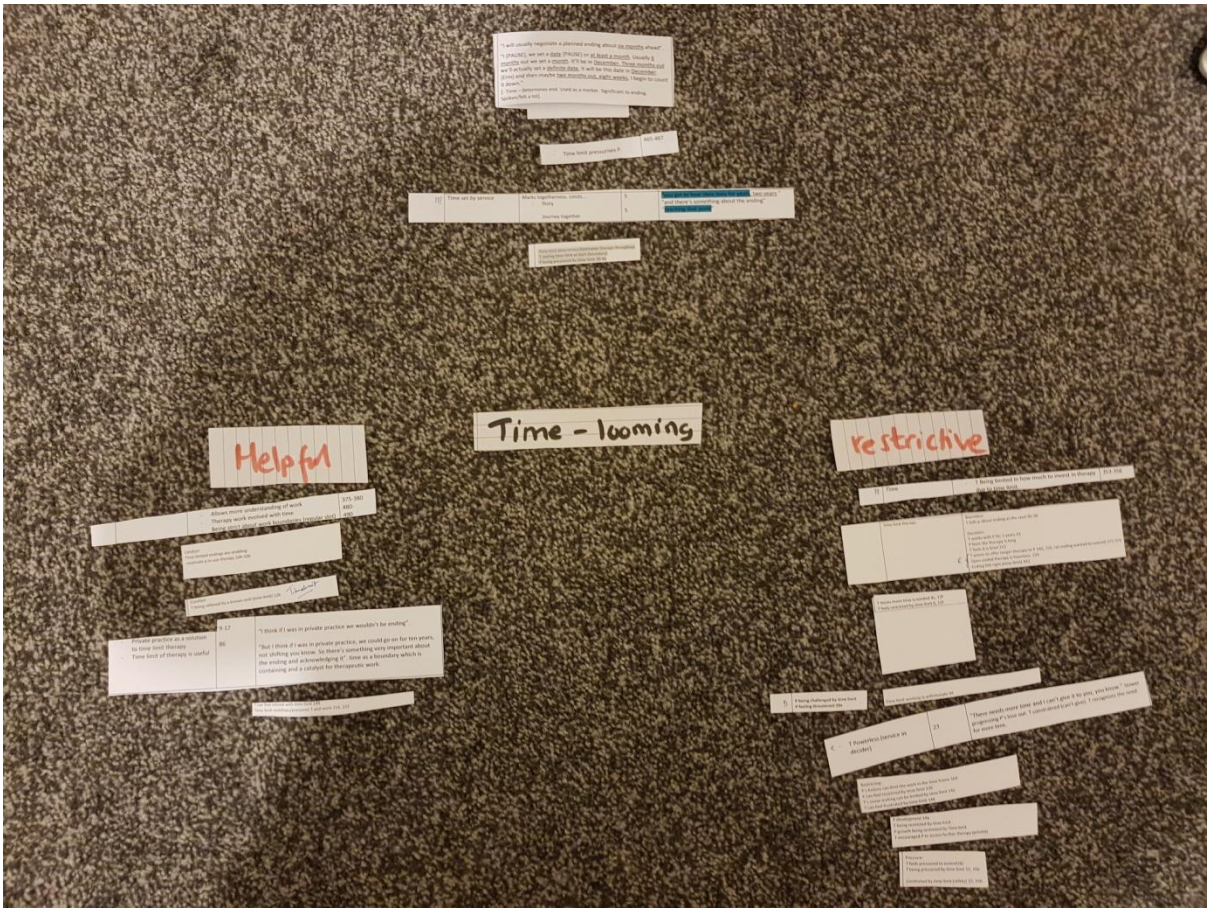
Example 1



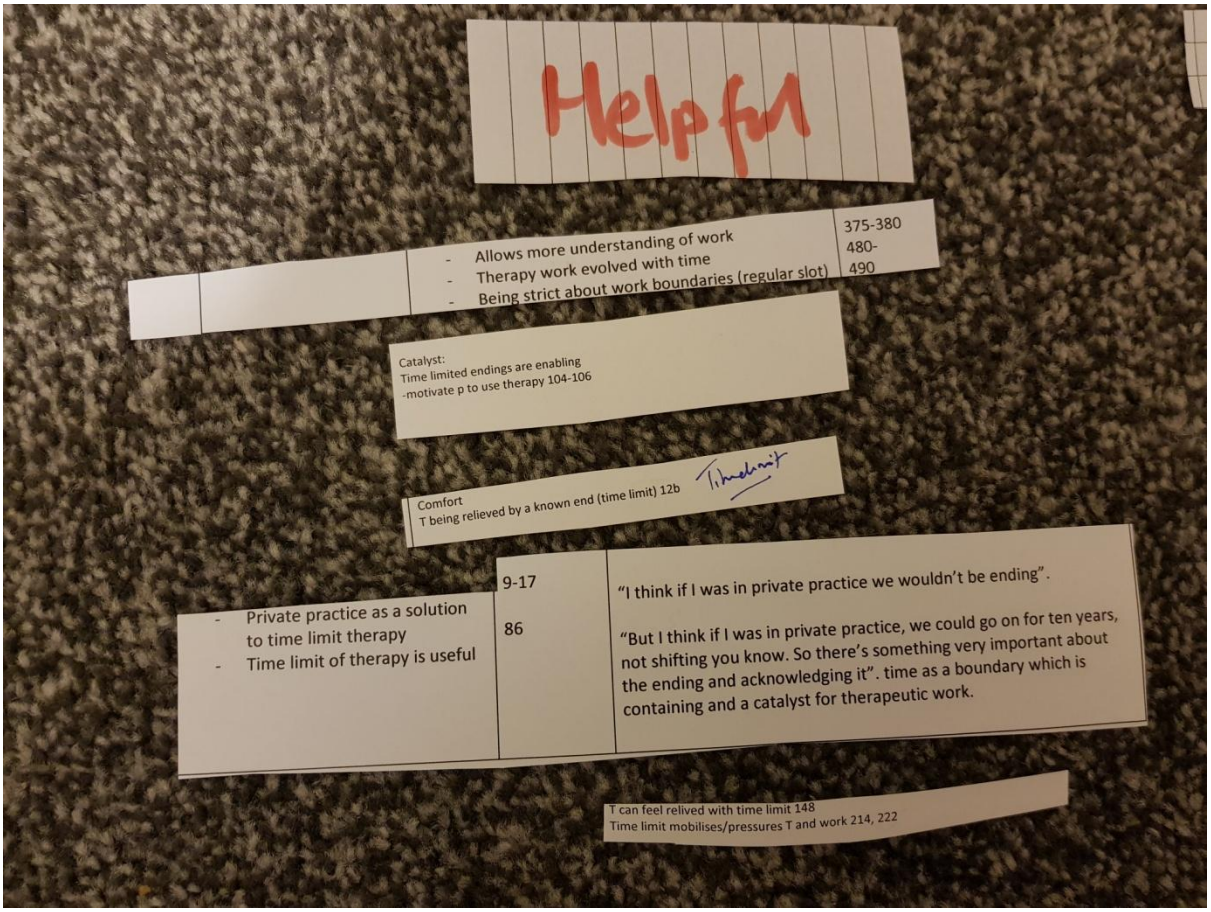
Close up shot to illustrate Example 1



Example 2



Close up shot to illustrate Example 2



Close up shot to illustrate Example 2