## DOCTORAL THESIS

# *Junior Clinical Psychologists' Experience of Processing the Death of a Therapy Client, From a Cause Other Than Suicide: A Qualitative Study*

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# DEDICATION

For all of the clients who inspired this study and for those who kept it going.

## CONTENTS

**ABSTRACT** 179
**INTRODUCTION** 181
INTRODUCTION TO THIS CHAPTER 181
OWNING ONE'S PERSPECTIVE 182
BACKGROUND 187
A BRIEF HISTORY OF BEREAVEMENT AND GRIEF RESEARCH 189
THE EXPERIENCE OF CLIENT DEATH FOR HEALTHCARE PROFESSIONALS: EMPIRICAL RESEARCH 192
SUMMARY AND IMPLICATIONS FOR FUTURE RESEARCH 214
**AIMS OF RESEARCH** 218
**RESEARCH QUESTION** 219
**METHOD** 220
A QUALITATIVE APPROACH 220
DATA COLLECTION 223
PROCEDURE 224
ETHICAL ISSUES 227
PARTICIPANTS 231
DATA ANALYSIS 233
PROVIDING CREDIBILITY CHECKS 236
**REFLEXIVITY CONTINUED…** 238
**RESULTS** 240
1. CONNECTED AND AFFECTED: BEING UNPREPARED FOR INITIAL REACTIONS TO THE CLIENT'S DEATH 243
2. 'WE DO IT SO WHY CAN'T YOU?' FACING INSTITUTIONAL DENIAL AND AVOIDANCE 252

3. ‘IT’S NOT SOMETHING I’VE FORGOTTEN ABOUT’,THE LASTING IMPACT OF CLIENT DEATH: LEARNING RELUCTANT LESSONS AND EXPERIENCING CONTINUING BONDS ........ 264

**DISCUSSION ........ 280**

REVISITING THE RESEARCH QUESTION ........ 280
JUNIOR CLINICAL PSYCHOLOGISTS EXPERIENCE OF THE DEATH OF THEIR CLIENT ........ 281
METHODOLOGICAL CONSIDERATIONS ........ 291
IMPLICATIONS FOR PRACTICE ........ 295
IMPLICATIONS FOR FUTURE RESEARCH ........ 298
FINAL REFLECTIONS ........ 300

**CONCLUSIONS ........ 301**

**REFERENCES ........ 303**

**APPENDIXES ........ 316**

APPENDIX 1: INTERVIEW SCHEDULE ........ 317
APPENDIX 2: EMAIL AND LETTER TO COURSE DIRECTORS ........ 321
APPENDIX 3: INITIAL PARTICIPANT EMAIL ........ 324
APPENDIX 4: INFORMATION PACK ........ 327
APPENDIX 5: PARTICIPANT SCREENING ........ 335
APPENDIX 6: CONSENT FORM ........ 336
APPENDIX 7: PRE-INTERVIEW BRIEFING AND DE-BRIEF ........ 337
APPENDIX 8: USEFUL RESOURCES FOR PARTICIPANTS ........ 341
APPENDIX 9: ETHICAL AND R&D APPROVALS ........ 343
APPENDIX 10: TRANSCRIPTION AGREEMENT ........ 352
APPENDIX 11: AUDIT TRAIL: INTERVIEW 7; CATHERINE ........ 354
APPENDIX 12: SUPERORDINATE THEME TABLE, BY PARTICIPANT ........ 363

# ABSTRACT

**Aim:** According to the existing evidence-base, the experience of the death of a therapy client (from a cause other than suicide) for Clinical Psychologists is substantially under researched. Moreover, previous studies into the experience of patient or client death for healthcare professionals indicate this may be an important focus for research. The present study aimed to explore the often unheard, lived experiences of client death for Clinical Psychologists at the beginning of their career. It was hoped that these research findings may assist training courses, clinical supervisors and other Psychologists of all grades to make sense of this experience in greater depth.

**Method:** A qualitative approach was adopted for this study. Semi-structured interviews were conducted with nine female junior Clinical Psychologists (Trainee, Newly Qualified) who had experienced the death of a client. The accounts were analysed using IPA, which attempts to illuminate the lived experience of a phenomenon for small samples of individuals.

**Results:** The analytic procedure highlighted three main themes as emerging from participants' accounts in the context of their client's death: *Connected and affected: Being unprepared for initial reactions to the client's death; 'we do it so why can't you?' facing institutional denial and avoidance; 'It's not something I've forgotten about', The lasting impact of client death: Learning reluctant lessons and experiencing continuing bonds.*

**Implications:** This study highlights the importance of recognising the impact of client death on Clinical Psychologists in particular, and healthcare professionals in general. Client death, by all causes, appears much overlooked within the current research base, which may have led to a self-perpetuating cycle of hidden and unspoken stories. The findings indicate death needs to be on the research and teaching agenda within the institution of Clinical Psychology. As a result we may be able to begin to break the current cycle of silence which has served to

potentially disservice us as professionals, our teams and most importantly our clients.

# INTRODUCTION

*‘Any man’s death diminishes me, because I am involved in mankind.’*
*John Donne, 1572-1631*
*(Donne, Hamilton, & Patrides, 2001)*

I have chosen the above quote as it reflects my position clearly. I believe that death touches many, if not all of our lives. As a result the following qualitative study will be focused on the experience of client death, from a cause other than suicide, for Clinical Psychologists at the beginning of their career.

## INTRODUCTION TO THIS CHAPTER

My research has been a long but rewarding journey. For this reason I wish to begin my introductory chapter by introducing the person who went on this journey (me), how I came to follow and progress down this particular path, and why I feel the experience of client death for Clinical Psychologists is an important focus for research.

Following this, I aim to provide the reader with a general introduction to the area of death, bereavement and grief. I will start to define how death, bereavement and grief will be understood for the purpose of my study, whilst also introducing the relevance and prevalence of death for health professionals within the context of the United Kingdom.

In order to provide a general introduction to the area of bereavement and grief a brief summary and history of the research base will be provided. Due to the vast amount of research in the area I will only be able to pay particular attention to the themes and developing trends over the past 20 years.

I will then move on to provide the reader with an insight into the availability of research into the experience of client or patient death for healthcare professionals in general. Following this, a critical review of the limited empirical and theoretical literature available in this area will be undertaken with the aim of highlighting the issue of death, bereavement and grief as an important, under-researched issue for health professionals in general, and Clinical Psychologists in particular.

I will show that the lack of available research in this area supports a qualitative approach to my study as this approach may begin to help us understand the experience of client death for Clinical Psychologists at the early stages of their careers.

Finally, this section will conclude by introducing the aims of the current project.

## OWNING ONE'S PERSPECTIVE

Elliott, Fischer and Rennie (1999, pg.221) believe that 'owning one's perspective' is important in the construction and development of good qualitative research. To be aware of one's position and ensure that this is clear to the reader is important, and this is how I aim to begin (Elliott, Fischer, & Rennie, 1999).

By being transparent about my position I hope the reader may begin to understand who I am as a person and a researcher, what I bring to this piece of work and my beliefs about this topic area.

### *My position: As a person*

My Mum and Dad tell me I was always a curious child. One of my first words was 'Hello!'

I have always been shy but quietly sociable. Always much more interested in the position of observer as opposed to being the centre of attention. In fact my friends tell me off for this, as I often listen without saying much at all.

Through observing and listening for much of my life I have become more and more fascinated in the untold stories of human existence, rather than those that played out in full Technicolor (the birth of a child, or the wedding of a friend).

It is the unspoken, sometimes feared, 'messy' topics of our lives, death and loss in particular, that have become of real interest to me.

Perhaps this started with the death of my dear granddad when I was twelve. I remember this very clearly. I do not remember the funeral or the kind words people said about him, but I remember the silence that replaced him and the silent tears I watched my dad cry.

Also, when my uncle committed suicide in 2001, it was not the shock and disbelief I remember or the anger I felt towards him at the time. I hold on to the memory of my mum crying for the loss of her brother, and my grandparent's disbelief at the loss of their son.  But more than this, I recall both of these events quickly becoming shut down and unspoken.

Over time I have observed how feared death and loss can be and this has fascinated, intrigued and scared me.

### ***My position: Theoretical***

I recognise that my own experiences are only one side of the coin. Should I speak to my dad about his father's death he may tell me a different story now (2009). This new story may be affected by many factors, the passage of time, our ages and relationship as father and daughter and even my current position as a Trainee Clinical Psychologist. I believe, however, that this story will be no less valid.

The unique, multi-storied nature of human experience (White, 1995) has always been of interest to me and these beliefs have influenced many areas of my life, from home to my clinical work. My beliefs that there are multiple, socially constructed realities and my resistance in believing in one single truth means my ontological position is relativist as opposed to realist (Guba & Lincoln, 1989). Subsequently I assert my theoretical position as Constructivist (Guba & Lincoln, 1989).

My Constructivist position means that I also believe in the interactional, co-constructed nature of knowledge. Guba and Lincoln (1989) define this as an interactive as opposed to interventionist epistemology.

Methodologically it is suggested that the Constructivist paradigm adopts a hermeneutic position (Guba & Lincoln, 1989). The hermeneutic position goes beyond the description of experiences and looks into their meanings (Lopez & Willis, 2004). As a result Constructivist theorists state that activities such as research should be carried out in a way that illuminates a variety of constructions about a topic and in turn, enables the development of co-constructed meaning (Guba & Lincoln, 1989). A single explanation for a complex phenomenon is deemed impossible (Appleton & King, 1997; Guba & Lincoln, 1989).

As ever, this position is not without its criticism. Often adopting a Constructivist, generally qualitative, position as a researcher may lead to criticism about poorly controlled and unscientific findings. However, with time and effort such claims can and will be actively managed throughout this project (Elliott, Fischer, & Rennie, 1999). Please see my method section for more detail with regards to these issues.

### ***How I came to this study***

My second placement on Clinical Psychology training at the University of Hertfordshire started me on my long journey with my research idea.

It was here that I again lost someone with whom I had developed a close relationship. Although I knew he was unwell, I did not feel that the time and date of his death was predictable and his loss came as a shock. This person was not a family member or a friend, but *a client*.

The experience of losing a client provided me with an opportunity for reflection and consideration of what it is like to experience death not only in the work place, but also as a trainee and as a person. I felt the bond of the therapeutic relationship placed me in a difficult position. I valued the time I had with my client; we had developed a great rapport and then he was gone. If this were a family member I would have attended the funeral, spent time with family and held on to my own personal grief, yet I felt confused about what to do after he died.

I wondered if there were other psychologists in my position; I wondered what or who had helped them, yet those around me (my colleagues, course team members, my supervisors) and the existing literature could tell me very little about the experience within our profession (Schwartz, 2004).

I began to ask around within my training cohort to establish if my experience had been out of the ordinary. Was it unusual to experience the death of a client from a cause other than suicide in mental health settings? As I went around the room I realised it was not. From my brief survey, seven out of fifteen trainee colleagues had experienced the death of a client prior to and/or during training. I realised at this point that this could be a valuable focus for my third year research project.

As I embarked on increasingly systematic journey of literature searching and reading around the impact of death for other healthcare professionals, I realised that interest had been building in this area over time. Despite there being very few publications, I remained encouraged.

During the process of building on my project idea I have been privileged to hear many informal narratives of the experience of a client's death, which I am grateful for. Over time, there were many unheard stories about this experience, both positive and negative and my research aim was to hear and understand these subjugated voices (Sori & Hecker, 2008).

## BACKGROUND

### *Defining Death, Bereavement and Grief*

Death is defined as a universal human experience which can occur at any age (CAH, 2004). It has been constructed as the action or fact of dying; the instance of a person dying or the end of something (Soanes & Hawker, 2005).

As a result of death it is suggested that many people will experience bereavement. Bereavement is defined as the loss (a term which is often used interchangeably) of a loved one (CAH, 2004). It has also been suggested that individuals may experience grief, defined as the resulting emotional milieu and distress the bereaved experience (CAH, 2004). The terms death, bereavement (loss) and grief, as defined above, will be used throughout this study.

### *Introducing the issue: Death statistics and implications for healthcare professionals*

The Department of Health suggests there has been a limited amount of personal and professional dialogue about death in the United Kingdom (DOH, 2008). This lack of dialogue is suggested to have served to place the experience of death and bereavement low on the social and political agenda (DOH, 2008), inadvertently impacting the availability and provision of services for the dying and bereaved (DOH, 2008).

To combat this the Department of Health have, only recently, placed death on the national agenda (DOH, 2008). In their publication concerning the provision of care at the end of life, they assert the importance of psycho-social care for the dying and bereaved (DOH, 2008).

It has long been recognised that those who die will not do so in a vacuum. The deceased will, more than often, have been surrounded by their families, friends and often healthcare professionals who exist within a particular socio-political context. Such systems may have mediated the person's experience of death and consequently affected those who continue to survive (CAH, 2004; DOH, 2008; Neimeyer, 2001b).

### *Prevalence*

The Office for National Statistics (ONS) recorded a total number of 504,052 deaths in the United Kingdom and Wales in 2007. Mortality Statistics indicated that 58% of deaths registered in 2007 occurred within a hospital setting. Such statistics indicate that many healthcare professionals, such as Doctors and Nurses, will be involved in caring for a patient at their time of death.

In relation to mortality rates in mental health or psychiatric settings the Office for National Statistics (2007) reported 3325 deaths. This number appears small in comparison to deaths in general hospital settings (<1%) meaning these deaths appear to receive little attention.

It has been illustrated however, that 98% of deaths within psychiatric units in the United Kingdom and Wales were caused by health related problems. Less than 2% were recorded as external causes of morbidity such as suicide (ONS, 2007). These findings indicate mental health professionals are likely to be involved and working with individuals around the time of their death. At present statistics relating to the number and types of healthcare professionals, for example Nurses and Psychologists, involved with individuals who have died is not available.

However, it could be argued that the numbers are significantly higher than current records suggest.

To conclude, death and bereavement can be constructed as a universal experience that affects us all. Statistics illustrate that most deaths in the UK will occur in healthcare settings, with both physical and mental health practitioners being involved in end of life care.

It may be possible to argue here that the experience of death for healthcare professionals, from a cause other than suicide, may be a valuable area for research. Particularly as the existing research base considering the experience of suicide for many professions such as psychology, psychiatry and nursing, appears better resourced (Linke, Wojciak, & Day, 2002). Alongside this, is the Department of Health’s drive to increase psycho-social care at the end of a persons’ life (BPS, 2008; DOH, 2008).

## A BRIEF HISTORY OF BEREAVEMENT AND GRIEF RESEARCH

Death and resulting issues of bereavement and grief have been shown to be an important focus for academic and clinical research (Bonanno, 2001; CAH, 2004; Gillies & Neimeyer, 2006; Jeffreys, 2005; Katz & Johnson, 2006; Klass, Silverman, & Nickman, 1996; Kubler-Ross, 1969; Matsuyama, 2005; Neimeyer, 2001a, 2001b).

Over the last twenty years there have been many attempts to shed light on the experience of bereavement and grief, for various groups, from spouses and parents (Jeffreys, 2005; Klass, 1996; Klass, Silverman, & Nickman, 1996; Moulton Milo, 2001; Neimeyer, 2001b), to hospice workers and medical professionals (CAH, 2004; Hopkinson, Hallett, & Luker, 2005; Papadatou, 1997, 2000; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Swanson & Cooper, 2005; Worden, 2002).

As research in this area has been varied and extensive, with multidisciplinary contributions, it will not be possible to provide a comprehensive summary of all available literature. Instead, this section will attempt to focus on the main themes and trends in bereavement and grief research over the years as identified by relevant review papers and summaries (Bonanno, 2001; CAH, 2004; Gillies & Neimeyer, 2006; Neimeyer, 2001a; Stroebe, 2001; Stroebe, Hansson, Schut, & Stroebe, 2008; Stroebe & Schut, 1999).

### ***Themes and trends in bereavement and grief research***

In a recent review commissioned by the Project on Death in America in 2004, the Centre for the Advancement of Health were asked to report on the current state of bereavement and grief research (CAH, 2004). This report served to update an earlier publication produced by the Institute of Medicine named; Bereavement: Reactions, Consequences and Care (Osterweis, Solomon, & Green, 1984).

The Centre for the Advancement of Health (2004) examined a number of resources including review articles and major publications in order to identify key themes and trends in grief and bereavement research (Bonanno, 2001; Stroebe, 2001) . All review papers acknowledge that the themes identified were not definitive, and the following review shares this position (Bonanno, 2001; CAH, 2004; Gillies & Neimeyer, 2006; Neimeyer, 2001a; Stroebe, 2001; Stroebe, Hansson, Schut, & Stroebe, 2008; Stroebe & Schut, 1999).

Despite the universal nature of the experience of death, it appears that no one theory, or predicted trajectory for bereavement dominates (Bonanno, 2001; Stroebe, 2001; Stroebe, Hansson, Schut, & Stroebe, 2008). Models which had traditionally brought our attention to the experience of grief and bereavement, for example Psychodynamic (Freud, 1957) and Attachment perspectives on grief (Bowlby, 1969, 1973, 1980) now appear to be accompanied by many varied theories developed by a multitude of professional disciplines (Neimeyer, 2001b; Papadatou, 2000; Stroebe, Hansson, Schut, & Stroebe, 2008; Worden, 2002).

Current trends appear to pay attention to a multitude of factors that may mediate the experience of bereavement (CAH, 2004; Stroebe, Hansson, Schut, & Stroebe, 2008). These include the quality of our relationships with the deceased, our own histories of loss, whether our losses are recognised and how we came to be bereaved e.g. sudden or expected (Doka, 2008; Neimeyer, 2001b; Papadatou, 2000; Stroebe & Schut, 1999).

Trends seem to suggest that there has been a move away from internal psychological processes alone in order to acknowledge social, contextual and environmental mediators of the experience and the course of bereavement and grief (Stroebe, 2001; Stroebe, Hansson, Schut, & Stroebe, 2008). Such an acknowledgement may be particularly important for the current investigation as a client’s death will have occurred in a particular professional context.

### ***Relevance of Death, Bereavement and Grief for Healthcare Professionals***

With regards to death, bereavement and grief for professionals working within a healthcare setting, recent review articles indicated that this is a traditionally under-researched area (CAH, 2004; Katz & Johnson, 2006; Redinbaugh et al., 2003). To illustrate this a review in 1984 concluded no empirical evidence had been available on this issue whatsoever (CAH, 2004; Osterweis, Solomon, & Green, 1984).

Fortunately the research base in this area is now growing. In 2004 the Centre for the Advancement of Health identified thirty-six qualitative and quantitative studies, of sufficient quality and rigor, relating to the education of healthcare professionals on issues of death and dying, their experiences of bereavement and grief, and the potential stresses of working in this area (CAH, 2004).

## THE EXPERIENCE OF CLIENT DEATH FOR HEALTHCARE PROFESSIONALS: EMPIRICAL RESEARCH

Following a systematic review of the literature in this area, a very limited research base has been identified in fields such as medicine, occupational therapy and psychological therapy in general (Baverstock & Finlay, 2006; Cipriani et al., 2000; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Schwartz, 2004).

The following section will explore the experience of death for healthcare professionals by focusing solely on studies where the impact of an actual, as opposed to hypothetical, death has been explicitly investigated.

In relation to the experience of a patient's death for nurses, I have decided to focus on evidence-based theoretical models as opposed to the entire nursing research base concerning this issue (Kaplan, 2000; Papadatou, 2000). This is primarily due to having limited space, coupled with a recognition of the slow but growing acceptance of the impact of death on nursing professionals (Hopkinson, Hallett, & Luker, 2005). Also this literature often focuses on specific issues such as hospice nursing, whereas my aim is to highlight general findings in this initial stage (Cipriani et al., 2000).

### *Medical Doctors*

Research examining the experiences of death for medical professionals is growing but still very limited. My literature search identified four papers on this topic (Baverstock & Finlay, 2006; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005)

Redinbaugh et al (2003) aimed to explore the emotional impact of a ‘typical’ patient death for medical doctors in the United States using a cross-sectional quantitative and qualitative design (Redinbaugh et al., 2003). The term ‘typical’ did not appear to be clearly defined by the researchers.  The rationale for the study related to ‘mostly anecdotal’ literature which indicated working with the dying was linked to feelings of sadness and guilt, as well as professional burnout and psychiatric disturbance (Redinbaugh et al., 2003, p. 1).

Participants, UK equivalent Consultant grades, Senior House Officers and junior doctors, were selected through regular reviews of inpatient records. These records held details of adults who had died in a general hospital or intensive care setting. Doctors involved at the time of the patient’s death were then identified and, as a result, 251 doctors were asked to participate and 188 doctors were included in the study’s final sample. Of these doctors less than a third (28%) had cared for their patient for more than one week (Redinbaugh et al, 2003).

All participants completed a questionnaire about the death they had experienced. They also completed three further psychometric measures; The grief reaction scale (Jacobs et al., 1986), the brief Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979), and the Brief COPE (Carver, 1997).

The results indicated that almost a quarter of the sample had found the death ‘very disturbing’ (Redinbaugh et al, 2003). Over a third of the doctors felt the death evoked strong emotional reactions such as feeling upset or numb. Redinbaugh et al (2003) also found that increased contact with patients led to descriptions of closer relationships and stronger reactions to the deaths.

Sources of support following a patient’s death included the supervising Consultants and spouses/significant others. Although, most Senior House Officers and junior doctors reporting a preference for support from one another (Redinbaugh et al., 2003). An important finding however, was that whilst a large number of doctors found their patient’s death upsetting and numbing, almost a quarter (24%) found no coping strategy helpful, increasing to almost half (46%) for Consultant grade clinicians.

Although the type of emotional reaction did not appear to be affected by level of training e.g. doctors of all grades experienced sadness, Junior doctors were reported as asking for significantly more emotional support than Consultant grade doctors (Redinbaugh et al., 2003). Female doctors were also noted as needing greater emotional support in general (Redinbaugh et al., 2003).

Rebinbaugh et al’s (2003) research was interesting and this is a well-reviewed, sufficiently powered investigation. However, this study also evokes many questions. Firstly, in relation to the active sampling method, I am left wondering about those who declined to participate; the unsaid stories. From an ethical standpoint, what it may have been like to have been approached for participation following a patient death.

Secondly, in relation to the study's findings I am curious about the possible variation in gender specific acceptability of emotional expression in a medical context, a factor unaddressed by this study. I am also curious about the contextual or individual acceptance of emotional expression for senior medical clinicians as they were no less affected by the death but less likely to find coping strategies helpful.

The second questionnaire-based study focused on the emotional responses of 42, UK-based, Specialist Paediatric Registrars towards a child's death (Baverstock and Finlay, 2006). The results indicated very few Registrars reported having enough time to reflect on the death of their patient (9%). The results also indicated that over a third of the Registrars still had 'unresolved issues' relating to the death of a child (41%) and almost all participants still thought about a particular child's death (91%), particularly those who were parents themselves (Baverstock & Finlay, 2006).

Most Registrars described a dual role of being supported and supportive. They reported being most likely to provide support for nurses and Senior House Officers following patient death (62% and 51% respectively) and seeking support from their Consultants (76%), their partners (69%) and family/friends (50%).

From a critical perspective, this paper was difficult to understand as the authors do not present any demographic or contextual participant data such as gender or the amount of patient contact, factors which have been highlighted as potentially important in previous research (Redinbaugh et al., 2003). The research also leaves unanswered questions about the emotional impact of a child's death for Specialist Registrars. This finding remained unreported despite the research aims.

I am interested in how the authors explicitly frame the death of a child as a 'tragic' experience in their discussion of results, a position which is not explicit earlier in the paper. This leads me to wonder if there was an assumption on behalf of the researchers that all participants would experience death in this way, as opposed to being open to multiple stories of the experience of a child's death.

In spite of the above issues, Baverstock and Finlay's (2006) paper did highlight some useful findings, for example, the importance of formal and informal support structures for Specialist Registrars and the dual role of being supportive and supported as senior clinicians.

More recently Moores, Castle, Shaw, Stockton and Bennett (2007) conducted a study of UK medical professionals' reactions to a patient death which had been memorable for any reason. They surveyed 188 doctors (78.7% response rate) of all grades, using opportunity sampling and a questionnaire based on Redinbaugh et al's (2003) research and feedback from their own pilot study. The primary justification for this study related to the authors' concerns over the lack of training doctors received in coping with emotional work-related experiences (Moores, Castle, Shaw, Stockton, & Bennett, 2007).

The findings illustrated that the most memorable death for the doctors was rated as both disturbing and professionally rewarding, with Consultant grades being most likely to report feeling rewarded (Moores et al, 2007) In contradiction with previous research, gender and professional grade, did not appear to be associated with different responses to a memorable death as a small but significant percentage of participants experienced moderate to severe reactions regardless of these factors (<17%). The reactions included problems sleeping, changes in appetite and feelings of anger. Sadness of a moderate to severe degree was reported by just under half of those surveyed (43.7%). The only finding related to gender differences, appeared to be the increased likelihood of female doctors to report crying in response to death (Moores et al, 2007).

There was a non-significant relationship between the exposure to previous training and mediated responses to a death. In spite of this, over half of participants felt they could benefit from further training (57%) and a fifth of the sample felt they would like access to a trained counsellor in such challenging circumstances (21.8%). Participants perceived an increased need for training and support where intense reactions were indicated e.g. fear, loss of confidence (Moores et al, 2007).

Moores et al (2007) argue that their findings serve to demonstrate that doctors are human and compassionate, marked by their emotional reactions following a memorable death. This assertion potentially highlights such qualities as unfamiliar and unacknowledged within this profession. The authors also present death as a positive learning opportunity for a proportion of doctors, an interesting and novel idea in the context of the previous research findings. Moores et al (2007) also argue that repeated exposure to emotionally provoking circumstances, such as death, could become a potential source of burnout when unsupported.

It was interesting to note that senior professionals in the UK sample were more likely to present an emotional reaction to death when compared to the US sample (Redinbaugh et al, 2003). Perhaps Redinbaugh et al’s (2003) earlier work has filtered into the medical profession in the UK; raising an awareness of, and increasing the acceptability of emotional reactions to a patient’s death. Or this could have been related to cultural differences between the UK and United States.

In conclusion, Moores et al (2007) argue further research is needed into the experience of patient death for medical professionals. They also argue that a more pro-active stance to normalising emotional reactions coupled with an emphasis on emotional coping strategies at an undergraduate level may be helpful, a suggestion applicable across professional groups.

### *Medical students*

Rhodes-Kropf et al (2005) conducted a study focusing on the experience of a 'memorable death' for 65 randomly selected, third year medical students in the United States. This investigation used open−ended and closed questionnaires and a further 36 semi-structured interviews with its participants focusing on this experience (Rhodes−Kropf et al., 2005, pg 635). This research was also closely linked to that of Redinbaugh et al (2003).

Rhodes-Kropf et al (2005) reported that two-thirds of the participants had experienced one death on training so far (66%). Almost half of the participants had known their deceased patients for more than four days and over three-quarters rated themselves as not at all or minimally close to their 'memorable' patient (77%). Factors such as length of time with the patient, closeness of relationship and participant demographic data were recorded and considered in the data analysis.

Findings from both the questionnaire and interview data highlighted four main themes in the participants' responses including; the experience of strong emotions in reaction to death; the use of multiple strategies for coping with the death; a perceived lack of support from their team; and death and emotions as negative aspects of their profession (Rhodes-Kropf et al., 2005).

The study reported that the majority of medical students had found the memorable death highly or moderately emotionally powerful (86%). Further to this, a linear relationship between degree of individual disturbance and emotional impact was also found e.g. the more powerful, the more ‘disturbed’ a person was (Rhodes-Kropf et al., 2005).

For many medical students in the study, their most memorable death was often the first death they had experienced (Rhodes-Kropf et al., 2005). In addition to this, an unexpected difficult death or sudden loss was experienced as highly powerful, often evoking visual memories of this event. The emotional reactions of medical students, commonly sadness or shock, did not appear to be related to the time spent with their patient (Rhodes-Kropf et al., 2005).

The ‘memorable’ deaths raised questions of competency for the students and issues of self-relevance (Rhodes-Kropf et al., 2005). Coping strategies such as talking to others and avoiding the issue were used and participants seldom reported support from their training institution (Rhodes-Kropf et al., 2005). In relation to workplace support, two-thirds reported the death was not discussed within their medical team (66%). When discussion took place it rarely focused on the psycho-social aspects of the death (Rhodes-Kropf et al., 2005). As a result of such factors, coupled with the observed behaviour of more senior medics, medical students reported learning two main messages during their training: Doctors should not have emotional reactions to death and death is a failure (Rhodes-Kropf et al., 2005). Rhodes-Kropf et al. (2005) argues these constructions should be addressed, a finding in line with the later study by Moores et al. (2007).

In conclusion, this study served to raise the importance of issues such as the impact of experiencing a first patient death and also the impact of an unsupportive system on a participant's beliefs about their profession (Rhodes-Kropf et al., 2005).

Rhodes-Kropf et al (2005) have critiqued their study for its small sample size, however, from my Constructivist, qualitative perspective, I wondered if their sample was too large. The interview data, and illustrating quotes used throughout the paper was rich in emotion, indeed the study was named 'This is just too awful; I just can't believe I experienced that…'. Therefore, it may have been interesting for this element of the study to be expanded, although I am aware of my own bias in this suggestion.

Although the above research is not without its flaws, it appears that the findings from all studies have highlighted the experience of death for medical professionals as being in need of more attention. The studies have highlighted that patient death is not simply an important experience because of the physical event itself, it may also be mediated by a number of factors such as the acceptance of emotional expression in the workplace and the availability of support (Baverstock & Finlay, 2006; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005).

### ***Non-medical professionals***

My review will now consider the experience of client death for non-medical professionals. My literature search of this area has revealed one published and one unpublished study explicitly relating to this experience (Cipriani et al., 2000; Schwartz, 2004).

Other papers identified related to hypothetical scenarios with death and dying, death anxiety and suicide (CAH, 2004; Kirchberg, Neimeyer, & James, 1998; Linke, Wojciak, & Day, 2002). Although I acknowledge these important studies, I have excluded them from this review due to my focus on the experience of an actual death from a cause other than suicide.

### *Occupational Therapists*

Cipriani et al (2000) conducted a study focused on the experiences of client death for forty-three Occupational Therapists (OTs) in the United States. This study used questionnaires and four further in-depth interviews to explore this issue. The participants were mostly female (87.5%), had an average age of 36 years, and, on average, 8 years clinical experience (Cipriani et al., 2000).

The findings illustrated that almost the entire sample had experienced the death of a client (95%), with over half experiencing ten or more deaths (within long-term care settings). Half of the sample reported a client's death in the month prior to returning their questionnaire (Cipriani et al., 2000). They also highlighted the use of many coping strategies by OTs following a client's death. These included believing a patient was at peace and viewing death as part of life. The participants also recounted talking to co-workers and offering support to the bereaved family as a means of coping (Cipriani et al., 2000). However they also described becoming detached or used to death (15%).

In line with the previous medical literature, over a third of the OTs surveyed reported receiving no support from their work place or educational institution (prior to qualification). It appeared less formal support systems such as talking to colleagues, were preferable to education and literature on this matter (Cipriani et al., 2000) .

The interviews, conducted with one male participant and three female participants, added a greater depth to the understanding of the experience of a client's death. From this, Cipriani et al (2000) identified three major themes in the participants' stories; connecting to the death, a lack of education and the value of experience and maturity.

For some feeling connected to the death, meant they had had a personal experience of loss (death/divorce) which increased their empathic capacity or ability to cope with client death (Cipriani et al., 2000). In relation to education, all four interviewees described receiving much of their training within their jobs, particularly in hospice settings, as opposed to during undergraduate training (Cipriani et al., 2000). The value of experience and maturity was related to a belief that such characteristics enhanced a person's ability to cope with death. Greater experience provided comfort whilst increasing the likelihood of participants being honest about their support needs. Cipriani et al (2000) indicate these findings as being supported by the least experienced interviewee.

Cipriani et al's (2000) study clearly produced some interesting findings, particularly as almost all participants had experienced a client's death. However, a note of caution accompanies this finding too, as individuals who had experienced a death were perhaps more likely to return the questionnaire, meaning the statistics could be disproportionate.

From a critical standpoint, the sample size for the qualitative arm of this study was acknowledged as a limitation by the authors, however, a more appropriate criticism may have been the limited use of supportive quotes within the paper (Cipriani et al., 2000). Supportive quotes were discussed as a way of providing 'truth-value' or validity to the analytic process within this study (Cipriani et al., 2000, pg 69). However, these quotes were often poorly presented or summarised by the authors of the paper, without explanation. This meant it was difficult to get a sense of the shared and unique experiences of the four interviewed participants, in the context of client death. Further to this, the emotional experiences of OTs also remained excluded from the study's findings and I am left curious about this. Again this paper positions death as a difficult experience and I wonder if this influenced the authors' ability to hear multiple constructions of client death.

The results overall, as with previous studies, have highlighted the importance of informal support and the general absence of educational or workplace preparation (Cipriani et al., 2000). Furthermore, factors such as experience or having personal connections with the death was positive. It also appeared that a client's death may be more difficult at an earlier age and career stage, which related well to previous findings for medical students (Cipriani et al., 2000; Rhodes-Kropf et al., 2005).

### ***Psychological Therapists***

The final research study I will present in greater detail is an unpublished PhD thesis from the United States (Schwartz, 2004). The use of this unpublished study was carefully considered. It is fully recognised that there may be many drawbacks and benefits to using unpublished research. From a critical perspective, this PhD is not easily accessible to the public, although it has been examined it may not have been extensively peer-reviewed, and therefore its quality may not be assured. Also it has not been completed at a UK academic institution and therefore assessment standards may differ (in both ways e.g. more stringent, less stringent examination criteria). However, to have discovered and discarded this study, in the context of it being the only available, closely linked study I have uncovered would have meant my literature review would be overlooking important and relevant data. Therefore its use is justified.

This PhD, despite being lengthy and time consuming to read, provides a useful insight into therapists' experiences of client sudden death, from a cause other than suicide (Schwartz, 2004). Sudden death, in this studies context, was defined as being distinct from a death that could be predicted (e.g. chronic illness), or purposeful (e.g. suicide).

Schwartz (2004), a Counselling Psychologist who experienced her own client's death, describes an insufficient amount of literature pertaining to this issue. This lack of empirical grounding enabled Schwartz (2004) to justify a qualitative, phenomenological approach to her investigation and the use of one or two, sixty to ninety minute, semi-structured interviews with each participant.

A total of nine therapists who had experienced the sudden death of at least one therapy client took part in this project. The sample consisted of four qualified Psychologists with ten to twenty-six years experience (Clinical/Counselling), three Clinical Social Workers with six to ten years experience and two Trainee Psychologists (US equivalents) with five to six years experience. Schwartz (2004) had initially specified a minimum of six months contact with the deceased client however, this criteria was broadened as it excluded many suitable and interested participants.

It is important to acknowledge at this stage that this piece of research was very detailed and lengthy as it is an original, five-year PhD. Therefore, it will only be possible to present the studies key findings here (Please see Schwartz, 2004, for a full account).

From a descriptive phenomenological analysis of the transcribed interviews Schwartz (2004) uncovered five main themes relating to the experience of sudden client death: attachment in the therapeutic relationship; therapist bereavement; the therapist left holding the bag; coping with client sudden death, and, lessons learned.

Attachment in the therapeutic relationship referred to the quality and unique nature of therapists' relationships with clients and also the maintenance of the attachment in the face of death (Schwartz, 2004). In this theme it was emphasised that where a therapist perceived a good attachment with a client, related to both positive and negative aspects of a therapeutic relationship, the death was experienced at a deeper, emotional level. Importantly though, it was noted that those who described a lesser degree of attachment still experienced feelings of loss (Schwartz, 2004).

How the therapist found out about the death and their initial reactions were the focus of the second theme, therapist bereavement. Therapists described a multitude of emotional, cognitive and physiological reactions on hearing about the death of their client. These experiences included feeling shock, disbelief and sadness, feeling shaky, tearful and sick, and dreaming about their client. However therapists' difficult feelings improved over time (Schwartz, 2004).  The impact of concurrent life events (death/divorce) also influenced reactions, as therapists found it difficult to disentangle their experiences.

Therapists' bereavement was a very rich theme. Here Schwartz (2004) explored the applicability of Doka's (1989) concept of disenfranchised or unrecognised grief to her data. She suggested participants had experienced workplace disenfranchisement; the workplace did not recognise the death. At least six therapists had experienced academic disenfranchisement; not being exposed to the idea of death during training. Finally, Schwartz (2004) also described self disenfranchisement, where therapists did not view themselves as having the right to mourn. This appeared to be related to a fear of judgement by others, the difficult nature of a professional relationship- being close, but maintaining distance- and a concern about upsetting the client’s family.

The third theme, ‘left holding the bag’ was related to a sense of uncertainty and unfinished endings in the face of the death. Death was reflected upon as the ultimate termination which evoked feelings of regret and sadness at not being able to say goodbye (Schwartz, 2004). Knowing intimate details about clients and having contact with families after the death was difficult and anxiety provoking too. Some therapists felt unsure of a family’s knowledge of their clients’ problems.

The fourth theme, coping with the death, involved eliciting support from friends, family and therapists, attending rituals such as funerals, as well as allowing themselves to feel their evoked emotions. The therapists found support from colleagues the most useful, with some describing a struggle in deciding whether to discuss their experience with a supervisor (Schwartz, 2004). Some therapists had found supervision useful, others indicated feeling misunderstood and pressured to discuss emotional reactions when they were not ready. It seemed difficult for reactions to be formalised in this way (Schwartz, 2004)

Schwartz’s (2004, p 340) interviews provided a space for her interviewees to impart ‘pearls of wisdom’ for those who may read the study. Here the interviewees reflected on what they might have liked to have known, and what they would tell other therapists about the experience of client death.

The many pearls of wisdom included:

- Expecting that you will have at least one if not more deaths throughout the course of your practice
- Expect all kinds of feelings which should be accepted and normalised rather than avoided
- Do not expect lots of support, you may have to rely on yourself
- The death will affect each of us differently
- Talk, talk, talk
- Know that the experience of client death can enhance you personally and professionally

It is clear that the experience of sudden client death, for the nine therapists in the study, had a significant impact. This included experiencing difficult reactions, feeling disenfranchised and needing to find support for the loss (Doka, 1989; Schwartz, 2004). This study also importantly highlights both the positive and negative personal, and professional, changes experienced by the therapist over time. This was clearly demonstrated in the many ‘pearls of wisdom’ the therapists presented (Schwartz, 2004).

Schwartz’s (2004) recommendations do indeed suggest that more research is needed in this area. She believed that such research could serve to normalise and recognise the deaths experienced by therapists (Schwartz, 2004). Further studies could also address the limitations of this one. To illustrate, although Schwartz (2004) purposely sampled for experiences of ‘sudden’ death, seven out of her nine participants believed the deaths could have been predicted either through their client’s risk taking behaviour or health issues. She found that even when an expectancy of death was present it still felt sudden, which may raise questions about the construction of expected versus sudden death.

Furthermore, it was recognised that Schwartz's (2004) sample of participants had a wide range of professional experiences and backgrounds, which raised unanswered questions about the influence of such factors. This issue could be addressed by sampling a more homogenous group e.g. one professional background of the same grade.

The analysis from this study was also fairly descriptive (with approximately 50 subthemes) and I wondered if a more interpretative analysis may have added richness to such an important study (Heidegger, 1962/1927).

Overall this study was an important, detailed, exploration of the experiences of client sudden death for a small sample of therapists in the United States.

### ***Relevant theoretical models***

The Centre for the Advancement of Health's (2004) review cited the work of two authors who had attempted to build theoretical models of healthcare professionals grief following a client's death (Kaplan, 2000; Papadatou, 2000). These models will be presented as they provide an insight into *how* professionals may cope with death.

Papadatou (2000) a Clinical Psychologist of Greek origin, was the first to publish her tentative model of a health professionals' grieving processes. She believed concepts such as 'burnout', defined as a loss of ability to cope with the emotional burden of work (Brennan, 2004), oversimplify the experience of death for professionals. She also believed that existing models of grief and bereavement may be inappropriate as they are designed to focus on the death of a loved one, as opposed to patients.

To combat her dissatisfaction with existing explanatory frameworks Papadatou (2000) developed a model based on her own professional experience and the results of a trans-cultural study concerning the death of a child for paediatric-oncology nurses in Greece and Hong Kong (Papadatou, 1997, 2000). To further inform the development of this model, systemic and phenomenological theories were utilised (Papadatou, 2000).

Papadatou’s (2000) theoretical model is process-orientated as opposed to linear, which fits well with recent trends in bereavement and grief research (See Figure 1: Model of Health Professionals Grief). As a result of theoretical influences it was also designed to highlight the importance of individual, social and contextual meaning making in the face of death. Further to this, loss transcendence; recognising and accepting death whilst creating a new sense of self and of life which extends beyond the work setting, was an integral part of the process.

From a critical perspective, although this model is acknowledged as useful and tentative, it has not been empirically validated and it can be understood as one possible, culturally-specific, construction of this experience. As the model was also based on the repeated deaths of children alone, it is specific and limited in its transferability. Again, it may be the death of a child is more challenging for some, and I am curious how the model may account for those who may not experience grief. At present it appears they may be described as ‘avoiding or repressing’, which may not provide an adequate representation of this experience.

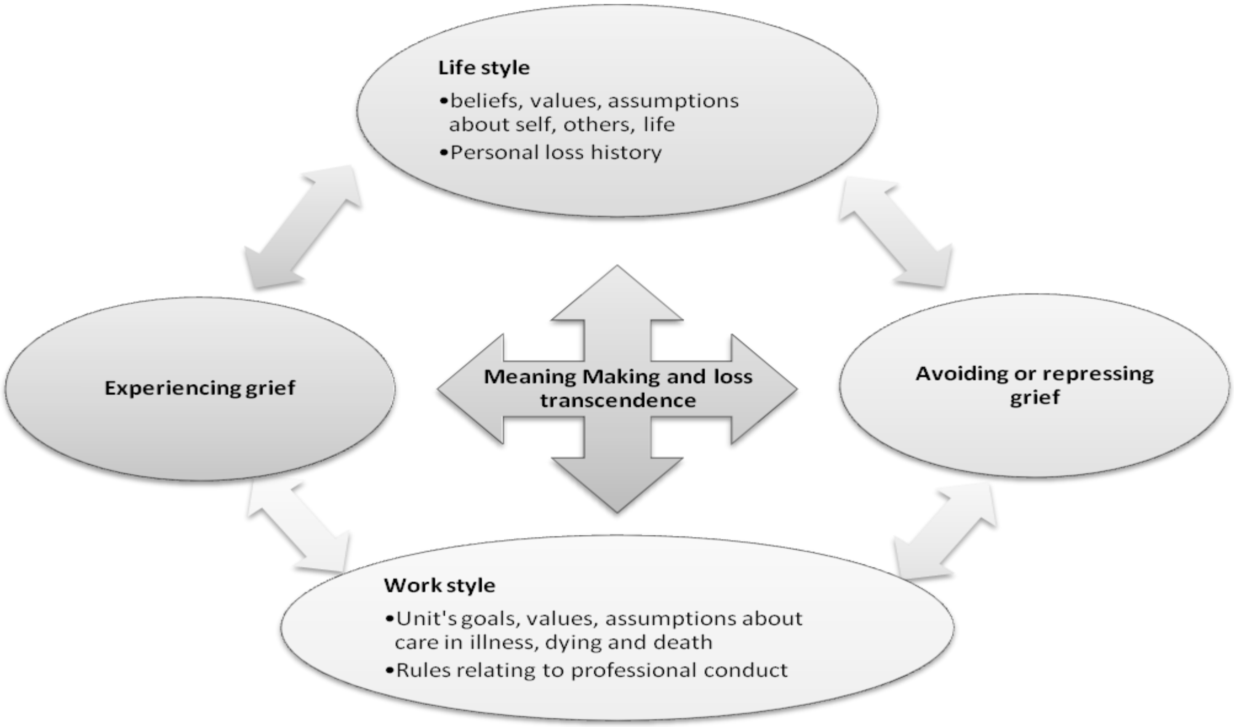

*Figure 1: Model of Health Professionals Grief (Papadatou, 2000)*

Further to this, Papadatou (2000) noted participants involved in her original study were mostly female nurses, with varying levels of experience, leaving questions about which experiences were prioritised during model development. These issues may be important as previous research suggests factors such as gender and experience may be important mediators of impact (Cipriani et al., 2000; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005).

To conclude, Papadatou (2000) suggested it is important to recognise grief and bereavement in work settings. She also believed this is an area in need of more general as well as specific attention, with a focus on issues such as training, the cultural mediators of death and specific experiences of death e.g. child/adult.

A second model of ‘caregivers’ grief in response to patient death has been proposed by Kaplan (2000). This model was also based upon American oncology nurses who had experienced multiple child deaths (See Figure 2: Model of Caregivers Grief). Kaplan (2000) suggested that for many, the death of a child evokes thoughts of an untimely death, coupled with feelings of stress and disbelief. Kaplan (2000) argues that for some, expected death is described as a ‘relentless prolonged horror’ for which paediatric professionals feel unprepared.

Kaplan (2000) conducted a qualitative, interview based study to explore this experience further. The findings of the study which included fifteen, mostly female nurses, served as the foundation for this tentative model (Kaplan, 2000).

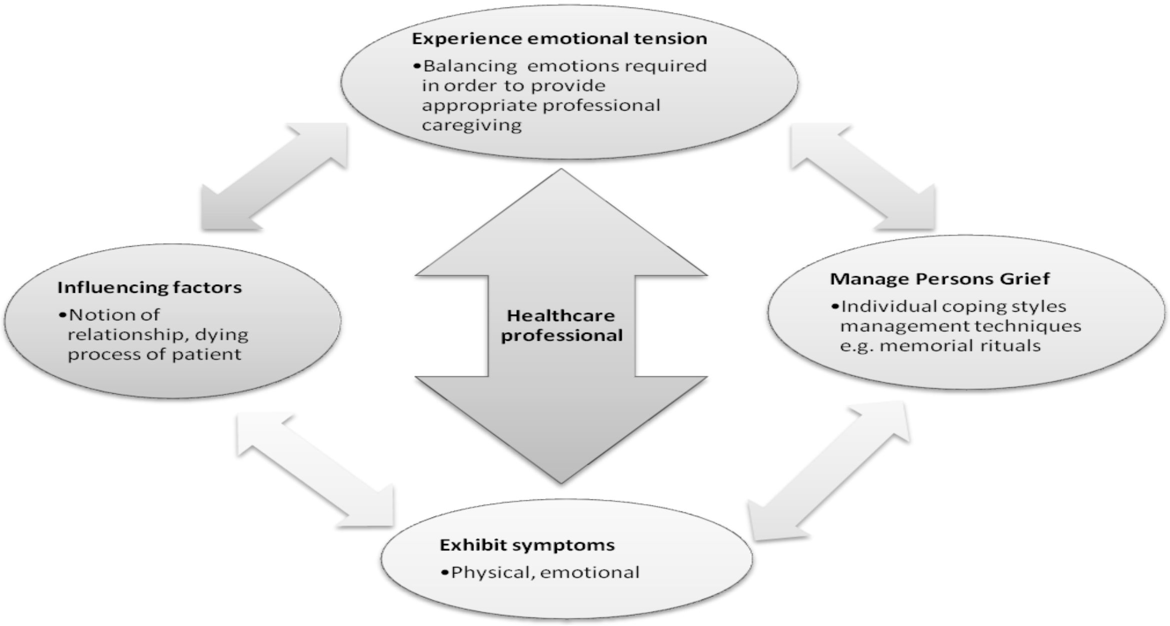

*Figure 2: Model of Caregivers Grief (Kaplan, 2000)*

Again this model is process-orientated and consists of three interactive, kinetic components; experiencing emotional tension; managing personal grief; exhibiting symptoms (Kaplan, 2000). The model suggests people work through and cope with client death by moving within and between these components. She also suggests that the idea of ‘working through’ is often overlooked in the workplace and in the context of a death (Kaplan, 2000).

Kaplan (2000) does present some interesting ideas about the process of coping with client death. However, this model appears to be limited in its generalisability as again it is focused on multiple child deaths for nurses, a niche area.

Overall, both models may provide a useful first step in understanding *how* healthcare professionals may work through their grief and bereavement in the face of a patient, or child’s death. Despite their niche focus, these models serve to highlight this issue as worthy of attention. Further to this both authors reiterate the need for more research into the experience of client death in multiple areas (Kaplan, 2000; Papadatou, 2000).

### ***Non-academic literature***

I felt it was important to briefly acknowledge the increasing number of anecdotal discussion papers or books which consider the experiences of client death for many varied professionals (Barnett, 2009; Duckett, 2005; Jeffreys, 2005; Katz & Johnson, 2006; Klass, Silverman, & Nickman, 1996; Matsuyama, 2005; Mirando, 1999; Reynolds, 2006; Swanson & Cooper, 2005; Wolpin, Chabner, Lynch, & Penson, 2005; Worden, 2002)

I will not be able to explore these papers and books, many of which have been inspired by the experience of client deaths, in depth here. Instead, I will focus on two discussion papers: one which illustrates an untold story of client death, and one which directly relates to Clinical Psychology in the UK (Duckett, 2005; Matsuyama, 2005).

Before these papers are discussed however, it is important to mention a body of literature which will be excluded from this study. Particularly, in the context of the recent publication ‘When death enters the therapeutic space’ by Barnett (2009); A book which considers life and death issues in therapy from an Existential perspective. Although I acknowledge Existential theory as a potentially useful addition to this literature review, my rationale for its exclusion, as noted previously, is due the immense theoretical diversity which already exists in the field of grief and bereavement research. Therefore if I were to include Existentialist theory, it is possible to argue I could add Psychodynamic theory, Personal Construct theory etc to this literature review. However, word constraints alone deem this impossible, but more than this I wanted to ensure my Constructivist framework remained as the central focus for this research project. It is important to note however (as will become evident in the method section) existential philosophers such as Heidegger, Sartre and Merleau-Ponty, have remained immensely influential throughout this project.

In a moving discussion paper, Matsuyama (2005), a psychologist herself, reflects upon her thoughts of an Oncologist who cared for her husband in his final days. She was comforted by the doctor’s display of emotions and grief in the face of her husband’s death. For me this paper emphasised not only the importance of how we as professionals manage grief following a client’s death, but how this is perceived by their families too.

Duckett’s (2005) discussion of client death for Clinical Psychologists in particular, presents ideas about professional issues surrounding death e.g. confidentiality, our responses as individuals, and our potential obligations toward families. Duckett (2005) argues it is inevitable that the death of a client (another fellow human being) will have an impact on us as professionals as well as people. He also reiterates a lack of focus on the experience of a death in the research base, whilst suggesting further examination of this issue may be fruitful.

## SUMMARY AND IMPLICATIONS FOR FUTURE RESEARCH

Death, despite being a difficult topic for discussion, is an important focus for research. Previous studies have shown that a lack of ability, or opportunity, to talk about death in general can have a negative impact on both patients and professionals (Baverstock & Finlay, 2006; Cipriani et al., 2000; DOH, 2008; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Schwartz, 2004).

The current literature review highlights that the death of a client or patient has only just begun to receive the attention it deserves across professional disciplines (Baverstock & Finlay, 2006; Cipriani et al., 2000; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Schwartz, 2004).

Important findings have included the acknowledgement that client death occurs, not only in medical context, but in a mental health or psychiatric context, a predominantly unacknowledged finding (Cipriani et al., 2000; ONS, 2007; Schwartz, 2004). In response to a client death, medical professionals, nurses, occupational therapists and psychological therapists have been shown to experience a number of (both positive and negative) emotional, cognitive and physiological reactions (Cipriani et al., 2000; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003). Reactions which are often unanticipated and experienced in the context of perhaps less than adequate support systems (Cipriani et al., 2000; Rhodes-Kropf et al., 2005; Schwartz, 2004).

Factors such as professional grade, years of occupational experience, gender, relationship with the patient and the nature of a client's death was important to consider, although as noted, previous studies have highlighted conflicting findings (Baverstock & Finlay, 2006; Cipriani et al., 2000; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005).

An interesting issue (from my own perspective) relates to the variable construction of death and emotional experiences across settings (Rhodes-Kropf et al., 2005). Research involving medical students has highlighted that death may be understood as a failure within a medical context, with emotional reactions also being viewed as forbidden (Rhodes-Kropf et al., 2005). This has meant research findings within this area have asserted the importance of recognising medical professionals as human and compassionate in order to deconstruct this perspective (Moores, Castle, Shaw, Stockton, & Bennett, 2007).

For non-medical professionals a client's death did not appear to be constructed as a failure. However, it has been highlighted as an unacknowledged experience which attracts little attention (Schwartz, 2004). As a result non-medical professionals were left behind with a number of confusing emotional reactions and unanswered questions in relation to their responses to the death of a client (Cipriani et al., 2000; Schwartz, 2004).

Relevant theoretical models have argued that coming to terms with such deaths may involve a process of moving between experiencing and inhibiting emotional reactions (Kaplan, 2000; Papadatou, 2000). The mediating affect of contextual factors (workplace views of death, societal view) and intrinsic factors (beliefs, experiences) were noted as important in making sense of death, an argument which reflects the overall trend in grief and bereavement research in the past twenty-years (CAH, 2004).

The above research is not without its limitations, as noted in the critical review. Much has been US based and closely linked to those who may witness the physical event of death. However, the available research also illuminates the absence of a voice for non-medical professions in general, and Clinical Psychologists in particular (Schwartz, 2004). It can be argued that within Clinical Psychology the experience of a client's death has been largely overlooked.

Overall, the research highlighted in this review presents us with a strong call for future research. The increasing need for such projects is also supported by the development of national, end-of-life healthcare initiatives in the United Kingdom which place an increasing level of importance on issues such as death and dying for the benefit of patient care (DOH, 2008).

### ***Why focus on Clinical Psychologists?***

Clinical Psychologists in the United Kingdom are trained to work with individuals from across the lifespan, within many varied service contexts e.g. clinical health, child and family (BPS, 2006b). Death may not always be expected in a Clinical Psychologist's work but it is reasonable to suggest that this experience could occur at any time during their career.

Schwartz's (2004) study, has taken important steps in examining the experience of a client death for US based therapists, including psychologists, with interesting results. Her findings, coupled with the impact of this experience for other professionals, were powerful and asserted a need for further research into this subject for psychological therapists (Schwartz, 2004). Therefore, the focus of the current research project: The experience of client death, from a cause other than suicide, for Clinical Psychologists, appears justified as it will extend previous findings whilst addressing the gap in the UK evidence-base.

### *Narrowing the focus: Junior level Clinical Psychologists*

The narrowing of focus for this project toward junior level Clinical Psychologists (Trainees/Newly qualified up to 2 yrs) is also justified, particularly when revisiting the previous research relating to medical students and less experienced professionals in the face of death (Cipriani et al., 2000; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005). Such studies demonstrated that a ‘memorable’ emotive death tended to be the first death experienced, which is arguably more likely earlier in an individual’s career (Rhodes-Kropf et al., 2005). Further to this, previous research has indicated junior level professionals may be in need of increased support at these times, a factor which will be important for the current projects future implications (Cipriani et al., 2000; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005).

Many of the previous participant samples included a mixture of professional grades and experience levels; therefore it may be useful to adopt a narrower focus to improve the homogeneity of a sample, an important issue for qualitative research and the credibility of it’s findings (Smith, Flowers, & Larkin, 2009).

## AIMS OF RESEARCH

In accordance with the presented findings and arguments, the following study will adopt a qualitative approach to explore the often unheard, lived experiences of client death, from a cause other than suicide, for junior level Clinical Psychologists.

A qualitative approach is indicated as such methods provide an opportunity to gain a rich knowledge of an unexplored area (Barker, Pistrang, & Elliott, 2002). To date this approach has also yielded encouraging results within the under-researched area of client death (Cipriani et al., 2000; Kaplan, 2000; Papadatou, 2000; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Schwartz, 2004).

It is hoped that the research findings may assist those providing training courses, clinical supervisors and other psychologists of all grades to make sense of this experience in greater depth. The results may also present an opportunity for teaching about death, emotions and coping, as well generating ideas (if applicable) about the development of supportive frameworks for junior level Clinical Psychologists who experience a client’s death during their clinical work.

## RESEARCH QUESTION

In line with the aims of this study the main research question was framed as:

- How do junior Clinical Psychologist's experience the death of a client with whom they had been in therapeutic contact?

The following areas of interest were also explored with junior level Clinical Psychologists:

1) The potential impact of the death (positive and negative)

2) The potential coping strategies that were used

3) The support systems (available or desired) when their client died and the implications of this

4) The potential changes for participants as individuals and clinicians following a client’s death

# METHOD

The following section will provide an outline of my research methodology and design. I aim to present a rationale for my choice of method, my recruitment and data collection strategy, and the analytic procedure followed.

## A QUALITATIVE APPROACH

Qualitative methods are now widely accepted for use in psychological research (Barker, Pistrang, & Elliott, 2002). Such methods provide a vehicle for achieving an in-depth understanding of a range of human experiences, particularly where a rich description of an under-researched phenomenon is sought (Barker, Pistrang, & Elliott, 2002).

As my introductory chapter indicated, the experience of client death has been largely overlooked in the profession of Clinical Psychology in general and for junior level Clinical Psychologists in particular. Consequently, qualitative methods would be most appropriate in order to meet the current research aims. A qualitative approach was also indicated in the context of my Constructivist position which asserts the importance of a hermeneutic approach to research, uncovering multiple stories and meaning, as well as experiences of a phenomena (Guba & Lincoln, 1989).

### *Choosing a qualitative method: Selecting Interpretative Phenomenological Analysis (IPA)*

As the level of interest in qualitative research has expanded, so have the methodological options for the qualitative researcher (Creswell, Hanson, Clark, &

Morales, 2007; Starks & Brown Trinidad, 2007). As a researcher who has previously used Discourse Analysis (Potter & Wetherell, 1987), Grounded Theory (Glaser & Strauss, 1967), and Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999) I acknowledge there are many useful approaches available (Starks & Brown Trinidad, 2007).

My methodological selection for the current research project was a deductive process based on a number of factors such as; my ontological and epistemological position as a researcher; my specific research question and aims; my previous experience of qualitative methods (Guba & Lincoln, 1989). I have paid attention to the historical and theoretical foundations of the available methods in order to facilitate my choice (Carter & Little, 2007; Creswell, Hanson, Clark, & Morales, 2007).

As my acknowledged position is relativist, Constructivist and hermeneutic and my research aims were centred on uncovering individual and shared constructions of an unexplored phenomenon, I concluded that Interpretative Phenomenological Analysis (IPA) would be most suited to this project (Smith, 1996, 2004; Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2008). It was felt that IPA was appropriate as it aims to explore an insider's perspective of a phenomenon, in detail, whilst acknowledging the co-constructed nature of meaning and sense making inherent in the researcher-participant relationship; the double hermeneutic (Smith, 2004; Smith, Flowers, & Larkin, 2009).

Narrative analysis had been carefully considered due to its close epistemological connections and crossover with my chosen method (Smith, Flowers & Larkin, 2009). However, I felt that IPA in its broadest sense allows the consideration of narrative aspects, such as focusing on a temporal narrative, without being restricted by this focus. Also, the wider availability of expert supervision, workshops and training in IPA had also influenced my decision making.

### *Theoretical foundations of IPA*

An increasing amount of literature and discussion has taken place over the past decade in relation to the theoretical foundations of IPA (Smith, 1996, 2004; Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2008). I will briefly outline the main philosophical underpinnings at this stage. Please see Smith, Flowers and Larkin (2009) for what appears to be the most comprehensive summary of the theoretical foundations of this method at present.

IPA is considered to be a phenomenological method which is strongly linked with the interpretative, hermeneutic and idiographic traditions in research (Smith, 2004; Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2008). It has also been described as lightly Constructionist by Eatough and Smith (2006). The theoretical foundations have been linked to a number of philosophers and researchers, including, Husserl (1927), Heidegger (1962/1927), Sartre (1956/1943) and Gadamer (1990/1960).

Phenomenological theory, or the study of what an experience is like, has been majorly influential within the development of IPA. The contributions of Husserl (1927), Heidegger (1962/1927), Merleau-Ponty (1962) and Sartre (1956/1943), have been significant as they have collectively raised the question of how we come to know what we know, and how being within a world allows us a temporal and relational perspective on our lives (Smith, Flowers & Larkin, 2009). This is an important aspect of IPA, as researchers will inherently appreciate the complex, relative, sense-making processes of their participants.

Hermeneutics, or the theory of interpretation, has also influenced IPA (Smith, Flowers, & Larkin, 2009). Here contributions from Schleiermacher (1998), Heidegger (1962/1927), and Gadamer (1990/1960) have been noted as important (Smith, Flowers and Larkin, 2009). Within hermeneutics interpretation can be seen as an art, something which adds understanding to an experience which it's author cannot. Within this theory the complexity of the relationship between the interpreted and interpreter is acknowledged. Interpretations are iterative and co-created, with one's attempt to bracket preconceptions being only partially achievable. As previously noted the hermeneutic tradition is also closely linked with Constructivist epistemology (Guba & Lincoln, 1989).

Adopting an idiographic approach to research is the final component of IPA (Smith, Flowers, & Larkin, 2009). This approach to research, which focuses on the 'particular' or detail of an experience, contrasts traditional nomothetic approaches which focus on the generalisability of findings (Smith, Flowers and Larkin, 2009, pg 29). All of the above theories combined serve to highlight the complexity of thought within an IPA research project.

## DATA COLLECTION

### *Semi-structured Interviews*

Semi-structured interviews were deemed to be the most appropriate data collection method for this project. This type of interview allows the researcher to explore a limited topic area, in depth, with all participants (Burman, 2001; Smith, Jarman, & Osborn, 1999). It was also felt that semi-structured interviews would allow me to engage in close contact with my interviewees, developing trust and rapport. Important factors where research topics may be emotive or challenging

(Ponterotto, 2002; Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999).

Due to the Constructivist position of my research semi-structured interviews are acknowledged as complex, collaboratively constructed, meaning making occasions, as opposed to opportunities in which to discover a ‘reality’ or ‘truth’ (Holstein & Gubrium, 1995).

For the purposes of the interviews an interview schedule was developed based on my literature review, advice from my research supervisors, a pilot interview with a fellow trainee and relevant interview guidance (Burman, 2001). My interview schedule was also designed flexibly, so that I may follow my participants’ experiences and concerns about the death of their clients (Smith, Flowers & Larkin, 2009; See Appendix 1: Interview schedule)

## PROCEDURE

### ***Recruitment strategy***

In light of there being no available data with regards to the prevalence of the experience of client death for Clinical Psychologists, at any stage in their career, a sufficiently broad recruitment strategy was adopted for this study. Following NHS Ethical and Research and Development approvals, recruitment began by contacting the course directors of Clinical Psychology Doctorates in the North Thames and Eastern Region of the UK. The University of Hertfordshire was excluded from this study.

An initial email, which attached a letter outlining my project, was sent to course directors (See Appendix 2: Email and letter to course directors). This letter requested permission to contact Trainees and Newly Qualified Clinical

Psychologists from their courses in order to facilitate recruitment. When permissions were received initial contact emails were sent to Trainees and Newly Qualified Clinical Psychologists via their course teams e.g. administrators, research tutors or course directors (See Appendix 3: Initial participant email). I had no contact details for participants at this stage.

Once a participant expressed interest in the project via email an information pack was sent electronically or via post (See Appendix 4: Information pack). This pack included an information sheet and a reply slip so participants could indicate interest in the study. When participants returned their reply slips they were telephoned in order to discuss the inclusion and exclusion criteria for the study (See Appendix 5: Participant screening).

If participants gave verbal informed consent to participate an interview was arranged at a suitable location e.g. their home or university. Written consent was taken from all participants prior to their interview. All were provided with an opportunity to discuss the risks, benefits and potential burdens of the study (See Appendix 6: Consent Form). A pre-interview briefing and post interview debrief were undertaken with all participants to ensure any concerns or queries could be addressed (See Appendix 7: Pre-interview briefing and debriefing sheet). All participants were provided with a copy of their information sheet which included an official university contact and an external NHS contact in case of complaints. All were also provided with a list of useful support resources and references in relation to the interview topic (See Appendix 8: Useful resources).

### *Inclusion and exclusion criteria*

To ensure the sample was sufficiently homogenous participants were all junior members of the Clinical Psychology profession e.g. Trainees or Newly Qualified Clinical Psychologists. All were currently undertaking, or had recently completed their three-year training with North Thames or Eastern Region Doctorate in Clinical Psychology courses.

No disability, gender, ethnicity, religion, sexual orientation or age restrictions were in place for participants. However, the minimum requirement for entry onto the Doctorate in Clinical Psychology in the UK is an undergraduate degree. This meant all participants would be over 21.

It was a requirement that all participants had experienced the death of a client whilst in an Assistant Psychologist, Trainee or Newly Qualified Clinical Psychologist role within an NHS setting. All participants were required to have had direct clinical involvement with their client e.g. assessment, group, or individual work. No stipulations with regards to the length of contact were made based on the findings of Schwartz (2004) who indicated such limitations restricted recruitment.

Exclusion criteria for the study stipulated that the death of a client would not be caused by suicide or be subject to legal action e.g. murder. This was due to the larger research base on suicide and issues of compromised confidentiality where legal action is involved. The death was also required to be more than three months prior to interview. This was to ensure participants had enough time make an informed decision as to whether they were comfortable talking about their client’s death.

The final study criterion was the exclusion of non-English speaking participants. Access to this group was not possible for my UK-based study. Current selection criteria for Clinical Psychology training courses in the UK require all applicants to be proficient in the English Language due to their work in the NHS. Clinical training applicants with English as a second language are asked to provide copies of recognised English language qualifications.

For the above reasons it is recognised that the voices of non−English speaking junior psychologists will be excluded from this study, which will be a potential limitation in relation to its’ findings.

## ETHICAL ISSUES

NHS ethical approval was received from Hertfordshire Research Ethics Committee and Research and Development approvals were obtained from Cambridge and Peterborough and Camden and Islington NHS Foundation Trusts (See Appendix 9: NHS Ethical and R&D Approval).

### *Informed consent*

As detailed in the recruitment strategy above, fully informed consent was obtained from all participants in this study prior to their participation.

### *Participant confidentiality*

All identifiable information provided during the interviews was anonymised. Only the researcher remained aware of the participant's real identity. Those involved in participants training courses were not informed of who had participated.

All participants consented to their interviews being recorded and transcribed by myself and an external service. All participants were aware that the transcription service would sign a non−disclosure/confidentiality agreement prior to gaining access to the interview recordings (See Appendix 10: Transcription confidentiality agreement).

All participants were informed that some parts of the anonymised data collected for my research, would be assessed by authorised persons from the University of Hertfordshire and external boards. All participants also consented for anonymised sections of their interviews to be discussed and reviewed by research peers from my training course for the purpose of analytic integrity.

Participants were informed that they would not be identified in any report or publication. All consented to their anonymised quotes being used in the write up and in any future publications.

In case of the need to breach confidentiality all participants were aware that the British Psychological Societies professional code of conduct would be adhered to e.g. confidentiality may have been breached if a risk to self or others was disclosed (BPS, 2006a)

### *The deceased client*

The geographical location of the participants’ clinical work and the names of the deceased were not requested. Any names and locations disclosed during the interviews were replaced with an alias or deleted during transcription.

### ***Potential distress for participants***

Great care was taken in the design and construction of this study as it was recognised that enquiries about the experience of client death may have been potentially distressing for participants. As noted, fully informed consent was taken to ensure the risk of distress was minimised.

If participants became upset I took time to provide support, whilst remaining aware of my ethical obligations and a participants right to withdraw from the study. Following each interview I also provided participants with time to reflect on their interview experience, which was useful. Despite being aware of the minimal risk, all participants reported enjoying their interview. For many this was the first opportunity they had had to discuss the death of their client.

### ***Interviewing peers***

The issue of interviewing other Trainees and Newly Qualified Clinical Psychologists was also carefully considered due to possible concerns over bias (Mercer, 2007).

Mercer (2007) has recognised that there are both advantages and disadvantages of such research designs. Some of the advantages of completing research with ‘insiders’ is that it often leads to better access to a sample, a stronger rapport with participants and a deeper, readily available shared frame of reference (Mercer, 2007). However, the disadvantages of this position include facing challenges as a researcher, for example, needing to remain explicitly aware of both your own and your participants’ pre-conceptions of your research interests and goals (Mercer, 2007).

As a qualitative researcher I recognised numerous connections with my participants, for example my gender, age and even my love of jokes, not simply my role as an ‘insider’. Thus I have used support systems (e.g. peer review) to ensure I moved within, and outside of, my own pre-conceptions whilst conducting this research project.

### ***Emotional impact on researcher***

My own experience of the death of my client has been important for the development and completion of this project. Without this experience I may never have been asking such important research questions, a useful illustration of the co-constructed process of Constructivist, qualitative research (Guba & Lincoln, 1989).

For the purposes of my research and analysis I have attempted to continually pay attention to, and remain aware of my own thoughts, feelings and potential biases in relation to this experience. To achieve this I drew upon my experience of managing highly emotive, self-relevant topics whilst in therapy with clients by accessing the existing support systems I regularly use e.g. clinical supervision, peer support and meetings with my research tutors.

## PARTICIPANTS

### *The Sample*

*(See Table 1: Participant Information).*

Nine participants, three of whom were current third year Trainee Clinical Psychologists and six of whom were Newly Qualified Clinical Psychologists, took part in one semi-structured interview, lasting one to one-and-a-half hours. All had experienced the death of a client from a cause other than suicide. Five participants were Trainees at the time of their client's death, two were Assistant Psychologists and two were Newly Qualified Clinical Psychologists.

All participants were female, aged between 27 and 37 and of White British or White Scottish origin. All participants had been involved in therapeutic contact with their clients as part of an assessment or individual therapy, with therapeutic contact ranging from one assessment session to six months of intermittent individual therapy.

The deceased clients were across the lifespan, the youngest client being aged eleven and the oldest being in their eighties. The clients were also seen in varied service contexts and the most frequent cause of death was cancer. For six participants this was the first client death they had experienced (excluding suicide) in their careers.

| **Participant pseudonym** *(*first death in career, from cause other than suicide)* | **Age** | **Gender** | **Ethnicity** | **Current professional status** | **Professional status at time of client death** | **Setting where death occurred** | **Cause of death** | **Length of client contact** *(# approx)* |
|---|---|---|---|---|---|---|---|---|
| Vanessa* | 28 | Female | White, Scottish | Newly Qualified (Graduated 2008) | 3rd Year Trainee | Drug and Alcohol services | Heart Attack | #2 sessions |
| Ruth | 29 | Female | White, British | Newly Qualified (Graduated 2007) | Newly Qualified | Oncology and Palliative Care | Cancer | #2 months |
| Lisa* | 30 | Female | White, British | 3rd Year Trainee | Assistant Psychologist | Specialist Psychosis | Cancer | #6 months |
| Helen* | 28 | Female | White, British | 3rd Year Trainee | Assistant Psychologist | Oncology and Palliative Care | Cancer | #2-3 sessions |
| Natalie | 31 | Female | White, British | Newly Qualified (Graduated 2008) | 2nd Year Trainee | Drug and Alcohol services | Drowning | 1 session |
| Ella* | 33 | Female | White, Scottish | Newly Qualified (Graduated 2007) | 2nd Year Trainee | Older Adults | Heart Attack | #10 sessions |
| Catherine* | 27 | Female | White, British | 3rd Year Trainee | 1st Year Trainee | Clinical Health | Cancer | 3 months |
| Marie* | 37 | Female | White, British | Newly Qualified (Graduated 2007) | Newly Qualified | Community Neuro-rehab | Multiple Sclerosis | #2 months |
| Heather | 30 | Female | White, British | Newly Qualified (Graduated 2006) | 3rd Year Trainee | Paediatric Oncology | Cancer | #6 months |

*Table 1: Participant Information (*first death in career, from cause other than suicide)*

## DATA ANALYSIS

In this section I will present the procedure I have followed in order to analyse the study's interview data.

### *Interpretative Phenomenological Analysis procedure*

The original guidelines for conducting an Interpretative Phenomenological Analysis were developed by Smith in the mid to late 1990s (Smith, 1996; Smith, Jarman, & Osborn, 1999). More recently however, he has suggested that 'one cannot do good qualitative research by following a cookbook' (Smith, 2004, pg. 40). Therefore, I will present my adherence to these guidelines alongside the individual ideas I have used during the analytic process.

Please see Appendix 11[1]: Audit trail for an example of the analytic process for one of my interviews.

### *Immersion in the data and case by case analysis*

As IPA is an idiographic approach it requires close contact with participants' accounts (Smith, 2004). This meant for the purposes of my research each interview was analysed in its own right in the initial stages.

Prior to beginning the analysis, I spent time reading and re-reading the interviews in turn (Smith & Osborn, 2008). Due to time pressures I utilised a transcription service for eight interviews. As each transcript was returned, and to support

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[1] Appendix 11 will include the full transcript of Interview 7 for examination purposes only. It will be removed following examination and prior to hard binding for reasons of confidentiality.

analysis, I listened to each interview numerous times to re-immerse myself in participants’ experiences whilst ensuring accurate transcription and maintained confidentiality.

When I felt connected to the account I began to note down elements of interest in the left hand margin of the transcript. I also began to summarise and describe the participants’ experiences. At this stage I attempted to ‘bracket’ my own preconceptions (as much as possible) in order to facilitate what has been described as a ‘free textual analysis’ (Smith & Osborn, 2008, pg 67).

After this process was conducted several times my analysis moved into the interpretative stage. I brought myself back to the beginning of each interview and began to take an increasingly interrogative, abstract approach to the data, whilst remaining grounded in the text (Smith, 2004; Smith, Flowers and Larkin, 2009). At this stage I moved between bracketing and invoking my own theoretical and psychological knowledge. The themes produced at this stage were written in the right-hand column of each interview and they were named emergent themes.

After completing this step I wrote a rich description of each interview. This was a closely data linked, highly individual summary of the interviewees’ experiences of client death. This process helped me to consolidate what I had learnt from each interview before the clustering of themes took place.

### *Clustering themes*

Next a chronological emergent theme list was created from each interview. At this stage I attempted to find connections within and between themes, creating theme clusters. When the theme clusters were developed I revisited the original interview text. This helped me to ensure the themes remained connected to the data and reflective of participants' experiences (Smith & Osborn, 2008). Following this step the theme clusters were named and labelled as master themes and illustrative quotes were identified to provide a lived sense of participants' experiences.

This process was repeated anew with each interview as I wanted to remain close to each individual account.

### *Creating superordinate themes*

The next step was to begin clustering the master themes from all participants. To start, I revisited each transcript to ensure I was happy with my interpretations. I then created a list of all of the interview master themes on a separate piece of paper and I began to look for connections within and between themes.

This stage was difficult as it required making decisions about which themes to privilege and which themes to condense. I would like to note that I believe a thesis could have been written on each of the interviews, an approach increasingly advocated by Smith, Flowers & Larkin (2009). However, in order to uncover this unheard topic area, I felt a larger sample was indicated.

Finally, a table of superordinate themes was produced which included data from all nine interviews (See Table 2: Superordinate themes). Again I took time to go back to the interview data in order to ensure the themes remained reflective of the participants' experiences of client death

## PROVIDING CREDIBILITY CHECKS

Barker, Pistrang & Elliott (2002) suggest that traditional psychometric criteria for evaluating the reliability and validity in research may not transfer easily into the realm of qualitative methods. Instead, it has been useful to utilise specifically produced guidelines for evaluating qualitative research for this purpose (Elliott, Fischer, & Rennie, 1999).

Having initially referred to the publication guidelines produced by Elliott et al (1999) I will continue to refer to these for the purposes of illustrating 'credibility checks' undertaken with my data (Elliott et.al., 1999, pg.222). These guidelines have been deemed useful by Barker et.al. (2002) as they are specifically focused on research in the field of Clinical Psychology.

For the purposes of maintaining 'credibility' I utilised the support and knowledge of two experienced research supervisors, my peers who are completing IPA projects and the IPA workshops I have attended over the past year run by Professor Jonathan Smith and Dr Virginia Eatough (Birkbeck University).

Both research supervisors have audited my analysis to ensure clarity and transparency of process. This has been immensely useful as one supervisor is an expert in IPA and the other is an expert in Cancer and Palliative care and experienced in working with clients who have died. Both supervisors have reported being able to follow my analysis, whilst recognising similar themes to my own in order to authenticate my analytic process. Both research supervisors have also added richness to the analytic process with their own ideas, whilst recognising the Constructivist position of this project and the double hermeneutic inherent in IPA e.g. findings are reflective of the researcher's interpretation of their participant's interpretation of a phenomena.

Fellow Trainee Clinical Psychologists at the University of Hertfordshire, who formed an IPA special interest group, have also audited and triangulated my analysis. At this stage feedback from participants has not been sought as Smith (2004) contests the validity of member checking in its purest sense due to the double hermeneutic within IPA. However, I am personally interested in general feedback from participants (who were all interested in the study's results) and it has been arranged that they will receive a summary of the research findings in due course.

## REFLEXIVITY CONTINUED…

At this stage it feels pertinent to consider my experience with this research project over time and the contextual factors which may have influenced this experience.

In the initial stages of formal project development, I realised very quickly that death could be hard for people to face. At times my project was met with an uncertain reception. There had been concerns about interviewing peers and negotiating a project about death through NHS ethics and as a result, I became concerned about the focus of my study.

My feelings changed quite rapidly when I received contact from my first participant. The participants in this study have kept me going through the difficult stages of the project. Their accounts, which included both unique and shared features, led me to realise this choice of topic had been worthwhile. The knowledge that, for many, their interview had been the first opportunity they had had to speak of their client’s death, cemented this conclusion for me.

My changing experience of my project has also been influenced by the start of my final year placement in Cancer and Palliative care. As my project began (September 2008), I in tandem, started to work with those who were likely to die, and I continue to do so as I write.

On placement I regularly witness and feel the positive and negative impact of working with issues such as death and dying. My work in this setting has taught me the importance of care, honesty and empathy towards myself. I feel my ability to reflect on my own needs has also helped me to remain aware of my previous experiences and assumptions during the analytic stages of my project. When I have felt both touched and moved by the stories I have heard, I have spent time reflecting on why this may have been. I feel this has been very helpful in managing my shared experiences with my peers.

# RESULTS

The following section will present the findings of my Interpretative Phenomenological Analysis (IPA) of the experience of client death for nine Clinical Psychologists, in the early stages of their careers. As a result of a thorough IPA process (Smith, 1996, 2004; Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2008) I aim to provide the reader with an insight into the intricacy of this lived experience for participants whilst also focusing on how they attempted to make sense of this loss.

Three key superordinate themes will form the basis of the following account:

- ***Connected and affected: Being unprepared for initial reactions to the client's death***
- ***'We do it so why can't you?' Facing institutional denial and avoidance***
- ***'It's not something I've forgotten about', The lasting impact of client death: Learning reluctant lessons and experiencing continuing bonds***

My Interpretative Phenomenological Analysis should be regarded as one possible construction of the phenomenon of client death for a specific group of participants. It is fully recognised that the double hermeneutic, inherent in IPA, may have led to the production of different themes for another researcher, dependant on their 'own perspective' (Elliot et al, 1999). However, I have endeavoured to present a rigorous and rich experiential account of the researched experience, client death, here.

It is important to note that all nine accounts were rich and multilayered. This factor, coupled with the selection of a qualitative method which requires a depth of analysis, means that it will not be possible to represent all of the participants views and experiences in this chapter. There is also an acknowledged degree of overlap, opposition and agreement between and within the themes. Smith, Flowers and Larkin (2009) argue that this may be the dual quality of an IPA study. Not only am I attempting to illuminate the experience of client death at a general conceptual level, I am also paying close attention to the idiographic and idiosyncratic nature of participants' accounts (Elliott, Fischer, & Rennie, 1999; Smith, Flowers, & Larkin, 2009).

In order to illustrate my findings, verbatim quotes from the interviewees will be utilised[2]. Further to this, please see Appendix 12 for an illustration of how each theme has been represented across the nine interviews, a recommended addition where analysis is conducted with over six interviews (Smith, Flowers and Larkin, 2009).

I will now present my exploration of the three superordinate themes and their concurrent sub-themes (See Table 2: Superordinate themes).

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[2] Verbatim extracts: The extracts included in the following sections have been amended to facilitate readability. Repeated words, minor hesitations and words such as 'umm' have been deleted. Where meaning is inferred or references are made to earlier conversations within an interview additional material may be included in square brackets [ ] to facilitate contextual meaning. Bold words have been used to indicate increased word emphasis and …. has been used to indicate the continuation of text, or deleted text for readability. All identifying information has been deleted. All names have been replaced with aliases.

*Table 2: Superordinate Themes*

| **SUPERORDINATE THEME TABLE** |
|---|
| **CONNECTED AND AFFECTED:**<br>**BEING UNPREPARED FOR INITIAL REACTIONS TO THE CLIENT’S DEATH**<br>**Sub-themes**<br>• *‘A tailspin’: Confronted by death*<br>• *Feeling the death: A mixed bag of emotions*<br>• *Being left behind with losses and difficult ‘what ifs?’*<br>• *‘Just a death?’ Searching for meaning through comparison* |
| **‘WE DO IT SO WHY CAN’T YOU?’**<br>**FACING INSTITUTIONAL DENIAL AND AVOIDANCE**<br>**Sub-themes**<br>• *Alone in a fearful system: Uncovering systemic denial and avoidance*<br>• *Under pressure to contain the ‘mess’*<br>• *Surviving in the system* |
| **‘IT’S NOT SOMETHING I’VE FORGOTTEN ABOUT’,**<br>**THE LASTING IMPACT OF CLIENT DEATH: LEARNING RELUCTANT LESSONS AND EXPERIENCING CONTINUING BONDS**<br>**Sub-themes**<br>• *Being changed by a unique and memorable death*<br>• *The pain and comfort of continuing bonds*<br>• *Choosing to care and to feel*<br>• *Feeling threatened, becoming avoidant too*<br>• *The importance of ‘therapeutic’ time and space* |

## 1. CONNECTED AND AFFECTED: BEING UNPREPARED FOR INITIAL REACTIONS TO THE CLIENT'S DEATH

### *Overview*

The death of a client was a meaningful and emotional experience for all nine participants represented in this study. The first superordinate theme describes the initial reactions they experienced in the face of their client's death.

The story of a client's death came wrapped in a history of a relationship and experiences. Participants described having a sense of connection, or knowing a person at a deep and often intimate level, which meant they felt affected by the death. Memories of the particular instance when they learnt their client had died were evoked and recalled with remarkable clarity. At times the memory of this discovery appeared relived as it was described, evoking palpable emotions in the interview room.

In the early days and weeks after the death many participants felt they were in 'a tailspin'. The description of a 'tailspin', used by one participant (Ella[3]), reflected a sense of lost control and shock in the face of death. There appeared to be a striking sense of passivity during these initial stages, death was a confronting force and *it* was in the driving seat.  Participants' accounts were filled with complex and contradictory emotional experiences in response to their client's death. For many difficult thoughts of lost opportunities and lost chances pervaded as the emotional shock faded away.

All accounts reflected the death of a client as an unfamiliar and unpredictable experience. Some participants experienced feeling challenged by death in it's

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[3] Not real name. All names have been replaced with an alias.

initial stages. Accounts reflected attempts at sense making following the death, often through using comparisons, coupled with a clear striving for this experience to be understood by others.

### 1.1 *'A tailspin': Confronted by death*

> *…To be honest I was quite, I went into a bit of a tailspin really. In terms of kind of a responsibility and having failed him and not having seen it [death] coming…*
> *Ella*

The tailspin serves to illustrate an experience of being confronted with the unexpected, a client's death. When faced with this death, and despite all accounts reflecting a construction of death as 'normal' or part of life, it felt shocking and participants took little comfort from their beliefs. By looking at Ella's quote in detail, it could be suggested that the admission of a tailspin was difficult. Her words 'to be honest' and 'really' appeared to attempt to hide the power of death. Many participants seemed to believe they should have been ready for their client's death, it should have been expected, and they were to blame for their own reactions.

Issues of responsibility and perceived failure in the face of death, as noted in Ella's extract, were presented in many of the accounts. For Ella, the notification of death was accompanied by a suggestion of a potential suicide by her team. Her feelings of responsibility and possible failure were accompanied by fear and vulnerability. Ella was not alone as Vanessa's quote indicates.

> *…There was a bit of me that went home going ‘oh my fucking god is this suicide?’ have I, am I, gonna get hauled over the coals for this?...*
> *Vanessa*

The powerful imagery evoked in Vanessa’s quote of being ‘hauled over the coals’ in the face of (unfounded) fears of suicide, presents a rich sense of being dragged through her client’s death and being burned by it. However, it appeared as if Vanessa only allowed part of herself (‘a bit of me’) to engage with her fears. She was fighting for control.

Natalie’s extract illustrates the beginning of her tailspin.

> *…Another trainee on my course was doing her research in the drug and alcohol centre so she was continuing to work there and dip in and out for her research project. She had heard about the death of this person and had mentioned it … not, I don’t think she knew that I was involved, but obviously when there’s a loss in the service it is talked about. And she’d heard about this and then I said ‘oh my goodness, she was one of mine’…*
> *Natalie*

Natalie’s words as she said ‘oh my goodness, she was one of mine’ reflected a lived sense of her feelings of shock, connection and affection for her client who had drowned. Being connected and on a shared a journey with clients added an emotional depth to the ‘tailspin’ experienced by all participants, even where a relationship was described as not particularly close or positive.

The tailspin evoked uncertainty, fear, vulnerability and a sense of lost control across many accounts, the death of a client did not feel expected and the participants felt to blame for their reactions (if only momentarily).

### 1.2 *Feeling the death: A mixed bag of emotions*

‘Feeling the death’ represents the many mixed emotions of the nine participants immediately following their client’s death. These included relief, sadness, shock and even anger. The ‘mixed bag’ was a fluid experience, participants passed in and out of different emotional states over time.

> *…You kind of feel sad that they’ve gone … but on the other hand you’re kind of alright…*
> *Vanessa*

Vanessa’s mixed bag highlights sadness (feeling the death) yet being ‘kind of alright’ too. This fluid process meant the mixed bag never appeared to be static or representative of one emotion for her.  This may have provided some relief from the ‘tailspin’.

> *…A bit of a mix … but normally more so relief or a sense of ending than the sadness actually…*
> *Ruth*

Ruth presents a mixed emotional reaction, with relief as the predominant emotion. Within her extract it can be noted that death is spoken about in a general sense, Ruth does not locate her experience in one individual client. The mixed bag appeared to be an attempt to minimise and depersonalise the difficult emotions away from her (multiple) client deaths. It could be that ‘feeling the death’ in a mixed way was coping strategy for Ruth as it prevented her feeling overwhelmed. This could be understood in the context of what Ruth described as a challenging clinical role, palliative care. Here she had been regularly exposed to many deaths with what she felt was minimal support as a Newly Qualified Psychologist.

Marie and Heathers' accounts of 'feeling the death' presented an interesting juxtaposition to others.

> *…I don't know if it was partly because of how I was told. It was almost like my reaction, you know … I wasn't expected to have a reaction so I didn't…*
> *Marie*

> *…I don't really remember the moment that she said that he had died … so I don't know [laughs] really well what that says about my kind of experience? … I don't really remember where I was or how it was communicated or any of that stuff…*
> *Heather*

Despite a number of emotional reactions towards their client's death being evidenced throughout their interviews, Heather and Marie also presented a powerless and passive sense of disconnection from the moment they learnt of their client's death. This is an interesting paradox to feeling it, in Technicolor (e.g. 'oh my goodness' Natalie). Marie felt that she was not expected to 'feel the death' so she withheld her reaction. For Heather, her client's death had become tangled up with personal losses she faced at that time. This resulted in blurred memories of events. I wondered if their experiences were a further elaboration of the mixed bag, reflecting the numbness and confusion which accompanied their clients' deaths.

### 1.3 *Being left behind with losses and difficult 'what ifs?'*

Being left behind, represented being in a forced position of loss in the face of client death. This sub-theme was represented within six of the nine participants' accounts.

> *…I guess there was feelings of like loss. Not just in terms of her death and loss of a client who I had quite a good relationship with. But loss also in terms of like the work that we were doing and the input that I was giving. [short pause] … Yeah it kind, I kind of feel like, I still had all this stuff to give and no client to give it to anymore…*
> *Catherine*

Catherine's extract powerfully illustrates the lived sense of this sub-theme. There is a striking indication of something (perhaps more than just her client) being taken away from her, which is reflected in five other accounts too. For Catherine it was not simply the death which had provoked a sense of loss in the moment, it was her inward gaze at her lost sense of role and purpose in her work. She appeared to (briefly) lose a sense of herself as well as her client.

Some participants also experienced difficult 'what ifs' in the face of their client's death. Death played on their minds in a cognitive and perhaps visual way, as Natalie illustrates in the following quote.

> *…I just remember thinking gosh, you know. What if, you know, the what if questions. What if I'd managed to engage her?...*
> *Natalie*

> *…It's just it's really sad that that's how she ended. I also I used think, you know, I wonder who found her. Cause I never found out who found her. That sort of stuck in my head. I was wondering sort of, was it her son? Was it her partner? And how they picked up their life really afterwards…*
> *Natalie*

Natalie is almost imagining multiple pictures of the death in her mind. She also considers whether she would have been able to prevent the death on some level. This reflected a lived sense of responsibility and perhaps self-blame in the moment; a shared experience by all participants represented within this sub-theme.

> *…It felt like, I don't know, it just feels really sad. Like why didn't they push more to come and see him? Or why didn't he just let somebody in?...*
> *Lisa*

The death of Lisa's client from cancer confronted her with his lost future and the lost opportunities for his family. Her 'what ifs?' reflected the death as a 'really sad' yet frustratingly powerless experience.

### 1.4 *'Just a death?' Searching for meaning through comparison*

As noted in previous sub-themes, the death of a client had felt shocking and unexpected for all participants, even if death was predicted in some way. As a result they, at times, struggled to find the language to explain the death. The fourth sub-theme 'just a death?' represents the attempts participants made at creating a shared, understandable and interactional meaning for themselves, and perhaps others, through using comparisons.

For interviewees such as Catherine, who experienced the death of her client to cancer, comparisons emphasised an experience that was juxtaposed to her construction of a ‘normal’ end to therapy.

> *…You know it’s not like you’ve finished therapy and moved on. And no it’s very different. So yeah no there was nothing, I didn’t feel prepared for that at all…*
> *Catherine*

An ending by death was unique and this appeared to evoke a sense of unfinished business for her. Catherine had been prepared for the ending of therapy as this was routine within her clinical work, yet an ending due to death meant she felt unprepared to move on. She was left behind with plans which could never materialise, an uncomfortable experience reflected across accounts (See subtheme 1.3).

‘Just a death’ was a phrase used by Vanessa. She had experienced the death of her client whilst working as a final year Trainee Clinical Psychologist.

> *… so it was actually quite nerve-racking for about a week, having that kind a hangover you. Then it’s kind of like, no actually this is not gonna happen. And it’s just a death and that’s…alright…*
> *Vanessa*

Vanessa’s reflections illustrate a comparison between suicide and non-suicide. In the early segments of her interview this phrase ‘just a death’ presented a sense of death being tolerable if it was not a suicide. However, as we explored the meaning of her words further, it was clear they had changed over time.

> *…What I'm trying to say it does affect me.  I did I did take it home and then needed to talk about it. And I did just feel kind of how you feel maybe when a friend's grandparent or parent dies that you didn't know…*
> *Vanessa*

For Vanessa, sense making was a continuous journey (See sub-theme 3.1). From the moment her client died she was struck with fears that it could have been a suicide. Consequently she made sense of her client's death from a heart attack as 'just a death'; it was a relief in comparison. However, as the weeks passed she felt affected, she needed to share her experience, and she needed to be understood. Relief no longer felt applicable and she began to try and understand the complexity of her client's death through comparison e.g. like the death of a friend's grandparent.

A client's death was also compared to imagined alternatives which, in participants' minds, could have increased the negative impact of the death. Again, similar to the impact of 'just a death', hypothetical comparisons evoked a feeling of relief.

> *…If I had had a number of sessions with her I think I would have been much more affected. I think yeah because I only had that one meeting it sort of kept me at a distance really. And I think there might have been a more of guilt response if I'd had more sessions…*
> *Natalie*

Natalie believed she could have been more affected by guilt and feelings of responsibility if she had had more sessions with her client. This comparison attempted to create some distance between herself and the death, perhaps providing a temporary relief from her reactions. However, this could be seen as a contradiction to a previous extract from Natalie’s interview which illustrated her response of ‘oh my goodness’ in the face of death.

A client’s death, and the resulting sense of loss experienced by all participants, was far from ‘*just* a death’. Instead it was a meaning laden, emotional tailspin, for which participant’s felt unprepared.

## 2. ‘WE DO IT SO WHY CAN’T YOU?’ FACING INSTITUTIONAL DENIAL AND AVOIDANCE

### ***Overview***

The second superordinate theme presents the striking impact of the wider system in the context of a client’s death. The term system serves to illustrate those surrounding the participants, from teams to the wider cultural context of the UK, and perhaps even within the institution of Clinical Psychology.

The participants experienced feeling alone in systems where the death of their client was seldom regarded as significant or worthy of attention. It was perceived by participants as a disenfranchised (unrecognised) loss (Doka, 1989, 2008). This apparent denial of death’s impact, across various systems (colleagues, services, Universities) meant that the participants recounted feeling under pressure to inwardly contain the emotional milieu and ‘tailspin’ noted in the previous theme. Responsibility for this seemed to rest heavily on their shoulders and they reflected feeling ‘expected to care but not to feel’ (Marie) in their roles as Clinical Psychologists.

To survive, some participants searched for and felt provided with external validation from sources such as clinical supervisors. However external validation was not always achievable due to the participants' own perceptions of the widespread avoidance and denial of the impact of client death. As a result participants' accounts reflected different attempts at sense making with many striving to understand the system's denial by presenting possible explanations for it.

### 2.1 *Alone in a fearful system: Uncovering systemic denial and avoidance*

A sense of being alone in a fearful system was felt to some degree by all of the participants in the sample. By selecting the word 'uncovering' I am attempting to reflect their process of moving from having hope in the various systems, to almost losing hope that the impact of the death of their client would become recognised and supported.

The interpretation of a system being 'fearful' arose from Ruth's account.

> *…I mean my observations are within this particular team people have worked in this in you know this area of medicine for such a long time, twenty-five, thirty years, and so it's just what they do. And they cope with it for so long, and how ridiculous that you might not be able to after eight months or whatever, you know, that kind of not quite that but like "Well we do it so why can't you?"…*
> *Ruth*

> *…It was all about "Yeah fine". There's a real culture about needing to feel, needing for it to be fine...*
> *Ruth*

Ruth’s account raised many questions such as: Why does it need to be/feel fine? Why is it challenging to face an individual who ‘feels the death’? I wondered if Ruth questions were almost reflective a systemic fear of death. From her account as a whole, and the accounts of others, avoidance functioned as a protective strategy within the various systems. However, for the participants it was experienced as an isolating strategy. As a result they appeared to feel alone and inadequate.

For some the death of a client and its subsequent impact was perceived as being overlooked by a clinical supervisor, for others a training institution was viewed as side-stepping this issue.

> *Debbie:*
> *… did you feel prepared for the experience that you had?*
> *Catherine:*
> *No not at all. No no definitely not. And I don’t think even now we’ve had any kind of, I don’t think it’s even been mentioned what happens if a client dies when you see them. No. I didn’t feel prepared for that and I didn’t, I think that would have been helpful if they would have just said look even just think about what how you would feel or how would you respond because at the time it’s very much like what do I do now?...*

Catherine’s account suggested that, from her perspective, she experienced a level of denial within her training course pertaining to issues around client death. Her quote reflects a sense of feeling alone and unprepared in the tailspin of her client’s death as a consequence of this. Catherine indicated that an acknowledgement of the potential of client death at university may have helped prepare her for this unexpected experience. Although, the previous superordinate theme highlighted an awareness of death as less of a protective factor than the participants (and I) had expected (See sub-theme 1.1).

> *…Yeah, perhaps if I'd had loads of experience before I would know how you work with grief or something … You know. … Perhaps this is what everyone else knows [laughs] … it's so obvious they don't train us…*
> *Marie*

Marie appears self-critical in the face of what she eventually interpreted as her wider system's (Clinical Psychology/Team) denial and avoidance of the emotional impact of death. Prior to her increasing awareness of the systemic level of avoidance she experienced when her client died, she felt shrouded in concern and self-doubt in her role as a newly qualified Clinical Psychologist. Marie's changing awareness meant that she reflected on her feelings of vulnerability at that time, as unbelievable (as indicated by her laughter). However, her past vulnerability was no less painful.

Marie's experience alluded to a dominant issue across accounts in particular, and the superordinate themes in general; '*It's so obvious they don't train us'.* This phrase was powerful for Marie and it's meaning was represented across the sample; if it is 'so obvious' should it not affect us? It appeared that although participants were perceiving issues of denial and avoidance with peers, teams etc, their experiences or the perceptions of others could have reflected societal constructions of death as natural, normal and '*just a death'* as well.

### 2.2 *Under pressure to contain the ‘mess’*

Participant’s felt under pressure to contain their emotional reactions in response to a client’s death. This pressure was captured by Helen’s quote below which reflected the feelings of most participants within this study.

> *…I think my feeling at the time was more that’s normal. That’s, you, I think … I have to deal with it. That’s what happens in these settings people die … and you have to deal with it, and toughen up Helen and get on with the next thing because that’s message I’m getting…*
> *Helen*

As Helen was a (voluntary) Assistant Psychologist at the time of her client’s death to cancer, her words reflected a powerful sense of expectation. On the one hand she was learning a new role, how to be a Clinical Psychologist. Her account reflected that as a psychologist she felt expected to ‘feel’ or connect on an empathic level with her clients. However in the context of clinical supervision, Helen perceived her supervisor as being unable to acknowledge her client’s death. As a result she seemed to experience a crisis of identity and direction; she wondered what it actually meant to be a Clinical Psychologist.

At that time Helen questioned her empathic qualities, believing that she should ‘toughen up’. She felt an external pressure to contain or not show her feelings, which eventually translated into an internal pressure to hold them in and perhaps deny them (as evidenced above).

An interesting discovery in the accounts however, was not only the recounted expectation of being able to cope with client death by teams, supervisors and in the wider system of Clinical Psychology in general; it was the imagined consequences of not being able to contain these emotions.  In some accounts participants presented a fear of being judged by others as incompetent if they experienced difficult emotions (as the following quote from Lisa will demonstrate).

Both Lisa and Natalie raised the issues of roles and expectations in the face of emotionally challenging experiences such as death. These discussions occurred in the context of their dilemmas in sharing difficult emotions in supervisory relationships and in the workplace in general.

> *..it can be hard to be really honest with your supervisor … No matter how nice your supervisor is and like especially when you're a trainee and you know that you're getting judged… that, it can be really difficult to be as open and honest as you want to be. Even though your supervisor says "No it's fine you can say whatever you like" cause you kind of go no no no! but you're grading you're marking me…*
> *Lisa*

Lisa pays particular attention to the unique quality of her trainee role. In this role the consequences of honesty felt pertinent for her as it appeared this could have affected her grades. Her fear of 'getting judged' meant she found it difficult to be 'open and honest' increasing the potential of silenced stories within her role.

> *Debbie:*
> *…something about their trainee role?*
> *Natalie:*
> *Could be, and a role as a psychologist that…somehow you need to have a greater capacity to hold onto pain without letting it spill and be messy for other people. That somehow you need to be a container, and to need containing yourself is not unacceptable but uncomfortable maybe…*

Natalie suggested psychologists may be expected to contain the emotional experiences of others, whilst containing their own. This perceived responsibility was confusing and difficult for participants as they sometimes felt unable to share their own emotions with various systems, facilitating their hidden and unsaid nature.

Being ‘expected to care but not to feel’ (Marie) in the face of client death presented multiple dilemmas for participants. They appeared stuck and uncertain as to whether they should keep quiet or express their feelings for fear of negative judgement and ultimately failure in their professional role. Heather’s quote below provides a powerful summary of this experience.

> *…I just remember sort of thinking.. right I’ve gotta compose myself and I’ve gotta get through twenty minutes of talking about this case … and I remember that I got to about fifteen minutes and I’d been telling this very kind of you know sort of narrative story about [the] structure of what had happened … and the work that I’d done. And I got to the point where I had to say that he had died and that I’d seen him for the last time … and that I’d you know found out that he had died … and I just broke down and I started crying and I remember like [laughs], I don’t know, it’s like listen, you’re in university, there are various rumours that kind of circulate about orals and there was one if you cried in your oral then you failed [laughs]…*
> *Heather*

### 2.3 *Surviving in the system*

Surviving the system appeared a necessary yet double edged sword for participants. Their accounts reflected two possible positions in the wake of a client's death: Either you stayed with your emotions because you felt validated, or you accepted the (perceived) institutional avoidance and denial by explaining the system's behaviour. Of course, it was not as simple as this in all cases and the following sub-theme represents the complexity of participant's experiences.

Most participants reported some positive experiences of support in the context of their client's death. This support enabled them to feel validated and accepting of their own reactions in certain contexts. For Vanessa, Lisa and Catherine validation was provided through clinical supervision and from their wider teams. For others peer support, family support and contact with a family member of their deceased client helped to reassure and comfort participants when the wider systems were experienced as failing.

> *…They were actually really supportive. They took it seriously. They were absolutely like if you need if you need a little bit of time off, or a little bit of a break or whatever … I mean my supervisor, I think I went and told her that that afternoon and she was like 'right just go, just go home, go an y'know, go do a bit of shopping. Go relax. Go and look after yourself. Just go home. So that was that was really really nice...*
> *Vanessa*

Vanessa experienced feeling genuinely supported by her supervisor at the time of her client's death. She felt taken seriously and cared for. Vanessa also presented being surprised at feeling validated, as reflected within other accounts. For Vanessa, her experience of validation had been a contrast to her past experiences of feeling negatively judged for expressing difficult emotions in a supervisory context. This meant the perceived validation felt all the more powerful for her.

> *.. I think the team that I was working in then had a really good approach… everyone would talk about it. And they'd have debriefings and everyone went to the funeral and everyone met after going to the funeral and talked about it…*
> *Lisa*

Lisa experienced containment as well as validation by her team. She had an outlet where she could be honest and congruent with her feelings about her client's death, which seemed positive for her.

Heather, who experienced the death of her client as a third year trainee, provided a rich explanation of the impact of validation on her. This quote follows on from extract presented in section 2.2.

> *…but at the time when you're crying [laughs] 'I've failed' …and I looked up from sobbing and I said 'I'm really sorry'… 'I'm sorry, I'm just gonna need a few minutes' and I looked up and they were crying … and I remember suddenly having that feeling like this is where I was and actually there's this real sadness in the room. And it's okay to feel that … and I felt that when I was someone listening to someone else's [my clients] very sad story … and now here they are listening to my very sad story. And it's kind of like having that reflected back. And I suddenly felt like I know actually this is okay, because it* ***is*** *very sad and it's* ***okay*** *to feel very sad about it … and one of the lecturers said to me afterwards well you're the first person that's made me cry in an oral [laughs] … and it was kind of like well*

> *i'm pleased actually … I'm pleased that you have. And i'm pleased that you're human too. And that we're not all this kind of floating around, you know, as clinical psychologists…*
> *Heather*

This quote highlighted her journey from a fear of failure (because of her emotional response), to a sense of relief due to the humanity she perceived in the company of her course team examiners. Heather's account highlighted the power of mirrored emotions. She no longer felt alone, or perhaps incorrect in her feelings. She appeared to feel accepting of herself as a consequence of the system's response. Heather's examiners enabled her to feel heard, validated, and most importantly 'human' too.

Being perceived or accepted as 'human' (experiencing/showing emotions), cuts to the core of this subtheme. Throughout participants' accounts there appeared to be a struggle with being 'human' and knowing if it was acceptable for them as Clinical Psychologists to take this position. It seemed that 'human' qualities were, at times, experienced as hidden or feared. However, where participants experienced their chosen profession as 'human', there was a sense of relief. This experience of relief helped the participants connect with their own emotional selves, without a fear of rejection from their chosen profession.

> *…I think her kind of approach to it and attitude to it wasn't light-hearted, but it was very much like contained. And that helped me to contain my own feelings. I didn't feel like they were a mess that I had to try and juggle myself. It was, we could work through them together and you should have done that and it was safe…*
> *Catherine*

Catherine, who experienced the death of her client as a first year trainee, highlighted her experience of her supervisor's containing role. This sense of containment facilitated her feelings of control in the 'mess' of her client's death. In the above extract and in Catherine's account overall, containment also reflected a feeling of safety which appeared to negate her feeling of being alone with her emotions.

Although experienced differently, validation and containment were facilitators for participants as they seemed to enable the processing of emotional experiences following their client's death. They felt they had permission to be 'human', which appeared to feel like a relief.

On the other side of the coin and where validation and containment were not perceived by participants, a struggle with sense making began Participants' accounts reflected a desire to explain the perceived denial and avoidance they appraised within various contexts (e.g. university/teams) and within the profession of Clinical Psychology in general.

> *…But it's very sad that that gets left… maybe they think it's only a minority of people that have that experience. Actually maybe it's only a minority because people don't talk about it, and they don't talk about it because they think they're a minority, so it's [laughs] it's a self perpetuating problem… It I would be interested to know the statistics on how many people experience the loss of a patient. Because no I don't think anybody's ever talked about it… I don't think anybody knows…*
> *Natalie*

Natalie uses the idea of a 'self perpetuating problem' as she reflects on her experience of client death within the profession of Clinical Psychology. She felt that assumptions that client death does not occur accentuated the reduced acceptability of talking about it when it does happen. Natalie had a lot to say on this issue and she appeared curious as to the prevalence of this experience. Natalie's ideas also stretched to explanations of the absence of death talk as a cultural issue in the United Kingdom; presenting her view of society as fearful of death. Natalie was searching to understand her experience, in the midst of the confusing reactions by others.

> *…I think there's also something about a nursing or medical [laughs]… culture generally And needing to put on a brave face and cope, even in the sort of face of quite adverse circumstances… or sadness cause that's just your job...*
> *Ruth*

> *…I don't [want] to paint them as being sort of unfeeling … or you know kind of un-empathetic or sympathetic or anything like that because they were a lovely very warm team. And they did experience grief and loss and they did communicate some of their feelings around that but they also were there to do a job… and you know I suppose if you're around that all the time then you maybe get a bit more used to it than I was I think….*
> *Heather*

Both Ruth and Heather had not felt validated by the teams they had worked in when their client's died. Both had been working in oncology settings (adult and paediatric respectively) and both offered explanations which considered how people cope when death was 'just your job'.

Their accounts reflected a lot of respect for medical and nursing professionals who routinely work with death and dying, and in Heather's experience she had recognised grief in her team. However, for Heather, there were also questions as to the depth of her team's engagement with their grief. It also seemed from Ruth and Heather's accounts that they had less confidence in their ability to cope with death, in comparison to their colleagues, which had perhaps been a source of invalidation for them.

The justifications evident in participants' accounts were interesting and perhaps these attempts at sense making may have been less painful than facing the denial of their reactions.

## 3. 'IT'S NOT SOMETHING I'VE FORGOTTEN ABOUT', THE LASTING IMPACT OF CLIENT DEATH: LEARNING RELUCTANT LESSONS AND EXPERIENCING CONTINUING BONDS

### *Overview*

The final superordinate theme serves to illustrate the lasting impact of the experience of client death for participants. This theme captures a different stage of processing during the participants' journeys with their loss.

During analysis it became clear that all participants still remained connected, in some way, to their clients who had died. For some the remaining connection evoked feelings of a changed self and at times this connection, or continuing bond, was a source of comfort and of pain. Participants appeared to feel they were *being* changed by the death, which led them to learn reluctant lessons about themselves and others.

This final theme also captures the experience (over time) of participants who had felt re-connected with their ‘human’ selves within their professional roles (As noted in sub-theme 2.3). Accounts reflected a sense of integration and resolution between their professional and human selves which eventually felt like a positive change for participants.

The experience of death as a continued threat was presented in some accounts. This perceived threat was often highlighted by descriptions of active and planned avoidance, in the face of future deaths. Participants’ accounts described client death, and its resulting impact, as an experience they did not wish to replicate. This was the case, even when an increased feeling of confidence in their ability to cope with client death was described.

Such lasting experiences of the death of a client meant that all participants placed value on having ‘therapeutic’ time and space to help understand and process their experiences. Where a lack of such time and space was experienced, participants felt hindered in their emotional processing and challenged by their perception that little value had been placed on the lives and memories of their deceased clients.

### 3.1 *Being changed by a unique and memorable death*

Being changed indicated death as being in the driving seat once again. This was the case for participants whether the changes they described were positive or negative. Being changed by the death was related to a clear message presented in all of the accounts; death was an experience they did not choose, it came out of the blue and most would have preferred not to have faced this (See 3.4 for further exploration of this issue).

Reluctant lessons were often learned by the participants in the face of death. These lessons included; a raised awareness of existential time constraints (mortality); the meaningful nature of death as an ending, and the importance of being aware of health issues in psychiatric settings. The participants, at times, presented an increased feeling of vulnerability and resilience within their accounts. These qualities were often presented hand in hand, as resilience was constructed in the context of surviving a vulnerable time (See Helen's quote below).

> *…Part of me feels that [short pause] looking back, if I was able to kind of put myself in that situation that was incredibly difficult, I felt out of my depth, there's a kind of feeling in me that I'm quite resilient … and I can you know, it was difficult, but I managed...*
> *Helen*

> *…It's not something that I've forgotten about. And I guess if I was working with somebody who was ill then it might make me view my work with them a bit differently. It's also given me the kind of resilience that I know that, if a client does die, then I know a bit more about how I might deal with that. … yeah. And it probably has made me more aware of when I'm working with somebody that although you've got a set amount of time, it doesn't mean that for whatever reason that you're actually gonna have that amount of time together…*
> *Catherine*

The positive changes and resilience noted by Catherine above, and during her interview, also reflected her feelings of being under pressure in her work (actual and potential) with dying clients. Her account overall had reflected a fear of not being able to evaluate the effectiveness of therapy when her client died, and it was possible this led to greater insecurity and pressure to do a ‘good job’ in the face of death.

> *…I think it’s just actually made me realise … what you think of as just a death. You can think about… it’s just something that you need to get over… but actually yeah the kind of ramifications have pervaded quite a lot of my kind of professional life…*
> *Vanessa*

Vanessa’s initial explanations of her experience of client death reflected the general society-wide view of death as something ‘you need to get over’. However, this construction appeared to change as she became more experienced as a professional, and as her lived experiences were explored at interview. Death became acknowledged as difficult and challenging, Vanessa wanted to take time over this experience and it did have a lasting impact on her.

For Vanessa, talking about the death of her client appeared to cement the changes which she had experienced, a clear example of the co-constructed nature of qualitative and Constructivist research (Guba & Lincoln, 1989; Smith, Flowers & Larkin, 2009). Vanessa’s account (see sub-theme 1.4 also), and the accounts of other participants (Heather, Marie), showed client death as being viewed through different lenses in the ‘here and now’ (e.g. as a mother, as a more experienced professional).

> *Debbie:*
> *…Do you feel it’s had some any lasting impact on you as a clinician as a person?*
> *Marie:*
> *Uh yeah, I suppose, well I hope so [laughs]…*

Marie appears to say something important here about her experience of her client’s death. Her indication of a hope for change seemed quite striking and her experience of death felt yet to be processed.  She experienced a need to hold on and *become* changed by her client’s death and her account represented a person at the beginning of her journey with this loss. Although this was emotional for her during the interview, she was determined to continue on her journey

### 3.2 *The pain and comfort of continuing bonds*

There was a sense of pain and comfort in the accounts of the participants as they reflected on the death of their clients. The continuing bonds reflected the maintenance of a relationship with their clients even after they had died. As if part of the client lived on through them. This continuing bond was not always fully understood by participants but it was almost always felt.

> *… I think she’s a, sort of people… that I take away from placements…and there’s her and there’s another woman that I worked with that really kind of stay in my mind* ... *and I suppose [it] doesn’t feel to me that it means that they haven’t kind of been processed. It feels like they were big experiences and also I maybe I don’t want to forget…*
> *Helen*

Helen’s extract reflects a sense of holding on and not wanting to let go of the memories and bond with her client. The client’s death was presented within Helen’s account as defining and profound for her. This experience felt intense and yet there were feelings of comfort with this bond that she did not want to forget.

Helen’s words also reflected an idea that her memories may be perceived as unprocessed grief by wider systems e.g. colleagues. Within her account Helen appeared aware of a pressure to ‘let go’ of the feelings and thoughts of her client to prevent them being constructed as unprocessed or pathological. This felt almost disappointing for Helen and unreflective of her own experience with client death.

> *…I think if I was sitting with a [psychology] colleague talking about [memories of client], that would be very much within the PTSD kind of model of intrusions, or idea of intrusions… and that’s, you know, a form of trauma memory that hasn’t been processed properly because it’s still here and still alive for me … but I guess my feeling is more, or what I allied myself more with, is that **I’m** remembering the people and **I’m** keeping them alive…*
> *Helen*

Within Lisa’s account the continuing bond with her client was painful.

> *… I felt I would have felt horrible throwing it. And maybe it is something about a tie… that I did have a tie to this person and with throwing this away it feels like I’m kind of chucking that in the bin…like it felt **really** bad. I wish they hadn’t given it to me [laughs]…*
> *Lisa*

Within the interview Lisa spoke in reference to a memorial card she received when attending her client’s funeral. She described her dilemma of keeping the card or throwing it away. From Lisa’s descriptions this struggle was symbolic of the bond or ‘tie’ she experienced with her client following his death. She experienced uncomfortable feelings within this situation which could have been viewed as the pain of continuing bonds.

> *She represents now… almost the one that got away. And that will always be a sort of… a 'what if?' and could I have handled things differently, yeah sort of a real sense of missed opportunity I think….*
> *Natalie*

Natalie made reference to the 'now' which emphasised the temporal aspect of this superordinate theme overall. It also said something important about her experience of the death of a client specifically. Over time Natalie was reluctantly resigned to being left behind with losses, at the same time holding on to fond memories of her client. Eventually her client became a representation of 'the one that got away'. This could be viewed as a bond of comfort and pain.

### **3.3 *Choosing to care and to feel***

Choosing to care and to feel represents an important aspect of the experience of a client's death for Helen, Ella and Heather. Their experiences suggested that over time, they became re-connected or established their confidence in being a Psychologist who experienced and expressed emotions within a professional context. The accounts highlighted that these qualities were no longer feared as being unprofessional, or something to be ashamed of. Helen, Ella and Heather described feeling 'allowed to be' human.

> … *I thought it's just a kind of it's a job where we work for people and we can't do everything all the time and we're allowed to be human…*
> *Helen*

Their sense of choosing to care and to feel appeared to be facilitated by both an external source of validation (positive supervision experience) and an internal sense of striving for a preferred professional identity.

For Helen (above), the development of her ability to feel comfortable with her ‘human’ side had been experienced in the context of a placement supervisor who routinely explored such professional struggles. Helen’s experience of a struggle between being ‘me’ and ‘this other thing’ (her professional identity) had been represented throughout her account. Her decision to be more ‘Helen’ facilitated a feeling of relief, as if a weight had been lifted from her shoulders.

> *…I did spend quite a lot of time I think talking in supervision about how it’s okay to be sad about a client dying… it’s not unprofessional to have a kind of human sadness about the loss of someone’s life…*
> *Ella*

Ella’s account reflected a long journey with her ‘human’ self within her role as a junior Clinical Psychologist. The battle to integrate the psychologist and the ‘me’ position appeared pertinent for some participants; particularly in the context of negative experiences of systemic denial and avoidance of the impact of client death.

Being ‘human’ was not simply presented by participants as being useful for a professional role. It was experienced as important for the families Heather (below) and others had worked with.

> *…I suppose… I kind of feel like what I learned from this experience was sometimes you do become someone very important to a family, and especially when you’re going into people’s home where their child is dying*

> *and they're not seeing that many people. And you know, you're going in weekly, or whatever, I think it's difficult. I don't think I ever kind of breached any BPS guidelines, but I think I probably [I] let a few more boundaries down than I perhaps would have done had… I been working in a different field…*
> *Heather*

Heather's experience illustrated the comfort she found in being able to connect with families in their times of sadness. Within her account this experience enabled her to re-examine the sort of psychologist she wanted to be and she seemed liberated. Her extract also demonstrates, however, a hint of fear in relation to adhering to professional guidelines. Heather also connects her humanity to a specific context (paediatric oncology) to potentially justify her reactions. This could be understood as a further reflection of the fear of judgement and professional rejection presented in superordinate theme 2. Although there was a striving to be 'human', there was still a fear of this position's consequences within participants' accounts.

### 3.4 *Feeling threatened, becoming avoidant too*

The threat of future deaths appeared pertinent for Ruth in particular, although this theme was present across accounts. For her, this perceived threat provoked feelings of vulnerability and a need to re-consider the presence of death in her professional life. I have chosen to use more than one of Ruth's quotes here in order to illustrate this theme.

Following a thorough analysis of the data Ruth presented a unique, thought-provoking view of working with multiple deaths from her experience in palliative care. During her interview she reflected on her thoughts and feelings about issues of mortality and her experience of feeling ‘a bit burnt out’ after a year in her newly qualified post.

> *Ruth:*
> *…[Laughs] So yeah I haven’t made any firm decisions about where I go next or whether I even go from this area, but I’ve noticed feeling a bit weary about work feeling a bit burnt out [laughs]…*
> *Debbie:*
> *Right a year down the line*
> *Ruth:*
> *Yeah…yeah a year in….*

In my view, Ruth’s laugh represented the struggle she experienced with her own feelings in the context of (what she perceived as) an unsupportive system. Her account reflected several personal changes in the face of multiple deaths e.g. feeling weary. During the interview her admission of weariness also seemed difficult, as evidenced by her laughter once again. One possible reason for this could be related to her perception of others in her team (‘we do it so why can’t you?’), which could have led to a reluctance to admit any difficulties and her ‘feeling a bit burnt out’.

> *…Because it is working with a lot of real distress real misery illness death, and as I said earlier on, I think I’m someone who copes with life generally by being quite optimistic and positive… and I think I have noticed that over the course of a year working in a setting that really challenges that kind of approach to life, or you know, raises your awareness of yes that’s fine a very positive approach to life … but actually what might happen is something very different you know it challenges my core beliefs you like…*
> *Ruth*

In the above quote Ruth expands on her experience of working with multiple deaths in more detail. In a very powerful description she illustrates how death has nibbled at the core of her identity, making death feel like a disease that has begun to ravage her concept of self. The threat of death led to many existential questions for Ruth in relation to her own life and mortality in general, which felt uncomfortable for her to face.

At the end of Catherine's interview and in response to the following question; 'is there anything else that feels important to say about your experience that we haven't covered?' Catherine offered the following interesting narrative.

> *…I don't know if it's important, and I don't know if it's just because of my experience, but I did. When you were just, the previous question you were asking me something flashed up in my head. That is it put me off the idea of working in palliative care. And I don't know whether I would have been put off anyway… I don't know if that's just my personality, but I did think I don't want to have to handle this and if I can avoid it then I will try and avoid it. And when it came to picking third year placements, cause I really enjoyed my clinical health placement, there is a specialist one but it involved palliative care and I remember thinking I really actually don't want to have to go back into that. And I think that probably was influenced by her dying. Cause… if I can avoid it then I probably will try but I'm prepared for it if it happens.*
> *Debbie:*
> *Why do you think that is? That's really interesting.*
> *Catherine:*
> *I don't know. I'm wondering whether it's because at the time it was unexpected it threw up all these feelings. I don't wanna feel these feelings*

> *again. Maybe if it happened now it wouldn't throw up those feelings because I'd be a lot more confident. But I guess that because the first time it happened I can remember how I felt I don't really want to feel that way again. And yeah and it was sad, and even though logically I think in my head it wouldn't be like that the second time, I would be prepared I'd have some resources in place, there's still that part of me that goes no I don't wanna feel those feelings again I'm just going to avoid that situation [laughs]…*

Catherine's quote provides a lived sense of the findings from the interviews as a whole. From a hermeneutic perspective, this extract is the part which illuminates the whole study (Heidegger, 1962/1927; Husserl, 1927; Smith, Flowers, & Larkin, 2009).

She walks us through the feelings death 'threw up' and how she felt unprepared for this. How she feels she has changed over time e.g. becoming more confident in herself and even gaining coping resources following her client's death. However, her account illustrated that this was not enough to protect her from the perceived threat of death. Catherine's extract demonstrates she did not want to feel 'those feelings again'. To survive, Catherine planned her avoidance, perhaps to provide order and control for herself. She pushed death out of the driving seat for her own safety.

### 3.5 *The importance of 'therapeutic' time and space*

The importance of 'therapeutic' time and space in the context of death and loss was strongly supported by all participants in this study. Following the systematic discovery of this theme it was recognised that it's content mostly arose from the final reflections participant's presented during interview feedback. This will be illustrated with Helen's extract:

> *Debbie:*
> *... so has it been okay kind of talking about this experience?*
> *Helen:*
> *…it's been really useful… it's really nice to have the opportunity to actually to think through it and maybe, especially in the light of not having really done that very much. So it feels quite therapeutic…*

Helen's quote clearly illustrates the power of talking about loss and thinking it through in the absence of feeling heard previously. Time and space in the interview was experienced as 'quite therapeutic' and many of the other participants in the study expressed this too. This finding is in line with a paper by Birch and Miller (2000). Their study highlighted feeling listened to and enabled to talk during research interviews could be perceived as therapeutic by participants (Birch & Miller, 2000).

Participants' accounts stressed the importance of finding the time and space to process the death of a client without a fear of judgement. They also emphasised that client death does happen, it can be experienced as difficult and isolating, and there could be negative consequences where silence occurs. This is a point Ruth and Catherine illustrate in the previous theme and Heather and Natalie illustrate below.

> *…I think death is something that is very difficult for a lot of people. And I think it needs, [you need] to make sure that there's enough space and time given to processing that..*
> *Heather*

> *… I think you need to make space for loss…*
> *Natalie*

> *…And it was funny, when I got your email I thought 'I wanna do that' without really thinking too much about. It just felt, oh that sounds interesting … I've been surprised by, you know, what I think about it cause I hadn't really thought, I haven't talked about it with anybody….*
> *Natalie*

'Therapeutic' time and space seemed more than feeling listened to; it was experienced as enabling participants to embark on a journey with their loss. In Natalie's extract she reports experiencing feeling drawn to the research, without much conscious awareness of her reasoning. The 'therapeutic' time and space in the interview supported Natalie in not just talking about an unspoken loss; it enabled her to become consciously aware of her thoughts about the death of her client. Her account, and the interviews of other participants, indicated 'therapeutic' time and space could prove to be a powerful, facilitative experience for some, as Heather indicates below.

> *…I thought that I might feel sad again and I have… and but not kind of in a really desperate way, just as I'm telling you I notice every now and then that sort of my eyes get a little bit watery… and I think I'm surprised I'm not surprised that that's happened but I think I perhaps hadn't necessarily given [myself and my client's death] enough time and space…*
> *Heather*

The following extract from Marie's account illustrates her perception of the absence of 'therapeutic' time and space following her experience of her client's death.

> *…I suppose I've just avoided thinking about it probably [laughs]… um has it changed? No. I think that's the problem. I'm not processing yet, it's slightly frozen in time*
> *Marie*

The absence of dedicated, thoughtful space appeared to freeze Marie's loss in time. Marie's experience of the research interview could be understood as the heat which began to thaw this frozen experience. From Marie's account it appeared that this thawing was painful at times as she felt unprepared for the intensity of her emotions. This was a difficult, and yet reassuring experience for her, as evidenced by her desire to become changed (See sub-theme 3.1).

Finally, therapeutic time and space was not simply related to the participants' needs, it was experienced by participants as a way of valuing their clients.

> *…thank you very much for giving me the opportunity to honour Jack I think in that sort of yeah talk to someone about him…*
> *Ella*

As Ella shows, therapeutic time and space gave her the ability to 'honour Jack'. Being able (or allowed) to recognise their client as a person and not 'just a death', was important during all of the interviews.

## 4. FINAL THOUGHT

To complete this chapter a final quote taken from Heather’s interview will be presented. This quote represents an important viewpoint, reflected in the data, about the longevity of the experience of the death of a client.

For all Clinical Psychologists in this study, the death of their clients did not feel neat, tidy and processed. It felt important, and at times painful and messy. In spite of this all experienced death as something worthy of and indeed *in need* of attention both in the here and now and in the future, whether this be in five, ten, or twenty years time.

> *…it might be… another ten years before something else sort of comes back in my mind to remind me of that case and I’ll think ‘oh yeah… he’s still there’…*
>
> *Heather*

# DISCUSSION

The study's findings will now be considered in the context of my research question, existing literature and relevant theoretical constructs. During the discussion new literature will also be introduced. Smith, Flowers and Larkin (2009) argue that the selective introduction of new material is often necessary in IPA studies as analysis can often lead you down unexpected paths with your data.

Following this, methodological strengths and limitations of this investigation will be considered alongside the potential clinical implications arising from the research. Finally, I will present the future directions for research and my final reflections.

## REVISITING THE RESEARCH QUESTION

As previously indicated the main objective of this study was to explore how junior level Clinical Psychologist's experienced the death of a client with whom they had been in therapeutic contact. In addition to this the following areas were explored in detail:

1) The impact of the death (positive and negative)

2) The coping strategies used

3) The support systems available and the implications for these

4) The potential changes for the participant as a person and clinician following the death of their client

The following sections will therefore present the research findings in the context of the above points of interest.

It is important to emphasise at this stage that the ‘experience’ of the nine participants and the discussion of results reflects a Constructivist perspective on these issues e.g. it represents one possible explanation (Appleton & King, 1997; Guba & Lincoln, 1989).

## JUNIOR CLINICAL PSYCHOLOGISTS EXPERIENCE OF THE DEATH OF THEIR CLIENT

### *The experience and impact of the client’s death*

This section will present a discussion of the results in relation to the overall research question (experience) and the first area of interest noted above (impact), in the context of existing research.

The death of a client represented an important and memorable experience for all participants. All of the junior Clinical Psychologists within this study felt affected by their client’s death, a finding seldom acknowledged within the current research base.

Death was depicted as a potentially confrontational force which evoked many differing, challenging and often unanticipated emotional, visual and cognitive reactions e.g. shock, visualising the death, considering lost opportunities. A client’s death was often constructed from a passive position; as if it was something that happened *to* participants, something over which they had little control. Such experiences were reflective and supportive of previous research which highlighted the memorable, and emotional, impact of a client's death for medical professionals, occupational therapists and psychological therapists (Cipriani et al., 2000; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Schwartz, 2004). From the results of this study, client death appears to affect various professions, whether a physical death is witnessed or not, a factor which appears significantly overlooked in the current evidence-base.

The results of the current study provided striking support for the work of Schwartz (2004), who had investigated sudden client death for therapists. The level of similarity between both studies' findings had not been anticipated, despite study similarities. This connection, however, may relate to the rigorous use of qualitative methods in both studies, which ensured the experience of client death was grounded with the participants themselves. To illustrate, the first superordinate theme 'connected and affected' had outlined the participants search for meaning in the face of death, the emotional reactions client death provoked, and the resulting losses they had experienced. These findings appeared similar to themes within Schwartz's (2004) research, such as therapists' bereavement (emotional reactions) and left holding the bag (experiencing loss/uncertainty).

The current results also extended previous findings with their implication that a client's death may be experienced as an unexpected event (Schwartz, 2004). This was the case despite participants holding particular spiritual beliefs (Marie: life as impermanent) and personal beliefs about death (Lisa: natural part of life), or previous experiences of death, a contradiction to previous research findings which had highlighted these beliefs as coping strategies (Cipriani et al., 2000).

Historically, the construction of an expected versus unexpected death has been viewed as an important division of experiences, as Schwartz's (2004) study on 'sudden death' argued in its early stages. However the current study replicates the suggestion by Schwartz (2004) who eventually concluded that this division of experiences may be arbitrary for psychological therapists. It is also pertinent to suggest this division has meant certain types of death could be constructed as worthy of greater attention e.g. suicide, which may overlook the experiences of many clinicians. Based on participants' accounts, death, from any cause (expected or unexpected), appears to be an important focus for research and within clinical practice.

Although the similarities with Schwartz's (2004) work are important to note, the differences are also interesting. Within Schwartz's (2004) study the mediating influence of an 'attachment' in the therapeutic relationship was emphasised (e.g. stronger relationships equalled deeper emotional reactions), a finding also tentatively supported by Redinbaugh et al (2003). In the present study, however, all participants described similar reactions to their client's death even where variations in contact time and differences between their described relationships were presented. This is an important finding which links well with the work of Cipriani (2000) and Rhodes-Kropf et al (2006) who have argued that deaths may be memorable and important experiences even when little contact with a client had occurred. Although other factors such as feeling alone with the death, their 'lost opportunities' to provide therapy and the lack of 'therapeutic' time and space, may have mediated this effect in the current sample.

### ***Support and coping in the face of client death***

This next section will continue the discussion of results in context of the research question (experience) combined with the second and third areas of interest (coping/support). This section will also introduce the impact of working within a particular professional identity, Clinical Psychology, in the context of coping with a client's death.

Some participants had clearly felt supported by various systems in which they worked (e.g. supervisors, teams). Where support had been received, participant's recounted being open and congruent with their emotions and reactions, which was positive for them. Support was especially powerful when it was experienced as mirroring participants' emotions (e.g. by Heather's examiners). This normalised their reactions to a client's death and enabled them to feel 'human', which provided a powerful sense of relief. This finding amongst Clinical Psychologists is in line with a study by Moores et al (2007), whose results acknowledged the normalising impact of recognising doctors as human and compassionate in the face of death. This acknowledgement appears appropriate within this study too, particularly as these qualities seem poorly recognised for Clinical Psychologists within the research base which considers client death.

Although the receipt of support was important to acknowledge, experiences of support seemed inconsistent. At times a client's death was experienced as poorly recognised across various systems (teams, supervisors, Clinical Psychology). This lack of recognition negatively impacted the (perceived) level of support provided to participants; they often felt alone with the death and some felt close to 'burning out'. This finding is in line with the existing research base which indicates a limited recognition of client death can negatively impact healthcare professionals in general e.g. source of ‘burnout’ (Moores, Castle, Shaw, Stockton, & Bennett, 2007; Rhodes-Kropf et al., 2005; Schwartz, 2004).

As Natalie (participant 5) described, a lack of recognition (or avoidance) of the impact of client death may be a self-perpetuating cycle. Through not talking about client death, we may assume that it does not occur to others; as a result this area may not receive the attention it appears to deserve within the field of Clinical Psychology in particular (Duckett, 2005; Schwartz, 2004). This implies that an avoidance of death talk within a clinical context may serve to disadvantage many professions as fewer, perhaps necessary, sources of support may be available. These findings present a strong argument for the increased awareness of client death as a possible experience within the role of a Clinical Psychologist. This acknowledgement has begun within the working party for End of Life Care within the British Psychological Society (BPS, 2008). However, through only locating death within ‘end of life’ settings, deaths which occur across the lifespan may continue to be less well acknowledged.

The self-perpetuating cycle, noted above, may also extend to the wider societal context of the United Kingdom (UK). Within this context death talk appears much avoided, as evidenced by the limited UK evidence-base within this area and the reportedly under-resourced level of patient care at the end of life (CAH, 2004; DOH, 2008). Potentially the study’s findings present further implications at a government level, illustrating even more could be done to challenge the unspoken nature of death within in the UK to facilitate support and coping for many.

A further unanticipated finding from the study was the importance of the participant’s professional role or professional identity in mediating their ability to seek support in the face of a client’s death. By interviewing Clinical Psychologists in the early stages of their careers, issues specific to training and evaluation arose, for example, a fear of judgement and ultimately a fear of failure as a result of their reactions to the death. As if experiencing emotional reactions was incompatible with being an effective Clinical Psychologist.

LoGerfo (1998) suggests professional students may feel vulnerable in the early stages of their careers due to the strict standards of development and constant evaluation they face. It is argued that students within such contexts can often battle with being themselves, or the ‘me’ aspect located in the study’s data, for fear of being rejected or poorly evaluated (LoGerfo, 1998). Further to this, where emotionally challenging experiences are faced, an internal battle with how to respond in the face of a professional system can occur, particularly when students are not yet successful in their careers (LoGerfo, 1998).  Such findings may highlight some of the difficulties, or dilemmas participants had with ‘eliciting support’ as a coping strategy (Schwartz, 2004), or resolving professional/self conflicts in the context of a client death, where a fear of judgement or failure potentially exists; A finding supported by Cipriani et al (2000).

Ronfeldt and Grossman (2008) argue, in their US based study, that in their view Clinical Psychology as a profession, attempts to support its trainees in developing and testing out possible professional selves e.g. using role plays and educational role models to explore feared or desired qualities. However, they suggest that even where this is the case, individuals may still experience struggles with translating these ‘possible’ or ‘provisional’ selves into clinical practice. This was explained as being related to the possible constraints and expectations placed on individuals within environments where training courses may have less influence e.g. training placements (Ronfeldt & Grossman, 2008).

The above research findings were relevant in the context of the current study as participant’s indicated the (perceived) reactions and expectations of others mediated their expression of their ‘human’ self (possible self) in both a positive and negative way (accepted versus rejected). Ronfeldt and Grossman (2008) argue that where tensions and contradictions occur e.g. expected to care but not to feel, individuals should attempt to reconcile these difficulties in collaboration with their training institution. This may enable Clinical Psychologists, at the early stages of their careers, to feel supported and more able to cope when a client’s death occurs.

Finally, all participants placed value on having ‘therapeutic time and space’ in order to cope with their loss. ‘Therapeutic time and space’ did not appear to relate to formal psychological therapy or counselling, as highlighted in previous research (Cipriani et al., 2000; Moores, Castle, Shaw, Stockton, & Bennett, 2007). Instead this reflected the need for a non-judgemental, empathic space in which participants could explore the impact of their client’s death within the context of their professional and personal identity, over time. Where available, open and safe discussions about death in the work of a Clinical Psychologist, combined with the dilemmas they may face in the workplace, could address fears and anxieties about working clients who may die (Kirchberg, Neimeyer, & James, 1998). However, few participants reported having access to ‘therapeutic time and space’ outside of their research interviews. Having a lack of time and space for loss was extensively highlighted by other professional groups within the existing evidence-base, therefore this finding is in line with previous studies (Baverstock & Finlay, 2006; Cipriani et al., 2000; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Schwartz, 2004).

### *Changes and consequences*

This final section will present a discussion of the results in relation to the overall research question (experience) and the final area of interest (changes/ consequences), in the context of previous research. Issues of professional identity will also be considered once again in the context of the changes and consequences for participants.

The lasting impact of a client's death was clearly illustrated in the accounts of the nine participants, with both positive and negative connotations. Previous research had indicated healthcare professionals may be disturbed by a client's death (Baverstock & Finlay, 2006; Redinbaugh et al., 2003), or rewarded by this experience over time (Moores, Castle, Shaw, Stockton, & Bennett, 2007). Interestingly, such themes did not appear in the current participants' accounts. Over time, feelings of resilience were noted by participants. However, they often arose in the context of 'surviving' feelings of vulnerability and as a result; they were not experienced as rewarding. This is an original finding in relation to the existing evidence-base.

Issues of avoidance were highlighted as a lasting consequence within some participants' accounts. This meant some had actively chosen not to engage in work settings which involved death and dying following their client's death. However, avoidance strategies were complex. They seemed to not only relate to memories of a client's death, but also to how they were supported at the time, the acknowledged impact of death in their clinical work and, for some, their own increased awareness of mortality. This is a particularly important finding in the context of national and professional policy proposals, which highlight an increased need for psychological input for individuals (and those around them) at the end of life (BPS, 2008; DOH, 2008).

Such national policy proposals may lead to the creation of jobs for Clinical Psychologists in these areas, without an adequate discussion of the impact or consequences of client death for professionals. These issues have not been overlooked entirely. The British Psychological Society's (BPS: 2008) guidelines, which translate the current End of Life Care policy into clinical practice (DOH, 2008), do highlight necessary issues of self-care, adapted from Brennan (2004), such as dealing with 'stress in the workplace' and recognising 'burnout' (suggested as an inadequate construct by Papadatou, 2000). However, they do not explicitly address the experiences of working with clients who die and the possible impact of this. This is a gap that the current findings, coupled with future research in this area, could potentially fill.

For some participants, their battle with their 'possible selves' reached integration (Ronfeldt & Grossman, 2008). This seemed to enable participants to become less fearful of showing their 'human' characteristics in future clinical contexts. This, in line with previous research, was beneficial for both themselves (provided relief) and others e.g. client's family, teams (Matsuyama, 2005; Schwartz, 2004). Although these findings did not appear related to a participant's current professional status explicitly, this may be important to consider. Particularly as all participants were at a transitional stage in their development (third year trainee/ newly qualified). However, the experience of integration, suggests the importance of recognising the 'person', not simply the 'professional' within a clinical role and in the face of death.

From the findings noted above, participants' journeys may be reflective of the processes outlined within the theoretical models of a healthcare professional's grief by Kaplan (2000) and Papadatou (2000). Both models indicate an individual's response to their client's death will occur within a particular professional context, which in turn may mediate the grief (and perhaps coping) process for them e.g. able to be human. Such models appear reflective of experiences previously reported within the evidence-base and they may therefore warrant further attention in the future (Cipriani et al., 2000; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Schwartz, 2004).

For all participants, the final consequence of the death meant that many experienced a lasting connection or bond with their client. This lasting connection felt important, if not difficult at times. Experiencing what has been coined as a ‘Continuing Bond’ in the face of bereavement (in general) is a key trend within the current bereavement research base (Klass, Silverman, & Nickman, 1996; Stroebe, 2001; Stroebe, Hansson, Schut, & Stroebe, 2008). The Continuing Bond (attachment focused) and Constructivist (meaning making) trends appears to have developed to contrast approaches which emphasised ‘letting go’ of a loved one as the desired resolution of loss (Gillies & Neimeyer, 2006; Klass, Silverman, & Nickman, 1996; Neimeyer, 2001a, 2001b). Although newer models are designed with the death of a loved one in mind, they may also be useful for understanding the participants’ experiences within the current study. Many participants seemed to want to ‘hold on’ and ‘become changed’ by their client’s death, they did not want to let go.

For some participants, there was some concern about the perception of their continuing bond with a client by other healthcare professionals, including psychologists e.g. as pathological, inappropriate. Indeed, the evidence-base has often based its own judgment of the impact of an event on a person’s memories, emotions and even avoidance of the situation concerned; combined with the duration of reactions  (Baverstock & Finlay, 2006; Horowitz, Wilner, & Alvarez, 1979). However, the participants’ experiences have illuminated a subjugated story (Sori & Hecker, 2008; White, 1995). The maintenance of the connection with their deceased client was experienced as both comforting and painful, not pathological. Perhaps such memories or connections could be viewed as continuing bonds, as defined by the current bereavement research base (Klass, Silverman, & Nickman, 1996), as opposed to ‘unprocessed trauma’ (Helen). As a result, the taboo nature of talking about these experiences may be challenged, and support systems could be developed for those who find the death of a client traumatic.

## METHODOLOGICAL CONSIDERATIONS

This section will present a critical review of methodological issues within the study, coupled with suggestions for future improvements based on study strengths and limitations.

The current qualitative investigation, which adopted Interpretative Phenomenological Analysis (IPA) as it’s analytic method (Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn, 1999) has illuminated the phenomenon of client death for nine female participants working as junior Clinical Psychologists. Although the studies’ findings are acknowledged as relative, subjective and interpretative, it is hoped that they will have provided an original, interesting insight for the reader into the lived experienced of client death, for a small sample of participants (Appleton & King, 1997; Guba & Lincoln, 1989).

To enhance the validity of this study’s findings the results have been produced by following a rigorous, transparent and thorough IPA procedure (See Appendix 11; Audit trail: Elliott, Fischer, & Rennie, 1999; Smith, Flowers & Larkin, 2009). Further to this, I have explicitly owned my ‘own perspective’ (Elliott, Fischer, & Rennie, 1999) on the subject investigated, and my professional and personal position on death, whilst explicitly demonstrating my management of these issues

(See Method section). It is hoped that these measures will have improved the quality of this research project (Elliott, Fischer, & Rennie, 1999).

In reviewing this study a number of strengths and limitations were noted. To begin this discussion I will start by focusing on the experience of interviewing my peers.

From a positive standpoint interviewing fellow Clinical Psychologists was an interesting experience. I found that a good level of rapport and trust was able to develop quickly within the interviews which was a strength (Mercer, 2007). I also felt my shared experience with peers, facilitated recruitment. All participants were familiar with the demands of a final year project which meant they were very supportive of this research. This shared experience could have also enabled participants to talk about their challenging systemic experiences in greater detail in comparison with a non-trainee researcher. From a critical perspective, there may have been a larger degree of assumed knowledge within the interviews. I often reflected on whether different questions or areas may have been explored by an 'outsider' e.g. how clinical supervision operates. This is a limitation worth considering despite the active management of my own possible assumptions within research and peer IPA supervision (as noted in method section).

My own experience of a client's death was important to consider throughout this study, from it's development and throughout the analysis of accounts (See Introduction & method sections). Participant's accounts were moving, yet most felt different from my own experience. This was partly due to my conscious effort in attempting to 'bracket' my pre-conceptions during the interviews (Smith, Flowers, & Larkin, 2009), but also due to the passage of time since my client's death and the skills I have learnt as a therapist in managing self-relevant issues in therapy. I firmly acknowledge my own experience of client death has driven this project, however I feel the implications of my ‘own perspective’ have been managed effectively.

Working with data from nine interviews has been difficult yet fruitful. This rich data set presented multiple dilemmas, in particular having the responsibility of privileging certain themes over others. To address this I have been stringent in following recommendations and suggestions for the systematic management of larger samples (Smith, Flowers, & Larkin, 2009). In the future, however, it may be interesting to select one of my interviews for further analysis, in order to illuminate general versus specific issues in relation to the experience of client death (Elliott, Fischer, & Rennie, 1999) . Smith, Flowers and Larkin (2009) indicate that the idiographic foundations of IPA lend themselves well to case-study research projects, which they argue as being important for the further development of IPA.

In relation to the participants, the all female sample used within this study was appraised as fairly representative of the targeted group (junior Clinical Psychologists) and homogenous (See table 1: Participants). From a critical perspective however, issues of gender in the context of a client’s death (as raised within the existing evidence-base) were unable to be considered (Moores, Castle, Shaw, Stockton, & Bennett, 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005). The underrepresentation of male voices within this project may be a limitation. A further weakness is the absence of non-white, non-western, junior Clinical Psychologists within the study. Both of these participant groups could enable future research to consider issues of culture and gender in the context of client death in greater depth, currently underrepresented in the existing research base.

It may also be important to consider the implication of all participants having volunteered for this study. It may be that participants within this study were affected by the death of a client to a greater degree than those who did not volunteer. Or potentially there may be individuals who have been affected by death to a greater degree, who were unable to be sampled due to this study's focus on a particular geographical area; a possible consideration for future research.

The differing types of client death faced by participants may also have been mediating factors for their experiences and the death's impact. For one participant the drowning of her client was particularly shocking, for another the death of her client (who had cancer) to a sudden heart attack, felt challenging. Perhaps it may be possible to narrow the focus of future research onto certain types of death e.g. cancer, in order to explore these issues and potentially any discrepancies between experiences in greater detail.

Finally, the number of deaths experienced by participants within a clinical setting may also have been important. For some their client's death was their first death in a clinical context for others they had experienced multiple deaths. In the future it may be interesting to focus on those who experienced one death *or* multiple deaths, in order to illuminate any unique features of these stories to a greater degree than the current study allowed.

## IMPLICATIONS FOR PRACTICE

Although some implications for practice have been noted in the discussion above, I will present some further implications here. I have divided the following section to reflect the overall themes of this research: The impact of a client death on the individual (Junior Clinical Psychologists), within a specific systemic context; (UK Clinical Psychology training). As a result the focus will be placed on the implications of this research for clinicians and training courses, respectively.

### *Implications for clinicians*

One of the first clear implications from this study is that client death, from a cause other than suicide, can happen. Such implications are important as they could serve to normalise and raise awareness of this experience for Clinical Psychologists, in line with previous research suggestions (Schwartz, 2004). In particular this knowledge may prevent professionals feeling they are alone with this experience despite feeling this way at times, as the study's data indicated.

Secondly, the experience of a client's death may be challenging; evoking a number of reactions (positive and negative) over time, even if the death had been predicted on some level. Further to this, previous experiences or personal beliefs about death (as natural/part of life) may not always moderate the impact of a client's death in a positive way, possibly due to the unique connections psychologists develop with their clients (Schwartz, 2004). This is an important finding which could be applicable across professional grades as well as professional groups.

Thirdly, the experience of client death may raise concerns about the expression of emotional reactions in the role of a Clinical Psychologist. This could be related to the perceived systemic reactions, as well as an awareness of the expectations placed on Clinical Psychologists within a professional role, across professional grades (Kaplan, 2000; LoGerfo, 1998; Papadatou, 2000; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Ronfeldt & Grossman, 2008). However the recognition of a ‘human’ self in response to a client’s death may be useful for professionals, our clients, and the families of the deceased (Matsuyama, 2005).

### ***Implications for UK clinical training courses and Clinical Psychology***

The first implication for courses and the wider profession of Clinical Psychology is that client death, and its potential impact on junior Clinical Psychologists, should be recognised during Clinical Psychology training. Issues of death and dying may not be completely overlooked on courses. However, the extent to which they are covered is unclear. This could be a useful area for future research in its own right.

During the interviews participants presented many varied ideas for training courses, such as the introduction of reflective sessions on issues of death and dying, from suicide, to health-related deaths, to bereavement. Some also suggested inviting members of the profession who have experienced client death to talk about this with trainees. Teaching about client death on training could begin to combat the silence which appears to currently envelop this experience. Further to this, it may challenge the current stigma which exists in relation to talking about death within wider contexts e.g. teams, society (DOH, 2008).

The second implication relates to clinical placements. Participants suggested that conversations about death could be raised by placement supervisors, especially where death may be indicated as likely (e.g. palliative care). Again this may be carried out by some services already. However, this experience was not reflected in the current sample for many possible reasons e.g. a post was isolated. A lack of consistency in clinical contexts may further support a national training-based focus on client death.

Thirdly, although Clinical training institutions provide multiple support systems during the training, there could be a greater focus on support challenges in the face of emotional experiences once qualified. This could include responsibilities for self-care; as noted in the core competencies for Clinical training (BPS, 2006b), how to manage when supervisory experiences are unreflective of needs and Continuing Professional Development in issues of death and dying (Latham & Toye, 2006). This implication related to the concerns raised by participants about the reduced level of support they would soon have, or they had, in newly qualified roles.

Further to the above, support issues in Assistant Psychologist roles perhaps deserve greater attention. This suggestion is particularly related to the two participants who experienced the death of their clients whilst working, sometimes voluntarily, in such roles. Ethically, it may be important to consider the capabilities of junior Clinical Psychologists and the particular pressures working with death may elicit in speciality settings. So that individuals are not working beyond their capability for their own sake, and for the protection of clients (BPS, 2006a).

A fourth implication is that broader issues of professional identity could be discussed under the core competency of personal and professional development; particularly in the context of previous research and the current study’s findings (BPS, 2006b; LoGerfo, 1998; Ronfeldt & Grossman, 2008). Possible issues such as integrating a professional and personal identity and the emotional challenges faced in clinical practice, are worthy of discussion if not already covered on training.

Overall, this study has many implications for the experience of death in the work of a Clinical Psychologist. This means the implications presented here are not designed to be exhaustive, and some may have already been addressed. However, they are data-driven suggestions arising from the accounts of the participants within this study, and subsequently they may be useful.

## IMPLICATIONS FOR FUTURE RESEARCH

There are a number of implications for future research, many of which have been noted in the previous sections of this discussion. To avoid repetition, unaddressed implications will be prevented here, alongside the main implication arising from this study.

An issue left unaddressed by this study is the impact of client death for Clinical Psychologists in the UK who are further established in their careers. Throughout this study I have remained mindful of the research by Redinbaugh et al (2003) which highlighted that almost half of the consultant medical professionals in their sample felt affected by a patient death yet found no coping strategy helpful. Further to this, supervising grades, arguably across professional disciplines, may be expected to provide support for a wide range of experiences whilst receiving less support themselves. Such gaps in the research base highlight interesting areas for future research, which could extend the findings of the current study.

The main implication from the results of this study is that there is a need for further research into the experience of client death for Clinical Psychologists. The death of a client appears worthy of attention for the many reasons discussed e.g. lasting impact, development of support. Such research may help to break a self-perpetuating cycle of silence surrounding client death within Clinical Psychology at an individual and professional level. This, in turn, may be a step toward improving patient care across settings and maintaining future professional well-being.

## FINAL REFLECTIONS

I have learnt such a great deal from conducting this project, from the day I experienced the death of my client, to the day I wrote the final words of my thesis.

Following the completion of this project I have been reminded of the importance of our relationships with our client's both in their lives and in their deaths. How they may change a part of us and how much we can learn from them. My research project has also brought home to me the value of our working relationships with the teams, supervisors and colleagues we have beside us; particularly when we face challenging and emotive issues such as death and dying.

My journey with this project has been probably one of the most difficult roads I have travelled. At times I did not know if I would, or could, complete a doctoral thesis. I certainly questioned if I could do justice to the nine participants' experiences of client death within this study. However, I have realised that by conducting rigorous research you can produce tentative yet valid findings which can illuminate a hidden experience for many to see.

To conclude, I have been touched by participants' stories and I am glad they were able to share their client's death with me. Their stories have cemented my passion for the dissemination of my research findings. Further to this, I hope the participants' words will fuel the continued exploration of issues of death and dying within the profession of Clinical Psychology. Lastly, I am indebted to the clients who have inspired and driven this project in their death. I am sure my client would have felt touched by this research and I hope that those who read this will feel the same.

# CONCLUSIONS

This study provides an original contribution to the sparse research base with its investigation of the lived experiences of a client's death for nine junior Clinical Psychologists. Through utilising qualitative methods and IPA in particular (Smith, Jarman, & Osborn, 1999), a rich experiential account of this experience has been constructed, adding depth to, and extending, the existing evidence-base.

The main findings from this study indicated the death of a client was an unexpected event (even if predicted), for which participants felt unprepared. Participants described feeling as though they were in a 'tailspin' a state which evoked many varied emotions; feeling out of control, shock, sadness and numbness. They felt left behind with losses and difficult 'what ifs?' when their client died and they struggled, at times, to make sense of this unfamiliar experience. Some experienced validation and support in the wake of the death, other perceived systems/institutions (teams/training courses/wider societal context in UK) as denying this experience and avoiding issues of death and dying in general. For some this evoked a pressure to contain and perhaps hide their emotional reactions, for fear of actual or imagined negative evaluation. They felt 'expected to care but not to feel', which led to struggles with their professional versus 'human' selves in the face of death. Participants felt changed, sometimes reluctantly, by the death of their client. However, during analysis it also became clear that all participants still remained connected to their clients in some way. For some the remaining connection, or continuing bond, appeared to be a source of comfort and of pain. Over time (some) participants became re-connected with their 'human' selves within their professional roles. This sense of integration eventually felt like a positive change for participants. For some, the threat of death remained. This led to purposeful avoidance of clinical contexts where death was increasingly likely. Such lasting experiences of client death meant all participants valued having 'therapeutic' time and space to help understand and process the client's death. Where time and space was absent, participants felt hindered in their processing and challenged by (what they perceived as) the little value placed on the lives and memories of their deceased clients; with whom they had felt connected and affected. For all Clinical Psychologists in this study, the death of their clients felt important, and at times painful and messy. In spite of this all experienced death as something worthy of and *in need* of attention in the here and now and in the future.

This study's findings presented many implications for Clinical Psychologists, Clinical Training courses in the UK and the wider evidence-base which considers the experience of client death. The final quote presented next serves to capture such implications succinctly, illustrating the power of the participants' experiences.

***Debbie:***
*Is there anything… you think other people should know about your experience…of a client death?*

***Catherine:***
*…only that it happens [laughs]…and that… it's something that actually [is] so obvious everybody dies, so why wouldn't it be possible that one of your clients could die? And nobody really thinks about how they would handle that, or I certainly didn't think about how I would handle that, and it's probably just a good idea to, at least so that's in trainees' minds that… it's possible at one point somebody could die.*

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# APPENDIXES

## APPENDIX 1: INTERVIEW SCHEDULE

## INTERVIEW SCHEDULE

Questions relating to context/ background of the participant and their experience

1. BRIEF INTRO: To start It would be helpful if you could tell me a bit about yourself as a professional (rapport building)
    a. What brought you to clinical psychology?
    b. Experience prior to training
    c. Course
    d. Year
    e. How career has evolved

2. Can you tell me a little about yourself as a professional at the time the client you wish to speak about died
    a. Where working
    b. Stage in career

3. Prior to the experience you wish to talk about, had you had any experience of death
    a. personally
    b. professionally
    c. What was that like for you?

4. Thinking about your client, can you tell me a little about them
    a. What brought them to psychology?
    b. Age, gender, presenting issue
    c. How was the therapy etc going? Relationship etc
    d. How long did you work together

    e. Indications your client may die?

5. At what stage did you become aware that your client had died?
    a. Had you finished therapy etc
    b. Were you aware of how your client had died?

6. Can you describe your experience of finding out your client had died?
    a. How did you make sense of this experience?
    b. What was it like for you?

Questions related to coping with this experience

7. Who were you able to get support from during this time?
    a. Social
    b. Educational
    c. Work based.

8. I'm wondering, can you tell me a little about how you managed the experience of your client's death?
    a. What, if anything, helped you manage to the loss of your client?
    b. What, if anything, hindered you?

9. Thinking back were you aware of any impact your client's death had on your home/personal life?

Questions relating to support available during this experience

10. Were you aware of any support structures available to you e.g. via university, workplace, other organisations?
    a. Helpful?

11. What, if anything, would you have liked to have been available for you during the time of your client's death?

Questions relating to potential changes following this experience

12. Do you think the experience of your client death has had any lasting impact on you?
    a. As a clinician
    b. Personally etc

13. If so, what ways are you a different person now, if at all?
    a. Why do you think that change has happened (if it has)?

14. As a clinician do you think your experience of the death of a client will have any impact on you as a supervisor, practicing psychologist?
    a. If so why do you think this may be?

15. I'm wondering if your understanding of your experience has changed over time?

Final Questions

16. As we are coming to the end of our interview, is there anything else that you feel would be important for me, or other people to know about your experience?

17. Any question I haven’t asked that you were expecting?

18. How has it been talking about your experience?

## APPENDIX 2: EMAIL AND LETTER TO COURSE DIRECTORS

***Email:***

Dear (course directors),

I am a third year Trainee Clinical Psychologist at the University of Hertfordshire and I am about to embark on my final year doctoral research project.

I am hoping to recruit trainees and potentially newly qualified clinical psychologists from (Training courses) for my project. Therefore, I am writing to you today to request your consent to approach trainees and potentially newly qualified clinical psychologists from your course.

I have attached a letter to this email detailing my project and providing greater detail in relation to the recruitment procedure.

I thank you for your time and I look forward to hearing from you in relation to your response.

Best wishes

Debbie Ford
Trainee Clinical Psychologist
University of Hertfordshire

***Letter:***

Dear (Course Directors),

My name is Debbie Ford and I am currently a second year Doctor of Clinical Psychology trainee at the University of Hertfordshire under Programme Director Professor David Winter.

I am writing to you today to ask if you would consider granting me permission to contact your current and potentially newly qualified Clinical Psychology trainees to request their participation in my doctoral research project.

My project wishes to investigate what it may be like to experience, process and cope with the death of a client, with whom they have been in therapeutic contact, for both trainees and newly qualified Clinical Psychologists from a cause other than suicide. I have excluded the experience of suicide from my study as this area has been researched more thoroughly and instead I am wishing to talk to those who have experienced the death of a client from, for example, a health related issue such as cancer.

I am attempting to recruit 6 to 8 participants for this purpose. All will be asked to take part in a semi-structured interview of approximately 1-1 ½ hours in length at a location convenient to them. Prior to recruitment I will have gained NHS National Research Ethics Service (NRES) approval and following this my project will be closely supervised by the University of Hertfordshire.

Participation would take place on a confidential basis and I would be unable to inform each course of the personal details of participants in this project. Confidentiality may only be breached in accordance with the British Psychological

Societies code of conduct e.g. if any information is disclosed during the interview which leads to sufficient concern about the person’s safety or the safety of others. In these cases the researcher’s project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

The main aim of my project will be to explore the under researched area of client death for psychologists. Following this I am hoping that such research may help those who provide training courses, clinical supervisors and other psychologists themselves to make sense of, and understand this experience in more depth, potentially helping facilitate support systems for managing this experience.

If you consent I will not request any personal details of your trainees or newly qualified clinical psychologists. Instead I will email an initial contact message to you which can be forwarded on to potential participants for their consideration via email.

I hope you will consider your course’s participation in this project.

Please do not hesitate to contact me on the below email or telephone numbers should you have any questions.

Thank you for your time,
Kind regards,

Ms Debbie Ford
Trainee Clinical Psychologist
University of Hertfordshire
d.ford@herts.ac.uk
TEL: 01707 286 322

Supervisor: Dr Pieter Nel
Consultant Clinical Psychologist &
Academic Tutor
University of Hertfordshire
p.w.nel@herts.ac.uk

## APPENDIX 3: INITIAL PARTICIPANT EMAIL

Dear ………………………………………..,

My name is Debbie Ford and I am a second year Clinical Psychologist in training at the University of Hertfordshire. I beginning to recruit for my major research project and I am writing to you today to invite you to participate in this project.

I am currently investigating the experience of client death for trainee clinical psychologists and potentially newly qualified psychologists from a cause other than suicide. For my project I am looking to recruit 6 to 8 people who have experienced the death of a client with whom they had been in therapeutic contact (e.g. in a group, family or individually). The death may have been due to illness or some other cause, however the death must not have been caused by the individual themselves (e.g. suicide).

To protect potential participants I am requesting that the death did not occur in the last 3 months and I will be excluding any death where legal investigations have been undertaken or are still ongoing (e.g. accidents).

My project will aim to develop some understanding of how this experience is interpreted from an individual and systemic perspective. Following this I am hoping my research may help those who provide training courses, clinical supervisors and other trainees themselves to make sense of, and understand this experience in more depth.

To participate, you would be asked to take part in one tape-recorded meeting lasting around 1 - 1½ hours in a comfortable setting, which could be your own home. The meeting will involve talking to me about your experience with your client. It is fully acknowledged that telling your story may be a difficult process and that some questions I may ask you might feel sensitive. If any of the questions are found to be particularly upsetting you do not have to answer them.

It is wholly your choice as to whether you decide to participate or not. You are welcome to ask any further questions before this decision is made. If you do decide to consider participation you will be provided with the study information sheet to help your decision further. If you do decide to take part you are still free to withdraw at any time and without giving a reason.

All information collected about you throughout the course of research will be kept strictly confidential. Your name and other identifying information will be kept securely and separately from your tape-recording and the subsequent data-analysis. People involved in your course will not have access to any raw research data which may be able to identify you at any time. Confidentiality may only be breached in accordance with the British Psychological Societies code of conduct e.g. if any information is disclosed during the interview which leads to sufficient concern about the person's safety or the safety of others. In these cases my project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

If you are willing to consider participation, please feel free to contact me on the email address below or telephone me on 01707 286322. For further discussion and information about this project.

Thank you for your time, it is very much appreciated.

Kind Regards,

Ms Debbie Ford
Trainee Clinical Psychologist

University of Hertfordshire.
d.ford@herts.ac.uk
Tel: 01707 286322

Supervisor: Dr Pieter Nel
Consultant Clinical Psychologist &
Academic Tutor
University of Hertfordshire
p.w.nel@herts.ac.uk
Tel: 01707 286322

*This study has been approved by Hertfordshire Research Ethics Service who have raised no objections on ethical grounds. However, if you wish to complain or have concerns relating to this investigation please do not hesitate to contact my project supervisor.*

## APPENDIX 4: INFORMATION PACK

### INFORMATION SHEET (Version 2): 6th August 2008

**Study title**

*Junior clinical psychologists' experience of processing the death of a therapy client from a cause other than suicide. A qualitative study.*

Dear ……………………………………..,

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you.

Please do ask us if there is anything, which is not clear, or if you would like more information, and take time to decide whether you would like to participate or not.

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

My name is Debbie Ford and I am a second year Clinical Psychologist in training at the University of Hertfordshire and I am conducting this research for my 3rd year Doctoral research project.

I am currently investigating the experience of a client death for trainee clinical psychologists and potentially newly qualified clinical psychologists.

For my project I am looking to recruit 6 to 8 people who have experienced the death of a client with whom they had therapeutic contact (e.g. in a group, family or individually). The death may have been due to illness or some other cause, however the death must not have been caused by the individual themselves (e.g. suicide).

My project will aim to develop some understanding of how individuals may process this experience. Following this we hope this research may help those who provide training courses, clinical supervisors and other psychologists to make sense of, and understand this experience in more depth, potentially facilitating the development of improved support structures.

### ***Why have I been invited?***

Your Clinical Psychology Training course has consented to their psychologists being involved with this project should you so wish.
And
You have expressed an interest in my project via contact by email or by telephone.

### ***Do I have to take part?***

It is wholly your choice as to whether you decide to participate or not. If you do decide to participate you will be given a copy of this information sheet to keep and you will be asked to sign a form recording your consent.

If you do decide to take part you are still free to withdraw at any time and without giving a reason.

***What will happen if I take part?***

To participate, you would be asked to take part in one tape-recorded interview lasting around 1 - 1½ hours in a comfortable setting, which could be your own home. The meeting will involve talking to the researcher about your experience of a client death in your clinical practice.

If you consent, you may be contacted at a later date to ask if you wish to comment on our research findings. You are able to decline this offer without giving a reason.

***What are the possible disadvantages of taking part?***

It is fully acknowledged that telling your story may be a difficult process. Some questions I may ask you might feel sensitive. If any of the questions are found to be particularly upsetting you do not have to answer them.

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

We can not promise that the study will help you. However, the research project will allow you to have time and space to reflect on your often unheard experience. Potentially this research may help to help those who provide training courses, clinical supervisors and other Clinical Psychologists to make sense of, and understand the experience of the death of a client in more depth.

***What if there is a problem?***

If you have any concern about any aspect of this study you should ask to speak to the researcher who will do her best to answer your questions (Telephone number: 01707 286322). If you remain unhappy and wish to complain formally you can do so by contacting the projects Research Supervisor, Dr Pieter Nel (Telephone number: 01707 286322).

***Will my taking part in the study be kept confidential?***

All information collected about you throughout the course of research will be kept strictly confidential. Your name and other identifying information will be kept securely and separately from your tape-recording and the subsequent data-analysis. People involved in your course will not have access to any raw research data which may be able to identify you at any time.

Due to the time constraints on this project an approved transcription service may be used to transcribe your interview. In this case your recording will be labelled A, B, C etc. to protect identity. The service will sign a non-disclosure, confidentiality agreement.

Some parts of the data collected by this research will be looked at by authorised persons from the University of Hertfordshire (Sponsoring organisation). Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project. All will have a duty of confidentiality to you as a research participant.

Your recordings and any identifiable data relating to your participation will be kept for 5 years post research project submission (June 2014) according to the University of Hertfordshire’s ‘Good practice in research’ guidelines. All identifiable data will be destroyed by the chief researcher after this time in accordance with university guidelines.

### *Are there any reasons where confidentiality may be breached?*

As all participants will be regulated by the British Psychological Society due to your professional status the following code of conduct will be followed with regards confidentiality:

British Psychological Society: Code of Conduct.

1. If you disclose information during the interview which leads to sufficient concern about your safety or the safety of others it may be judged necessary to inform an appropriate third party without formal consent.
2. Prior to this occurrence the researcher's project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

### *What will happen to the results of this research study?*

The results will be written up in the form of a thesis for the purposes of gaining a Doctoral qualification in Clinical Psychology.

I will ask you if you would like to comment on the analysis of your interview to help with the accuracy of the results. You can decline your involvement.

The findings may be shared via academic publication and/or presentations. Participants will not be identified in any report or publication. Any quotes used will be fully anonymised. You have the right to decline the use of your interview quotes.

### *Who has reviewed the study?*

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, dignity and well-being. This study has been reviewed and given a favourable opinion by the Hertfordshire Research Ethics Committee who have raised no objections on ethical grounds.

Due to the academic nature of the research this project has also been subjected to both a formal and a peer review by the University of Hertfordshire's Doctoral Programme in Clinical Psychology.

### *Further information and contact details*

Should you have any further questions or any concerns during the study please do not hesitate to contact the researcher or her research supervisor using the contact details provided below.
If you are interested in potentially participating in this study please fill in the reply slip included with this information sheet and return to Debbie Ford (Chief Investigator) via email.

Should you wish to complain about this study the Independent Complaints Advocacy Service (ICAS) supports individuals wishing to pursue a complaint about the NHS. (See http://www.dh.gov.uk)
The contact details for the areas covered by this study are as follows:

- ICAS Bedfordshire & Hertfordshire Tel: 0845 456 1082
- ICAS North Central London Tel: 0845 120 3784
- ICAS North East London Tel: 0845 337 3059
- ICAS North West London Tel: 0845 337 3065

- ICAS South East London Tel: 0845 337 3061
- ICAS South West London Tel: 0845 337 3063
- ICAS Cambridgeshire, Norfolk, Suffolk Tel: 0845 456 1084

Thank you for taking time to read this information.

Kind Regards,

| | |
|---|---|
| **Ms Debbie Ford** | **Dr Pieter Nel** |
| **Chief Investigator** | **Research/Academic supervisor** |
| **Trainee Clinical Psychologist** | **Consultant Clinical Psychologist** |
| **University of Hertfordshire.** | **University of Hertfordshire** |
| **d.ford@herts.ac.uk Tel: 01707 286322** | **p.w.nel@herts.ac.uk** |

***<u>Reply Slip.</u>***

***<u>(Please tick the appropriate boxes and return by email to the researcher: d.ford@herts.ac.uk).</u>***

*1. <u>I am not</u> interested in participating in this project.* ☐

*2. <u>I may be</u> interested in participating in this project*
*but would like further information.* ☐
*I consent to you contacting me on the telephone number*
*Below/email address at the specified suitable times and days of week**.*

*3. <u>I am</u> interested in participating in this project.* ☐
*I consent to you contacting me on the telephone number*
*Below/ email address at the specified suitable times and days of week**.*

*My Details (Please Supply if you tick statement 2, or 3):*
*Name:*

*** Please Supply if Statement 2 or 3 have been ticked**:*
*Telephone number:*
*Email address:*

*Suitable days for contact (Delete as appropriate):*
*Mon / Tues / Weds / Thurs / Fri / Sat / Sunday.*

*Suitable times for contact (E.G. Mondays 12-2pm):*
*Day: Times:*
*Day: Times:*
*Day: Times:*

## APPENDIX 5: PARTICIPANT SCREENING

**STRICTLY CONFIDENTIAL:**

**Participant Screening.**

All participants will be asked the following questions to screen for inclusion and exclusion criteria of the study.

Was verbal consent obtained from the potential participant before asking the questions below? Yes/No

1. Is the participant a current trainee clinical psychologist/ or recently qualified?

……………………………………………………………………………………………

2. Did the participant experience the death of their client as a junior level psychologist in the NHS?

……………………………………………………………………………………………

3. Was the participant involved in therapeutic contact with their client prior to their death?

……………………………………………………………………………………………

4. Was the death more than 3 months ago?

……………………………………………………………………………………………

5. Was the death caused by suicide?

……………………………………………………………………………………………

6. To the best of a participants' knowledge, Is there any legal involvement in the case?

……………………………………………………………………………………………

7. Do they feel comfortable discussing their personal experience?

……………………………………………………………………………………………

Age:

Gender: Ethnicity:

## APPENDIX 6: CONSENT FORM

Centre number:

Study Number:

Participant identification number:

**CONSENT FORM**

**Title of Project:** *Junior clinical psychologists' experience of processing the death of a therapy client from a cause other than suicide. A qualitative study.*

Name of researcher: *Debbie Ford, Trainee Clinical Psychologist.*

To be completed by participant (Please initial each box):

| | |
|---|---|
| 1. I confirm that I have read and understand the information sheet dated 6th August 2008 (Version: 2) 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 I am free to decline entry into the study and I am able to leave the study at any time without reason? | |
| 3. I consent to the tape recording of my interview | |
| 4. I understand that relevant sections of the data collected by this research will be looked at by authorised persons from the University of Hertfordshire (Sponsoring organisation). Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project. All will have a duty of confidentiality to you as a research participant | |
| 5. I agree to take part in the above study. | |
| 6. I agree to be contacted for my comments on the findings of the study. I am aware I can decline my involvement at any time. | |
| 7. I agree that anonymised quotes from my interview may be used in any publications. | |

Signature: Date: Name:

<u>Participant</u>

Signature: Date: Name:

<u>Person taking consent</u>

## APPENDIX 7: PRE-INTERVIEW BRIEFING AND DE-BRIEF

### PRE-INTERVIEW BRIEFING.

1. Aims of investigation.
    - To investigate the individual experience of trainee clinical psychologists and possibly newly qualified clinical psychologists experience of client death.
    - To ensure personal experience is heard.
    - Long term goal: to disseminate information about trainees and newly qualified clinical psychologists experience for other psychologists, clinical supervisors and educational institutions.

2. Procedure of interview.
    - Interview will last for approximately 1 hour.
    - The interview will be tape-recorded.
    - All participants will be asked similar questions during the interview.
    - The questions will act as a guide for the interview.
    - The aim is to hear your experience.

3. During the interview.
    - If at any time you wish to stop the interview you may do so without reason.
    - You are in no way obliged to answer the questions provided by the researcher.

4. Confidentiality.
    - Your participation in this project will remain strictly confidential.
    - Your personal details will only be known by the researcher.

- Your personal details and tape recordings will be kept separately in a secure filing cabinet at the researchers premises.

5. British Psychological Society: Code of Conduct.
    - If you disclose information during the interview which leads to sufficient concern about your safety or the safety of others it may be judged necessary to inform an appropriate third party without formal consent.
    - Prior to this occurrence the researcher's project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

6. Provision after interview.
    - Following the interview you will be given further opportunities to ask questions regarding the project and any concerns you may have. If the researcher is unable to provide you with the correct answers for your questions she will endeavour to provide you with appropriate source of professional advice.
    - You will be provided with a list of support services you may be interested in contacting if you feel you may wish to talk about your experience further.

7. Questions.
    - Please ask any further questions you may have about the investigation.

## DEBRIEFING SCHEDULE

1. Recap on purpose of study

    - To investigate the individual experience of trainee clinical psychologists and possibly newly qualified clinical psychologists experience of client death.
    - To ensure personal experience is heard.
    - Long term goal: to disseminate information about trainees and newly qualified clinical psychologists experience for other trainees, clinical supervisors and educational institutions.

2. Review of interview

    - You will be asked how you found the interview.
    - You will be asked if you would have preferred anything to be done differently.
    - You will be asked if there are any recommendations for the researcher to aid improvement of the investigation.

3. Unresolved issues

    - The researcher will ask you if you feel that any issues have been raised during the interview which may have concerned you.
    - It is the researcher's duty to ensure any questions you ask are answered sufficiently. This may involve directing you towards the correct professional resources.

4. Professional Services

   - You will be provided with a list of support services.
   - If you require information about further support services in different localities this can be arranged.

5. Future concerns and contact with researcher.

   - If you have any concerns or further questions about this research please do not hesitate to contact the researcher or the project supervisor.
   - The researcher and supervisor will be available for contact up to 6 months after participation.

Ms Debbie Ford
Trainee Clinical Psychologist
Academic Tutor
University of Hertfordshire.
d.ford@herts.ac.uk

Supervisor: Dr Pieter Nel
Consultant Clinical Psychologist &

University of Hertfordshire
p.w.nel@herts.ac.uk

## APPENDIX 8: USEFUL RESOURCES FOR PARTICIPANTS

### Support Services & Useful References.

### Workplace counselling services

The Department of Health issued policy in 2000 to ensure all NHS staff had access to emotional support in the workplace.

Contact your employing trust headquarters or occupational health department for details of the available services in your area.

### Voluntary sector/ Professional organisations

**Samaritans - telephone 08457 909090**

You can also go to your local Accident and Emergency Departments at your nearest Hospital and speak to the Duty Psychiatrist.

**National**

For private counselling/ psychotherapy the following addresses/websites may be useful:

- The British Psychological Society

http://www.bps.org.uk/

- British Association for Counselling & Psychotherapy, BACP House,
  15 St John's Business Park, Lutterworth LE17 4HB,
  Tel: 01455 883300, Fax: 01455 550243, Minicom: 01455 550307

http://www.bacp.co.uk/

- United Kingdom Council for Psychotherapy

http://www.psychotherapy.org.uk/index.html

**Useful references**

Renee Katz & Therese Johnson (2006) When Professionals Weep, emotional and countertransference responses in end-of-life care. Taylor & Francis

Robert Neimeyer – multiple references including;

- R. A. Neimeyer ( 2001)

Meaning Reconstruction and the experience of loss
Washington: American Psychological Association

- R.A. Neimeyer & J Raskin (2000)

Constructions of disorder: Meaning making frameworks in psychotherapy
Washington: APA

- R.A. Neimeyer (2007) Grief Therapy a meaning reconstruction approach.

Lancaster: USA J&K Seminars (2 day workshop on CD with handouts, www.jkseminars.com)

# APPENDIX 9: ETHICAL AND R&D APPROVALS

## *Ethical Approval*

NHS

**National Research Ethics Service**

**Hertfordshire REC**
9th Floor, Terminus House
The High
Harlow
Essex
CM20 1XA

Telephone: 01279 418 439
Facsimile: 01279 419 246

19 August 2008

Miss Debbie Ford
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Mental Health Trust.
Doctorate in Clinical Psychology
University of Hertfordshire
Hatfield, Herts
AL10 9AB

Dear Miss Ford

| | |
|---|---|
| **Full title of study:** | **Junior clinical psychologists' experience of processing the death of a therapy client, from a cause other than suicide. A qualitative study.** |
| **REC reference number:** | **08/H0311/91** |

Thank you for your letter of 15 August 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

**Confirmation of ethical opinion**

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

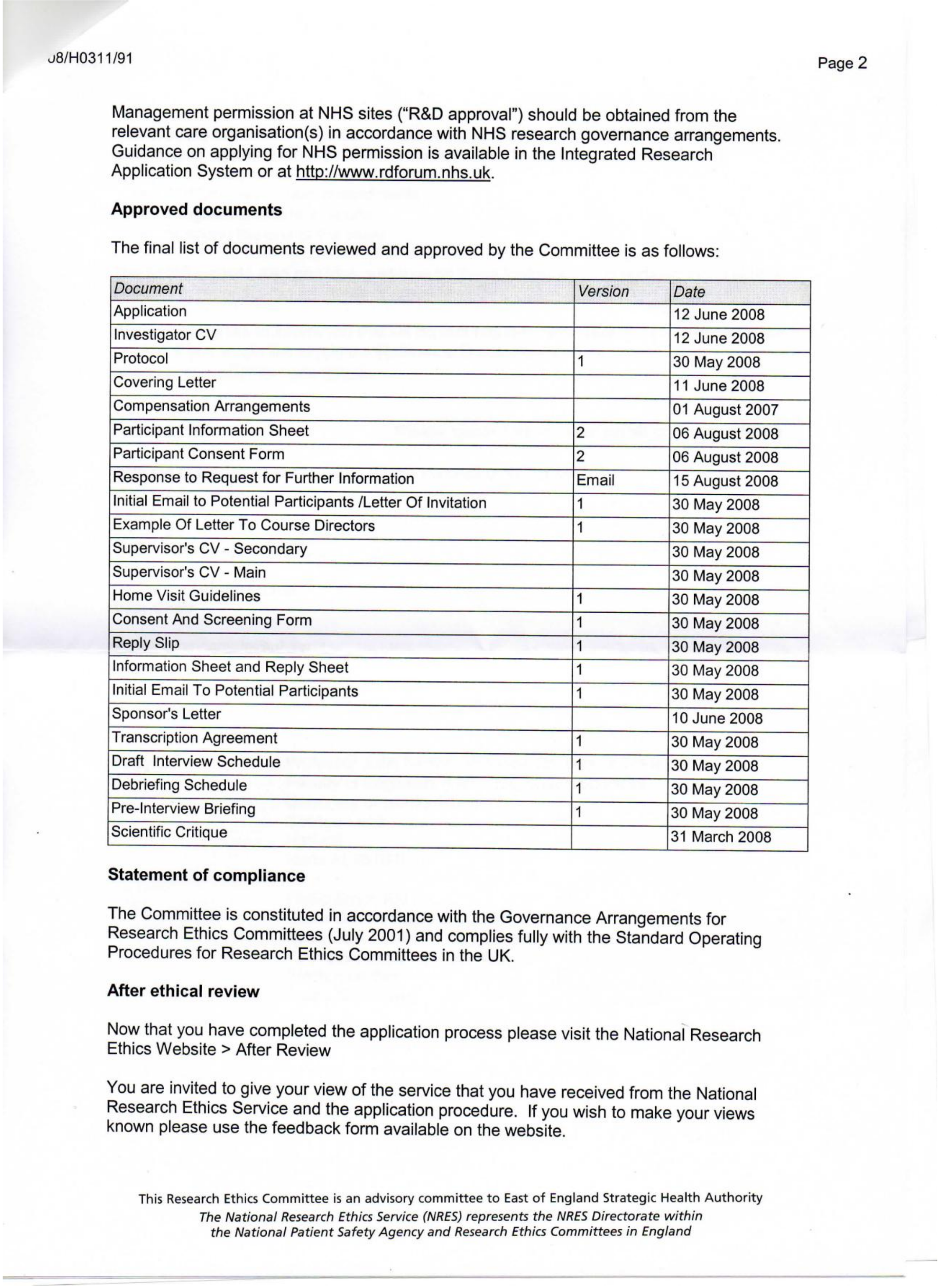
**Ethical review of research sites**

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>



Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

**Approved documents**

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

| *Document* | *Version* | *Date* |
|---|---|---|
| Application | | 12 June 2008 |
| Investigator CV | | 12 June 2008 |
| Protocol | 1 | 30 May 2008 |
| Covering Letter | | 11 June 2008 |
| Compensation Arrangements | | 01 August 2007 |
| Participant Information Sheet | 2 | 06 August 2008 |
| Participant Consent Form | 2 | 06 August 2008 |
| Response to Request for Further Information | Email | 15 August 2008 |
| Initial Email to Potential Participants /Letter Of Invitation | 1 | 30 May 2008 |
| Example Of Letter To Course Directors | 1 | 30 May 2008 |
| Supervisor's CV - Secondary | | 30 May 2008 |
| Supervisor's CV - Main | | 30 May 2008 |
| Home Visit Guidelines | 1 | 30 May 2008 |
| Consent And Screening Form | 1 | 30 May 2008 |
| Reply Slip | 1 | 30 May 2008 |
| Information Sheet and Reply Sheet | 1 | 30 May 2008 |
| Initial Email To Potential Participants | 1 | 30 May 2008 |
| Sponsor's Letter | | 10 June 2008 |
| Transcription Agreement | 1 | 30 May 2008 |
| Draft Interview Schedule | 1 | 30 May 2008 |
| Debriefing Schedule | 1 | 30 May 2008 |
| Pre-Interview Briefing | 1 | 30 May 2008 |
| Scientific Critique | | 31 March 2008 |

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

| **08/H0311/91** | **Please quote this number on all correspondence** |
|---|---|

With the Committee's best wishes for the success of this project

Yours sincerely

pp Jenny Ast

**Dr Sunda Uthayakumar**
**Vice Chair**

Email: jenny.austin@nhs.net

Enclosures: "After ethical review – guidance for researchers" *(SL- AR2)*

Copy to:
Professor John Senior, Pro-Vice Chancellor (Research)
Faculty of Engineering and Information Sciences
University of Hertfordshire
College Lane
Hatfield
Herts AL10 9AB

Phillip Smith RM&G
Essex & Hertfordshire CLRN
North East Essex Primary Care Trust
Kennedy House Kennedy Way
Clacton on Sea
Essex CO15 4AB

## ***Research & Development approvals***

Cambridgeshire and Peterborough **NHS**
NHS Foundation Trust

Understanding mental health, understanding people

Please reply to:
Natercia Godinho
CPFT- Fulbourn Hospital
Springbank
Cambridge
CB21 5EF

**Tel:** 01223 218 739
**Fax:** 01223 218 858
**E-Mail:** natercia.godinho@cpft.nhs.uk
**Website:** www.cpft.nhs.uk

R&D ref: M00326
REC ref: 08/H0311/91
Date: 11/09/2008

Miss Debbie Ford
Trainee Clinical Psychologist
Doctorate in Clinical psychology
University of Hertforshire
Hatfield, Herts Al10 9AB

Dear Miss Ford

***Full title of study: Junior clinical psychologists' experience of processing the death of a therapy client, from a cause other than suicide. A qualitative study.***

Thank you for applying for NHS permission to Conduct Research for the above named project. This study has now been validated and reviewed according to the Research Governance Framework For Health and Social Care for research appraisal. The study therefore has been granted full approval on the basis described in the application form, protocol and supporting documentation.

Trust approval of the above research applies to the research sites listed on the application form. Any changes to the above research should be communicated to this Trust and to the relevant Ethics Committee, and protocols followed accordingly.

Please note that any adverse events relating to this research should be notified to me. In accordance with the Trust Incident Reporting procedures you would also need to complete a risk incident form that can be found on www.cpft.nhs.uk.

Research Governance requires monitoring and auditing of all research projects. I ask that you let me have copies of any annual and final reports as well as details of any papers published arising out of your research.

We wish you well with your research. If we can be of further help, please do not hesitate to contact us.

Yours sincerely

Natércia Godinho
R&D Manager

**HQ** Elizabeth House, Fulbourn Hospital, Cambridge CB21 5EF
T 01223 726789 F 01480 398501 **www.cpft.nhs.uk**

**In partnership with the University of Cambridge**

Provider Services

Camden NHS
Primary Care Trust

**North Central London Research Consortium**
3rd Floor, West Wing
Camden PCT, St Pancras Hospital
4 St Pancras Way, London, NW1 0PE

Telephone: 020 7530 5375

Facsimile: 020 7530 3235
www.camdenproviderservices.nhs.uk

15 September 2008

Miss Debbie Ford
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Mental Health Trust
Doctorate in Clinical Psychology
University of Hertfordshire
Hatfield, Herts
AL10 9AB

Dear Miss Ford,

**Title**: Junior clinical psychologists' experience of processing the death of a therapy client, from a cause other than suicide. A qualitative study.

**LREC Ref**: 08/H0311/91

I am pleased to confirm that the above study has now received R&D approval, and you may now start your research in Camden PCT and Camden & Islington MH&SCT. May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.

- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Ethics Committee and R&D Office as soon as possible.

Please ensure that all members of the research team are aware of their responsibilities as researchers. For more details on these responsibilities, please check the R&D handbook or NoCLoR website: http://www.noclor.nhs.uk

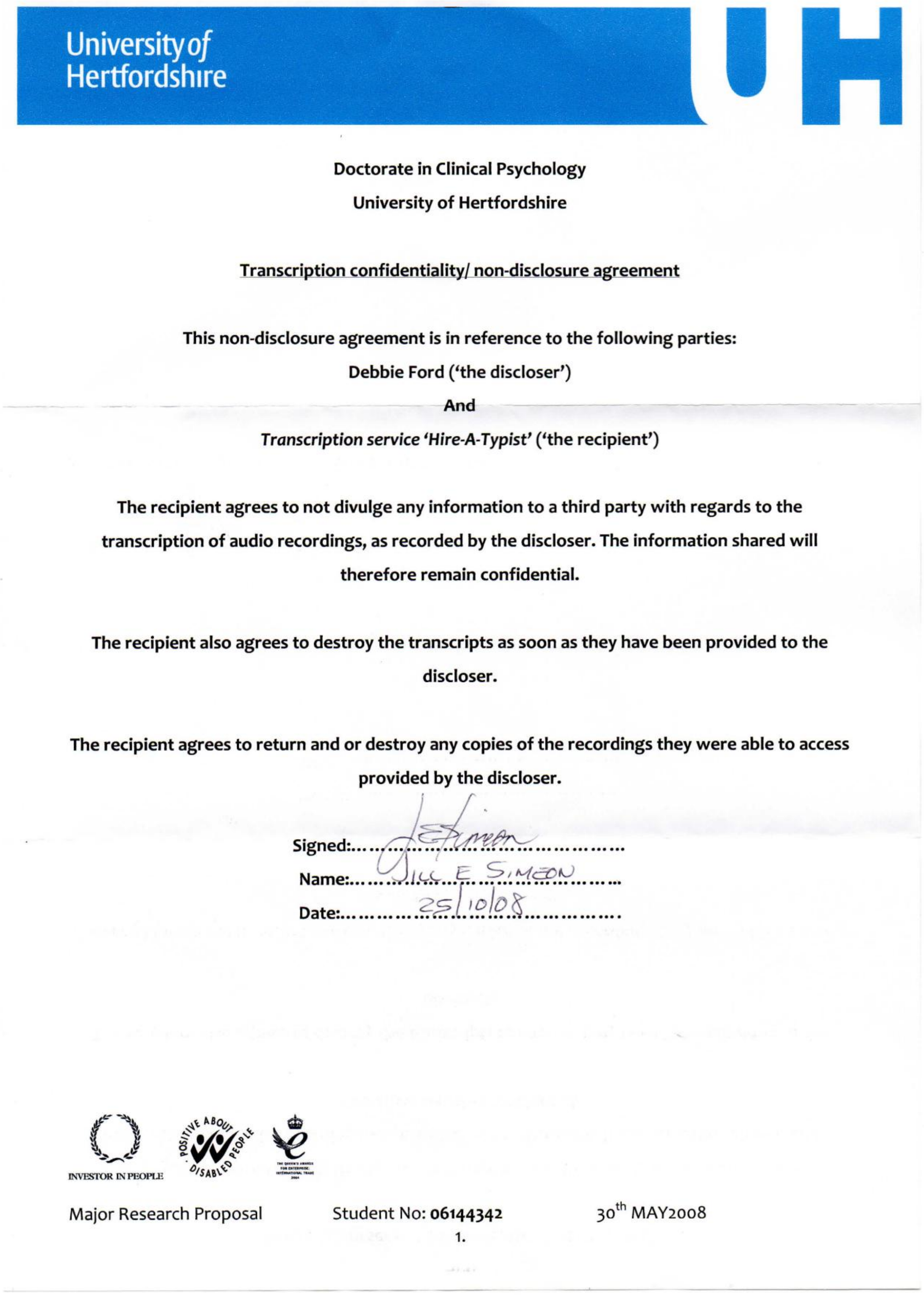
We would like to wish you every success with your project

Yours sincerely,

Angela

Angela Williams
Research & Development Manager

## APPENDIX 10: TRANSCRIPTION AGREEMENT



University of Hertfordshire

**Doctorate in Clinical Psychology**

**University of Hertfordshire**

**<u>Transcription confidentiality/ non-disclosure agreement</u>**

**This non-disclosure agreement is in reference to the following parties:**

**Debbie Ford ('the discloser')**

**And**

***Transcription service 'Hire-A-Typist'*** **('the recipient')**

**The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.**

**The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.**

**The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.**

**Signed:**……………………………………………

**Name:**……JILL E SIMON……………………

**Date:**…………25/10/08…………………….

INVESTOR IN PEOPLE

Major Research Proposal Student No: **06144342** 30th MAY2008

1.

## APPENDIX 11: AUDIT TRAIL: INTERVIEW 7; CATHERINE

***Initial themes from Interview 7:***

Terrifying
Emotional reaction
Fearing prof/personal inadequacy- before/ after death
Upsetting
Shock
Sadness
Experiencing self-doubt
Adjustment a continuous process
Finding comfort
Lost battle against time
Unpredictable experience
Finding company in the journey
Being understood
Shielded from death by supervisor
‘it was very much like contained’ L305
Messy
Containing the mess- supervisor/self
‘there was always someone there’ L370-371
Sources of support
Being validated
Reassurance seeking- being reassured
Death not self-relevant
Able to separate personal/prof
Taking control- fighting for control
Changed self - me then-me now- coping/ emotions/awareness
Unprepared for unexpected

Needing container- to being containing

Becoming self-contained

‘Don’t think support was obvious’ L569

‘I don’t think it’s even been mentioned what happens if a client dies’ L580

Unspoken

Indescribable experience- making comparisons

Unfinished endings

Powerless

Multiple losses- client, relationship, role as psychologist

‘I kind of feel like I still had all this stuff to give and no client to give it to anymore’ L632

Finishing the unfinished- taking charge of endings

Being helped- being helpful

Drama of death

Death becomes relevant & expected

Needing to learn how to cope ‘should be raised’ L868

Memorable- lasting experience

Expectations- prevent impact

Uniqueness of experience- as person/psychologist/ other professional

Becoming protective- container, striving to protect

Professional acceptance of death/ emotions as psych

Team rejection/ disconnection from death/ controlling emotional exposure- protection

Emotions too much- paralysed by feelings

Fear of being uncontained

Feeling vulnerable- Needing protection

Facing the unexpected expected: ‘I know it sounds awful cause obviously a client can die but you don’t you just don’t think about it and I don’t think it would have crossed my consciousness had it not have happened’ L1535

Avoidance

Unexpected= traumatic

Becoming prepared

‘everybody dies so why why wouldn’t it be possible that one of your clients could die’ L1720

‘it’s probably had more of an influence actually than I first thought’

Becoming hypervigilent

Unexpected becomes expected

Feeling reluctantly prepared

Self-protection (L1856)

## Interview 7: Catherine

### Rich description of interview and experience

Death was an unpredictable, unexpected, memorable and emotional experience for Catherine. This provoked feelings of self-doubt about her adequacy as a therapist in the face of loss. She sought support on this journey and found containment in the figure of her supervisor and peers- however she did feel support for the death was not obvious and the topic had not been raised previously. She experienced adjustment to the death of her client as a continuous process- over time she felt it helped her to become more contained; she took control of this unexpected, unpredictable experience. She also became more anxious and avoidant of situations involving death, or where they were more likely. Her overall feeling was that she was changed; death was a memorable experience from which she felt she learnt a great deal. She recognised the unique nature of the experience of the death of a client, particularly in the context of the system in which she worked; who had avoided and disconnected from death. Leaving her feeling death is an issue that needs to be raised on training to prepare and protect others in the future.

**INTERVIEW 7: Catherine: Developing Themes**

| INITIAL THEME CLUSTERS | DEVELOPING SUBTHEMES | MASTER & SUB THEMES |
|---|---|---|
| Facing the unexpected expected<br>Powerless<br>Unpredictable experience<br>Unprepared for unexpected<br>Indescribable experience- making comparisons<br>‘I don’t think it’s even been mentioned what happens if a client dies’ L580<br>Unspoken<br>‘I know it sounds awful cause obviously a client can die but you don’t you just don’t think about it and I don’t think it would have crossed my consciousness had it not have happened’ L1535<br>‘everybody dies so why why wouldn’t it be possible that one of your clients could die’ L1720<br>Unexpected= traumatic<br>Terrifying, Shock<br>Upsetting, Sadness<br>Drama of death<br>Messy<br>Emotions too much- paralysed by feelings<br>Fear of being uncontained<br>Experiencing self-doubt<br>Fearing prof/personal inadequacy- before/ after death<br>Feeling vulnerable- Needing protection | Feeling unprepared for the expected<br>Trying to make sense?<br>Experiencing mixed emotions<br>Facing self-doubt and vulnerability | **<u>Confronted with death</u>**<br>**Feeling unprepared, struggling to make sense**<br>I came away just feeling very down myself and feeling as though I didn’t know what to do to help this lady L111-113<br>I came to the kind of conclusion that actually you could never exactly when someone was gonna die L217-219<br>you know it’s not like you’ve finished therapy and moved on and no it’s very different so yeah no there was nothing I didn’t feel prepared for that at all L593-595<br>**Experiencing mixed emotions**<br>there was no indication that she would die within three months uh so it was a bit of a shock and and it was quite upsetting L150-152<br>**Facing self-doubt and vulnerability**<br>I probably reflected a lot more on had I actually helped her L158-159<br>‘those were the kind of things that ran through my head was like oh we didn’t know that this was gonna happen had we done had she had a good quality of life in the last …you know couple of months uh had I helped at all and had I yeah had it been significant’ L169-176 |

| **INITIAL THEME CLUSTERS** | **DEVELOPING SUBTHEMES** | **MASTER & SUB THEMES** |
|---|---|---|
| Loss of relationship<br>Unfinished endings<br>'I kind of feel like I still had all this stuff to give and no client to give it to anymore' L632<br>Multiple losses- client, relationship, role as psychologist<br>Lost battle against time | ' I kind of feel like I still had all this stuff to give and no client to give it to anymore' L632<br>Losing battle with time | **<u>EXPERIENCING LOSS AND UNFINISHED ENDINGS</u>**<br>**'I kind of feel like I still had all this stuff to give and no client to give it to anymore' L632**<br>I guess there was feelings of like loss not just in terms of her death and loss of a client who I had quite a good relationship with um but loss also in terms of like the work that we were doing and the input that I was giving L627-631<br>I guess it feels almost unfinished and that's a very hard feeling to kind of cope with I guess cause it it doesn't it feels like someone's finished it for you L605-607<br>**Losing a relationship**<br>'It was quite upsetting cause after at that point I'd felt like I'd we'd done quite a lot of work together and I'd built up quite a rapport with her ' L143-145<br>**Mourning lost opportunities**<br>'I remember thinking well maybe I should have just done it more immediate rather than six months cause we didn't obviously get to reach those uh….those goals<br>it probably has made me more aware of when I'm working with somebody that although you've you've got a set amount of time it doesn't meant that for whatever reason that you're actually gonna have that amount of time L903-905 |

| INITIAL THEME CLUSTERS | DEVELOPING SUBTHEMES | MASTER & SUB THEMES |
|---|---|---|
| Finding company in the journey<br>Team rejection/ disconnection from death/ controlling emotional exposure-protection<br>'Don't think support was obvious' L569<br>Sources of support<br>Containing the mess-supervisor/self<br>Shielded from death by supervisor<br>'it was very much like contained' L305<br>'there was always someone there' L370-371<br>Reassurance seeking<br>Finding comfort<br>Being understood<br>Being validated<br>Being reassured<br>Being helped- being helpful | 'Don't think support was obvious' L569<br>System rejected/disconnected from death?<br><br>Containing the mess – self, supervisor, peers<br><br>Being helped by being helpful | **<u>SEARCHING FOR & FINDING SUPPORT ON THE JOURNEY</u>**<br>**'Don't think support was obvious' L569**<br>I do think that actually the death of a client doesn't have to just occur in that situation it can occur across with whatever placement you're in and I do think that maybe you need to kind you need to think about those um how you'd respond to that whether it's suicide or whether it's you know death of natural causes I think that actually part of the training at some point that should be raised so that the trainees have an idea of how they might handle it or support 862-869<br><br>'I wasn't told of any other support and I didn't I didn't know I guess I could have contacted the Macmillan nurses um but I didn't and no I wasn't aware of any kind of support for me as a as an employee' L542-545<br><br>I guess it didn't occur to anybody to say you know oh how are you gonna deal with this… I think particularly as a first year I think that just came quite out of the blue and um yeah so I would have liked that beforehand I think just to even if it was just the thought in my head L825-833<br><br>**Containing the mess: 'there was always someone there' L370-371**<br>'It was a nice place to be able to reflect on those and have somebody who'd experienced client death before' L273-274<br>'It think her kind of approach to it and attitude to it wasn't light-hearted but it was very much like contained and uh that helped me to contain my own feelings' L304-306<br>And I think peers are always more available than supervisors so [laughs] sometimes when you actually need just to offload something they're there L407-409<br>it was nice to hear him (son) you know saying that that was good and he was kind of pleased about that L773-774 |

| INITIAL THEME CLUSTERS | DEVELOPING SUBTHEMES | MASTER & SUB THEMES |
|---|---|---|
| Taking control- fighting for control<br>Adjustment a continuous process<br>Becoming self-contained<br>Becoming protective- container, striving to protect<br>Able to separate personal/prof<br>Finishing the unfinished- taking charge of endings<br>Needing to learn how to cope<br>‘should be raised’ L868 | Fighting for control?<br>Learning how to cope<br>Becoming self-contained/ protective-self/others<br>Finishing the unfinished | **Taking control**<br>**Finishing the unfinished**<br>I think writing that letter might have helped me that that might have been more of a physical loose end for me because it was my way of saying right this is my ending the client L697-700<br>**Containing the mess**<br>I don’t think I’d have as many concerns now as I did at the time I felt very I felt very inadequate I think and I think that’s because of my stage of training L487-494<br>‘now I’m a lot better at containing it myself’ L528<br>**Becoming protective of others**<br>‘whether it’s suicide or whether it’s you know death of natural causes I think that actually part of the training at some point that should be raised so that the trainees have an idea of how they might handle it or support’ L866-869<br>I’d be a lot more reflective and containing if it happened to one of my trainees or an assistant I would actually thinking about it I’d probably feel quite protective of them and be quite concerned about how it would affect them L1131-1135 |

| **INITIAL THEME CLUSTERS** | **DEVELOPING SUBTHEMES** | **MASTER & SUB THEMES** |
|---|---|---|
| Feeling reluctantly prepared<br>'it's probably had more of an influence actually than I first thought'<br>Memorable- lasting experience<br>Changed self - me then-me now- coping/ emotions/awareness<br>Becoming hypervigilent<br>Professional acceptance of death/ emotions as psych<br>Unexpected becomes expected<br>Death becomes relevant & expected<br>Expectations- prevent impact<br>Becoming prepared<br>Self-protection (L1856)<br>Uniqueness of experience- as person/psychologist/ other professional<br>Avoidance | 'it's probably had more of an influence actually than I first thought' (Memorable/lasting experience)<br><br>Hypervigilence and avoidance- preventing impact<br><br>Being changed by death<br><br>Adjusting expectations/ Death becomes relevant and expected | **<u>Death had a lasting impact</u>**<br><br>**'it's probably had more of an influence actually than I first thought'**<br>yeah it probably has um it's not something that i've forgotten about and I guess if I was working with somebody who was ill then it might make me view my work with them a bit differently L890-893<br><br>It's also given me the kind of resilience that I know that if a client does die then I know a bit more about how I might deal with that 897-899<br><br>**Reluctantly prepared for death**<br>I remember thinking okay it's possible that my clients could die and I know how I'm gonna deal with that if they do L1001-1002<br><br>I guess it's also just raising awareness in my mind that it's possible that a client might die L990-991<br><br>I don't think it would have knocked me to the ground so much if if like a client had of died on that placement L1005-1007<br><br>**Becoming hypervigilent and avoidant**<br>I don't know if that's just my personality but I did think I don't want to have to handle this and if I can avoid it then I will try and avoid it and uh and when it came to picking third year placements cause I really enjoyed my clinical health placement there is a specialist one but it involved palliative care and I remember thinking I really actually don't want to to have to go back into that uh and I think that probably was influenced by her dying cause I if I can avoid it then I probably will try but I'm prepared for it if it happens<br>L1832-1840 |

# APPENDIX 12: SUPERORDINATE THEME TABLE, BY PARTICIPANT

| *Super-ordinate themes* | *Sub-ordinate Themes* | *1. Vanessa* | *2. Ruth* | *3. Lisa* | *4. Helen* | *5. Natalie* | *6. Ella* | *7. Catherine* | *8. Marie* | *9. Heather* |
|---|---|---|---|---|---|---|---|---|---|---|
| *Connected and affected: being unprepared for initial reactions to the client's death* | *In a tailspin; Confronted by death* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | *Feeling the death: A mixed bag of emotions* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | *Being left behind with losses & difficult 'what ifs?'* | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | |
| | *'just a death?' searching For meaning through comparison* | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| *We do it so why can't you? Facing institutionalised denial and avoidance* | *Alone in a fearful system: uncovering systemic Denial and avoidance* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | *Under pressure to contain the 'mess'* | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| | *Surviving in the system* | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |

| *Super-ordinate themes* | *Sub-ordinate Themes* | *1. Vanessa* | *2. Ruth* | *3. Lisa* | *4. Helen* | *5. Natalie* | *6. Ella* | *7. Catherine* | *8. Marie* | *9. Heather* |
|---|---|---|---|---|---|---|---|---|---|---|
| *The lasting impact of the death; learning reluctant lessons* | *Being changed by a unique and memorable death* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | *The pain and comfort of continuing bonds* | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | *Choosing to care and to feel* | | | | ✓ | | ✓ | | | ✓ |
| | *Feeling threatened, becoming avoidant too* | ✓ | ✓ | ✓ | | | | ✓ | ✓ | |
| | *The importance of time and space* | ✓ | | | ✓ | ✓ | ✓ | | ✓ | ✓ |