

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

**Doctoral Thesis:**

**A Qualitative Exploration of Emotional Expression for Healthcare Professionals**

**Working within End-of-Life**

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Word Count

<b>Section</b>	<b>Main Text</b>	<b>Appendices (including tables, figures, and references)</b>	<b>Total</b>
Thesis Abstract	300	N/A	300
Literature Review	7998	6615	14,613
Research Paper	7997	7255	15,252
Critical Appraisal	3780	N/A	3780
Ethics Section	5027	4844	9871
<b>Total</b>	<b>25,102</b>	<b>18,714</b>	<b>43,816</b>

## Abstract

This thesis consists of a systematic literature review, empirical paper, and critical appraisal. The literature review is a qualitative synthesis of emotional labour experiences for healthcare professionals working within end-of-life. Although previously explored within healthcare, it has not been considered within an end-of-life context. A meta-ethnography was completed to synthesise 18 qualitative studies that met the inclusion criteria. Five concepts were identified: The continuum of emotional expression; Being vulnerable to triggers; The dual-purpose; The emotional impact; and Building resilience. Findings suggest that healthcare professionals use emotional labour to align themselves with the expectations of their role. Recommendations for increased awareness and support (both formal and informal) are provided. The important role of the organisation in promoting a normalising and accepting culture has been highlighted.

The empirical paper considered the qualitative experiences of therapist crying in therapy for 10 psychological therapists working within end-of-life. Five clinical psychologists and five counsellors took part. Semi-structured interviews were completed and Interpretative Phenomenological Analysis was used to analyse these accounts. Three superordinate themes emerged: The role of the therapist; Being struck by emotion; and The balancing act. The findings indicate that crying in therapy can be therapeutic under some circumstances, as it can demonstrate therapist authenticity, the significance of an experience, and model a healthy response to emotion. Increasing therapist self-awareness may help to reduce over-empathising, that can lead to crying. Discussions about the therapist's tears are important and may help to normalise experiences.

This critical appraisal provides a reflective account of my research journey. It considers decisions made at various time-points during the research process, and the rationale for these. I considered the challenges I faced during the process, and how these were addressed. My

experience of conducting research within an end-of-life context is considered throughout, and links to my clinical practice are made.

## Declaration

This thesis represents work undertaken for the Doctorate in Clinical Psychology at Lancaster University Division of Health Research from January 2016 to November 2019. The work presented here is the author's own, except for where due reference is made. This work has not been submitted for the award of a higher degree elsewhere.

Name: Laura-Jayne Richardson

Signature:

Date: 26<sup>th</sup> November 2019

## Acknowledgements

First, I wish to thank the 10 psychological therapists that took the time and effort to share their stories with me. Many of you commented on your own challenging experience of conducting research as a trainee, and subsequently, how you wished to help ease my journey through your participation. I hope to be able to re-pay this kindness to another trainee myself one day.

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I wish to thank the clinical psychology team at Lancaster University. In particular, to Sarah Heard, for arranging my viva, and forgiving me for keeping the Dictaphone for so long! To Rob Parker for creating the online link to my research, and for doing this quickly so that I could start recruitment. I also wish to thank Anna Daiches, Jen Davies, and Ste Weatherhead for being my clinical tutors during the course. I have valued all of your guidance and support during training and have lovely memories of my time at Lancaster.

I would like to thank Caroline Gibson for her time spent helping me to produce a good literature search – and for advising me of nice places to go for lunch!

I would like to thank my colleagues at Maggie's for allowing me the time and headspace to finally finish my thesis.

I am fortunate to have such lovely friends that are still here for me – despite my disappearance over the last few months! A special thank you to Jennie for being my IPA-sounding board and for always picking up the phone when I needed it.

Finally, I would like to thank my family, who are always so supportive of everything I do.

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**Section One: Literature Review**

**Meta-synthesis Exploring the Experiences of Emotional Labour for Healthcare  
Professionals Working Within End-of-Life Care**

Word count: 7998 words

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### **Abstract**

**Aims:** To review and synthesise experiences of emotional labour for healthcare professionals (HCPs) working within end-of-life care.

**Background:** Emotional labour is defined as the suppression or induction of feeling to provide others with a sense of being cared for (Hochschild, 1983). Although previously considered within other healthcare contexts, a review of emotional labour studies has not been explored for HCPs working in end-of-life care.

**Design:** A meta-ethnography was completed which synthesised qualitative studies. The review is reported in line with the enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) statement for synthesising qualitative health research (Tong, Flemming, McInnes, Oliver & Craig, 2012).

**Data sources:** Five databases were searched (PsychInfo, Cinahl, Medline Complete, Scopus, and Embase) between 2004–2019.

**Review methods:** Papers included in the review were qualitative, employed a definition of emotional labour considered consistent with Hochschild (1983), and included direct accounts from HCPs working with patients and families approaching end-of-life.

**Results:** Five concepts were identified: 1) The continuum of emotional expression; 2) Being vulnerable to triggers; 3) The dual-purpose of emotional labour; 4) The emotional impact; and 5) Building resilience.

**Conclusions:** The review identified how HCPs used emotional labour within end-of-life care to align themselves with the display rules of the organisation. Situations leading to emotional labour, and the strategies HCPs used to manage emotions, were explored. The need for formal and informal support mechanisms was highlighted.

**Keywords:** emotional labour, death and dying, palliative care, end-of-life, qualitative, meta-synthesis, literature review

## Introduction

Considerable variation exists within the literature as to when an individual is considered to be dying (Department of Health & Social Care, 2008; Krau, 2016; Leadership Alliance for the Care of Dying People, 2014). NHS England (2014) suggests end-of-life care is provided in “the last year of life” (p.5). This may be from disease-specific teams, generalists including primary care hospital-based teams, or palliative care specialists (National Institute for Health and Care Excellence [NICE], 2019). Palliative care is concerned with improving the quality of life for those affected by progressive life-limiting illness. Although previously offered primarily to individuals with cancer, palliative care can be provided to anyone experiencing an illness from which they will ultimately die (World Health Organisation [WHO], 2014). The approach aims to offer pain management, relief from suffering, and address physical, psychosocial, and spiritual issues that can occur (WHO, 2019).

Working at end-of-life is considered one of the most difficult, complex, and demanding areas of nursing (Croxon, Deravin & Anderson, 2017; Parola, Coelho, Sandgren, Fernandes & Apostolo, 2018). Caring for such individuals can place considerable demands on healthcare professionals (HCPs), resulting in psychological difficulties including anxiety, stress, and compassion fatigue (Browall, Henoeh, Melin-Johansson, Strang & Danielson, 2014; Luxardo, Padros & Tripodoro, 2014). Helplessness, and a sense of failure, may be experienced when the focus is on end-of-life care rather than curative treatment, which can conflict with the HCPs training (Ablett & Jones, 2006; Gelinias, Fillion, Robitaille & Truchon, 2012). Frequent death can lead to depression, and grief at patient loss (Papadatou, 2000). However, end-of-life care can also be rewarding, leading to personal growth and resilience (Ablett & Jones, 2006; Festic, Wilson, Gajic, Divertie & Rabatin, 2012).

## Background

HCPs may perform emotional labour (EL) to manage the challenges of working at end-of-life (Bailey, Murphy & Porock, 2011; Browall et al., 2014). Hochschild (1983) defined EL as: “the induction or suppression of feelings in order to sustain the outward countenance that produces the proper state of mind in others of being cared for in a convivial safe place” (p.7). Based on emotion work theory, EL suggests individuals work to regulate inner and outward emotions (Hochschild, 1983). This is based on societal and cultural norms, or on socially constructed “feeling rules,” which influence the emotions that can be felt or displayed within a context (Hochschild, 1983, p.18). Thus, within a work setting, individuals do not always “show what they feel, or feel what they show” (Riley & Weiss, 2015, p.7).

Initially, EL research focused on the experiences of flight attendants, although it has since been applied to sociology, psychology, organisational behaviour, and healthcare (Grandey, Fisk, Mattila, Jansen & Sideman, 2005; Hochschild, 1983). Despite this, a lack of consensus exists regarding its defining characteristics (Choi & Kim, 2005). Hochschild (1983) suggested three criteria that must be met for a behaviour to be considered EL, shown in Table 1.

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EL may occur when a dissonance, or internal conflict, is experienced between the expectations of an individual and the organisation (Hunter, 2004, 2005; Msiska, Smith & Fawcett, 2014). Recently, attempts were made to define and expand on the construct, and it was suggested that common features may exist across definitions. For example, that



emotional labour involves using strategies to modify, create, and alter the expression of emotion within paid employment (Choi & Kim, 2005). Thus, allowing the individual to manage their emotional expression in order to meet professional expectations (Diefendorff, Croyle & Gosserand, 2005).

Surface and deep acting are strategies through which EL can be performed (Hochschild, 1983). In surface acting, individuals change their outward expression (e.g. facial expression, gesture, or tone of voice) to fit organisational expectations. In this instance, emotions are simulated that are not actually felt. Alternatively, deep acting is when an individual alters their inner experience to induce a genuine emotion (Msiska et al., 2014). To do this, they use their professional training, imagination, thoughts, images, memories, and experiences (Hochschild, 1983; Kruml & Geddes, 2000).

Ashforth and Humphrey (1993) suggested that surface and deep acting do not sufficiently explain the concept of EL, as it does not allow for when an expected behaviour occurs due to a naturally-felt emotion, rather than organisational demands. This may be relevant for HCPs, as the concept of EL may underestimate and over-simplify the altruistic nature of their work (Bolton, 2000). HCPs are often thought to experience satisfaction from caring for others, and may perform EL because they wish to, rather than due to the expectations of the role (Bolton, 2000; Mann, 2005; Rodriguez, 2011).

HCPs are thought likely to encounter significant EL due to the caring nature of their role (Bolton, 2000). Thus, exploring EL within healthcare contexts may be important, given its relevance to the provision of care (Phillips, 1996). However, the support and training needs of HCPs are often overlooked, with EL being an assumed, and often hidden, part of their role (Riley & Weiss, 2015; Williams, 2013).

Within healthcare contexts, EL may involve listening, engaging in conversations, updating patients and families, and supporting other professionals (James, 1989). Theodosius (2008) proposed three types of EL: therapeutic; collegial; and instrumental, shown in Table 2.

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Other sources of EL include managing the suffering of patients and families including negative or uncertain health outcomes, lengthy treatments, anger, anxiety, and death (Gray & Smith, 2009; Humphrey, Ashforth & Diefendorff, 2015; Huynh, Alderson & Thompson, 2008). In such instances, expressing genuine emotion may not always be beneficial or possible (Henderson, 2001). Subsequently, emotions may be managed or suppressed including anger, frustration, irritation and disgust, so as to provide “service with a smile” (Grandey et al., 2005, p.38). EL can assist the HCP in displaying favourable emotions including compassion, kindness, and humour (de Castro, 2004; Smith & Gray, 2000).

Although surface and deep acting can help others feel cared for, this may have an impact on the HCP (Debesay, Harsløf, Rechel & Vike, 2014; Mann & Cowburn, 2005; McQueen, 2004). Deep acting is associated with positive aspects of EL including job satisfaction, increased patient connection, and improved care (Chou, Hecker & Martin, 2012; Golfenshtein & Drach-Zahavy, 2015). In contrast, surface acting may lead to emotional exhaustion, stress, burn-out, psychological and physical ill-health (Schmidt & Diestel, 2014). Surface acting is considered more emotionally challenging as a discrepancy exists between authentic feeling and emotional expression (Karimi, Leggat, Donohue, Farrell & Couper, 2014). This dissonance can feel particularly difficult for HCPs who may wish to feel a certain

way but are unable. Consequently, their perception of their professional self as a caring individual could be challenged, resulting in feeling disingenuous (Cheng, Bartram, Karimi & Leggat, 2013).

### **Previous reviews**

Five reviews have considered EL within a physical health context (Badolamenti, Sili, Caruso & Fida, 2017; Delgado, Upton, Ranse, Furness & Foster, 2017; Huynh et al., 2008; Riley & Weiss, 2015; Ryan & Seymour, 2013). These considered the quantitative and qualitative experiences of nurses, apart from Riley and Weiss (2015), who synthesised qualitative papers considering the experiences of HCPs (nurses, midwives, paramedics, doctors & care assistants), working across various healthcare settings. With the exception of Ryan and Seymour (2013), who focused on the experiences of intensive care unit (ICU) nurses when caring for dying patients and their relatives, none considered EL within a purely end-of-life context.

Although the review by Ryan and Seymour (2013) holds similarities to the current research, their review appeared to provide a summary of the phenomenon (ICU nurses use of EL), rather than a qualitative synthesis and interpretation, that would lead to the development of novel concepts. Such meta-syntheses provide a detailed and rich account of experience, and subsequently, qualitative reviews are increasingly valued (Dixon-Woods & Fitzpatrick, 2001). See Table 3 for details of previous reviews.

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## **The review**

### **Aim**

As there are no known qualitative reviews exploring HCPs experiences of EL within an end-of-life context, the current review aims to address this gap in the literature. This is important, due to the challenging nature of end-of-life care (Burt et al., 2008). Subsequently, HCPs working within this context may experience EL differently to those working in other healthcare contexts, and have unique support needs. This meta-synthesis aims to address the following research question: “what are the experiences of EL for HCPs working within end-of-life care?”

### **Design**

Qualitative meta-synthesis is the integration of findings from individual studies to produce new knowledge relating to a particular research question (Atkins et al., 2008; Polit & Beck, 2008). For the current review, a meta-ethnography was chosen (Noblit & Hare, 1988). In this type of meta-synthesis, an interpretative analysis is produced, rather than a summary of papers (Murray & Forshaw, 2013). The ability to develop theory, a model, or new interpretation has been described as a key strength of meta-ethnography (France et al., 2019).

The approach is underpinned by a Critical Realist framework, suggesting that “knowledge of reality is mediated by one’s beliefs and perspectives” (Tong, Flemming, McInnes, Oliver & Craig, 2012, p.5). This review has been reported in line with the ENTREQ statement for the synthesis of qualitative health research (Tong et al., 2012).

### **Search methods**

The Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool was used to guide and develop the research question posed in the review (Cooke, Smith & Booth, 2012). This can be seen in Table 4.

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A search strategy was developed with advice from a Lancaster University librarian with specialist knowledge of health research. Five databases relevant to the research question were used to complete the search (PsychInfo, Cinahl, Medline Complete, Scopus, and Embase). For each database, a combination of subject terms or Medical Subject Headings (MeSH) and free-text search terms (of the title and abstract) were used, to ensure a comprehensive search. Database limiters applied included: academic journals only, written in English language, and a date restriction of 01/01/2004 to 24/05/2019 (date of the final search). See Appendix 1-A for search terms.

Papers published before 2004 were excluded. This date reflects the publication of a WHO (2004) document that resulted in a change in the understanding and use of the term “palliative care.” Prior to this, palliative care was largely used in relation to cancer and provided by services with a specialist focus on end-of-life. The WHO publication suggested that palliative care should be offered to all patients approaching end-of-life, regardless of diagnosis or setting. As the current review wished to consider multiple conditions across various healthcare contexts, this definition of palliative care appeared consistent with the research aims.

#### *Inclusion/Exclusion Criteria*

Inclusion and exclusion criteria are outlined in Table 5.

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All papers which met the criteria for inclusion were qualitative in nature.

### **Search outcome**

A total of 3738 papers were retrieved from the databases (PsychInfo: 608; Cinahl: 350; Medline Complete: 669; Scopus: 50; Embase: 2061). Of these, 1010 duplicates were removed. Of the 2728 studies remaining, the title and abstract sections were read against the inclusion and exclusion criteria, to consider eligibility for inclusion in the review. At this stage, 2421 papers were excluded. If it was uncertain whether a paper was relevant, then the paper was read in full. In total, 307 papers were read, and the inclusion and exclusion criteria were applied. Following this, 14 studies were included in the review. In order to be thorough, the reference section of each paper was considered, and citations were checked on Google Scholar. This revealed a further four papers, giving a total of 18 papers selected for the review.

See Figure 1 for a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram demonstrating this process (Moher, Liberati, Tezlauff & Altman, 2009)

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### *Study characteristics*

Detailed characteristics of the 18 papers can be seen in Table 6. One paper did not provide detailed information about the context in which participants worked (Msiska et al., 2014). Participants were nursing students who shared their perceptions of EL during clinical placements. Therefore, participants worked across different settings, and were not limited to

end-of-life. This paper was considered suitable for inclusion however as there was a clearly identified theme relating to death and dying. Three further papers also included participants who worked across different contexts (Brown, Bain, Broderick & Sully, 2013; Gray & Smith, 2009; Li, Gao, Shen & Liu, 2014). These were considered suitable for inclusion, as they had clearly defined themes relating to the experience of EL in an end-of-life or palliative context.

One paper included a varied sample of participants including nine “social support workers” (e.g., social workers, chaplains, or counsellors), two medical directors, two volunteers, and eight administrators or managers (Cain, 2012, p.398). This paper was included as the results appeared relevant to the research question. Additionally, the author provided a rationale for the sample, stating: “this sampling procedure ensured that I captured the diversity of experiences of the frontline care workers in the hospice” (Cain, 2012, p.399).

Finally, two papers were by the same authors (Funk, Peters & Stieber Roger, 2017; Funk, Peters & Stieber Roger, 2018). Although not explicitly stated, it was considered likely (by comparing both papers) that the same sample was used. As the focus of the papers differed, it was decided to include both, as they could contribute differently to the analysis.

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### **Quality appraisal**

The 18 papers were appraised for quality using the Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit, 2013). The CASP compares research quality across 10 domains considered relevant to qualitative research. This was used alongside a three-point rating system, developed by Duggleby et al. (2010). Each domain was

given a score of weak, moderate, or strong. These tools were selected as they have been used previously in published meta-ethnography research (e.g., Murray & Forshaw, 2013).

Spencer and Richie (2012) questioned the value of quality appraisal in meta-synthesis research. In the current review, the purpose of quality appraisal was to understand the strengths and weaknesses of each paper. It was hoped this would reduce bias, and as such, scores were considered during the analysis and writing-up stage. No papers were excluded due to a low score however, as this may be the result of poor-quality reporting, rather than a true reflection of the research itself (Atkins et al., 2008). Quality ratings can be seen in Table 7.

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### **Data abstraction and synthesis**

A seven-step analysis process was followed, based on Noblit and Hare's (1988) guidelines for synthesising qualitative literature. This was considered alongside a worked example undertaken within a healthcare context (Atkins et al., 2008).

The seven-step process can be seen in Table 8.

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Table 9 provides a summary of first and second order constructs for each paper, and their contribution to overall concept development.



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### *Reflexivity*

The lead researcher (LR) was a trainee psychologist with some experience of working with individuals approaching end-of-life. The findings in this review are based on her interpretation of the studies included. As the current review synthesised qualitative research, a degree of subjectivity is expected when interpreting data. A reflective diary was kept throughout the analysis process to ensure transparency, and regular supervision was sought with the project supervisors.

### **Results**

Five concepts emerged: 1) The continuum of emotional expression; 2) Being vulnerable to triggers; 3) The dual-purpose of emotional labour; 4) The emotional impact, and 5) Building resilience.

#### **The continuum of emotional expression**

Display rules dictated to participants the expected emotional expression within each organisation. This differed across papers; appearing as a continuum of emotional expression. EL was used by participants to align their response to the display rules of the organisation.

For most participants, limited emotional expression was preferred. This portrayed professionalism and was based on a belief that being emotionally detached resulted in better care. Experiencing too much emotion was dangerous, and could render the participant unable to perform their role. An intensive care unit (ICU) nurse described: “the best way to be able to help patients is to fulfil the duty with my professional expertise... it is no help to save the

patient in such an emotion” (Li et al., 2014, p.700). For some, limiting emotional expression demonstrated care, as they put their own emotions to one side for the well-being of the patient.

Subsequently, some participants felt that more extreme forms of emotional expression (e.g., crying or sobbing), demonstrated an inability to cope. This suggested an individual was unsuited to end-of-life work, and should seek alternative employment. A palliative nurse described: “I’ve worked with a few that... cry a lot... I’m tired of whiners... it’s like, this is not where you should be. You’re not ready for this” (Funk et al., 2017, p.2215). In this example, showing grief in response to patient death demonstrated inexperience, fear, a lack of professionalism, and skill.

Limiting emotional expression could go too far however, appearing as a lack of care towards the patient and family. A palliative nurse described: “they’ve taught themselves to be too far the other way... [that] comes across in their care towards the patients” (Brighton et al., 2019, p.497). For these participants, some emotional expression was acceptable, providing it met certain conditions. For example, that it was under the control of the participant, and that their upset was less than those they were caring for (Brighton et al., 2019; Cain, 2012; Sorensen & Iedema, 2009). Cain (2012) described how participants working in a hospice felt that sadness and crying was acceptable in relation to patient death, as long as it was constrained via “the moderated cry” (p.339).

Expressing emotion was considered therapeutic by some, as a way of acknowledging, understanding, normalising, and responding to grief (Cain, 2012; Sorensen & Iedema, 2009). For patients and families, it could demonstrate care, empathy, and that the participant was human (Funk et al., 2017; Sorensen & Iedema, 2009). An ICU nurse described crying with a patient’s relatives: “they said, ‘thank you, you actually feel what we feel, it’s good to see that; you’re not pushing us away and ignoring our grief’” (Sorensen & Iedema, 2009, p.12).

Some participants attempted to find a balance between following organisational rules of appearing professional, and their personal desire to appear authentic, or human. This could result in personal conflict however, leading to significant EL. An ambulance team leader described: “the last thing you want to do is be sobbing... then again, part of me thinks that actually I’m human, and there’s nothing wrong with showing your human side” (Brighton et al., 2019, p.497).

### **Being vulnerable to triggers**

Various triggers emerged that made participants vulnerable to EL, and threatened their ability to meet the organisations’ display rules. These occurred in response to interactions with patients, families, colleagues, and the organisation. Some were specific to end-of-life care, and others were unique to the participant.

Participants experienced various emotions while working at end-of-life including anxiety, uncertainty, and helplessness. Sadness emerged when patients died, particularly when this was linked to aspects of their caring role (Cricco-Lizza, 2014; Lovatt et al., 2015). Several papers described grief in response to patient death. Grief was greater when death was cumulative, when participants felt emotionally attached to the patient or family, or when death was considered unfair (Brighton et al., 2019; Funk et al., 2017; Raffi et al., 2015; Tuna & Baykal, 2017). For some participants, the intimate nature of their caring role added to the grief experienced (Funk et al., 2018; Lovatt et al., 2015;). A care home worker described: “I spend more time with the residents than my own wife. It’s like the death of a family member... it’s very difficult” (Vandrevala et al., 2017, p.159).

Managing relationships with colleagues, alongside providing care, could result in EL. For example, differences in approach towards death and dying between doctors and nurses on an ICU led to a “fracture line” developing (Sorensen & Iedema, 2009, p.11). While doctors

coped with dying through avoidance, detached concern, and withdrawal of medical intervention, nurses engaged more fully.

At times, participants acted in ways they disagreed with morally, to align themselves with organisational display rules. This included performing procedures that resulted in pain or distress in others, or coping with quick room turn-overs after a death (Funk et al., 2018; Sorensen & Iedema, 2009). Despite the emotions of the HCP, they were expected to perform such tasks. An ICU nurse described:

When a patient's... dead, it's "get the patient downstairs and get the bed cleaned because there's a patient in accident and emergency that's got to come in..." the bed's not even cold and there's someone else in that bed... that really disgusts me.  
(Sorensen & Iedema, 2009, p.14)

For some participants, end-of-life care was challenging when it held personal significance. This could be due to a fear of death and dying, when participants questioned their own mortality or the mortality of loved ones, and when the work reminded them of experiences of death within their personal lives (Cain, 2012; Huang, Chen & Chiang, 2016; Li et al., 2014; Vandrevalla et al., 2017). A hospice nurse shared how a personal experience impacted on her professionally: "when my grandmother was dying, she did not close her eyes until she saw me... when I was caring for that elderly patient, I couldn't help but relive that scene in my mind" (Huang et al., 2016, p.112).

Some participants described similarities between themselves and the patient or family, which made caring difficult (Funk et al., 2017; Cricco-Lizza, 2014). For example, female nurses working on a neo-natal ICU described how their relationship with motherhood impacted on their professional interactions with mothers and babies (Cricco-Lizza, 2014). As such, nurses that were currently pregnant reported anxiety over the health of their unborn

baby, and those without children described how this acted as a barrier to developing relationships with parents.

### **The dual-purpose of emotional labour**

Participants described using various strategies to perform EL. These were dual purpose: helping the patient and/or family to feel cared for, and also benefitting the HCP. Strategies allowed the participant to connect emotionally with patients, or to disconnect, and create emotional distance.

The desire to connect emerged across accounts, with participants wishing to appear genuine, human, and authentic (Cain, 2012). A palliative nurse described: “you have to feel as they feel. You have to be with them... to go on that road with them” (Brown et al., 2013, p.251). Subsequently, deep acting was the preferred strategy for some participants, as it resonated with their caring values (Li et al., 2014). Intentional efforts to empathise emerged across accounts (Bailey et al., 2011; Brighton et al., 2019; Funk et al., 2018; Huang et al., 2016; Msiska et al., 2014). An oncology nurse described: “how much can we empathise? Can we say, ‘what would I do if I were in that bed?’” (Tuna & Baykal, 2017, p.932).

Sometimes, participants felt unable to perform deep acting. This was when they were experiencing their own distress, when they disliked a patient, or did not feel authentically cheerful (Funk et al., 2018; Li et al., 2014). In these instances, surface acting was used, which enabled participants to demonstrate care in the absence of genuinely-felt emotion. This could also benefit the participant, appearing as a form of self-protection.

Some described suppressing emotions during interactions with patients (Cricco-Lizza, 2014; Funk et al., 2017; Huang et al., 2016; Sorensen & Iedema, 2009). One paper suggested that doctors might be more likely to suppress feelings, in order to prevent emotional vulnerability, and cope with the responsibility of their role. A doctor described this: “our work is to salvage people, and when they’re dying, I’ve finished with that one... bed four is

dying, don't even worry about it, because I've got 24 other people" (Sorensen & Iedema, 2009, p.14).

Similarly, getting "too close" to the patient or family was considered dangerous, and put the participant at risk of emotional distress (Cricco-Lizza, 2014, p.618). Subsequently, some participants avoided tasks that were emotionally difficult (Bailey et al., 2011; Brighton et al., 2019; Cricco-Lizza, 2014; Huang et al., 2016; Li et al., 2014; Sorensen & Iedema, 2009; Szymczak et al., 2018). Sometimes, this included being emotionally distant, as described by an oncology doctor: "for patients that I know have a terrible disease up front, I purposefully keep a little bit of distance... I emotionally don't let myself get too involved" (Szymczak et al., 2018, p.1263).

The use of a "persona" was referred to across several papers (Brighton et al., 2019; Cricco-Lizza, 2014; Funk et al., 2018; Li et al., 2014; Sorensen & Iedema, 2009; Tuna & Baykal, 2017). The nature of this differed across accounts but held a similar function - of demonstrating care, an ability to cope, and facilitating trust (Funk et al., 2018; Tuna & Baykal, 2017). Sometimes, participants used this strategy when they did not feel as they thought they ought to in a particular situation. One neo-natal nurse described: "I don't let on. I put on a happy face and smile" (Cricco-Lizza, 2014, p.620). Interestingly, some participants appeared to draw strength from their persona, suggesting it may also be considered a form of deep acting.

Similarly, humour was considered an "antidote" to grief, as it could relieve sadness and distress for both the participant and the patient and/or family (Cricco-Lizza, 2014; Funk et al., 2017, p.2214; Funk et al., 2018). A neo-natal nurse commented: 'I just throw a little bit of humour in there just to break the ice, and just to put myself at ease, and hopefully put the mom at ease as well' (Cricco-Lizza, 2014, p.623).

The use of “transitional time” (Cricco-Lizza, 2014, p.622) to and from work was referred to, a strategy that helped participants prepare mentally for their role. A neonatal nurse described: “[I] sort of get myself mentally organised... just gathering myself... I’m emotionally like, I can do this!” (Cricco-Lizza, 2014, p.622). This was also useful when returning home, as participants could use this strategy to leave their distress at work. Thus, protecting their family from emotional spillover.

Alongside surface and deep acting, some participants experienced an unintentional empathic response (Brighton et al., 2019; Sorensen & Iedema, 2009; Tuna & Baykal, 2017). This occurred when participants identified with the patient and/or family due to perceived similarities, because of a prolonged relationship, or when they experienced an emotional attachment. An ICU nurse described supporting the family of a dying patient: “when they finally accepted it... they all broke, and I nearly broke with them... I got a big connection with the family while it was happening” (Sorensen & Iedema, 2009, p.13)

### **The emotional impact**

Across papers, the impact of EL was addressed. The consequences appeared two-fold. On the one hand, participants encountered emotional challenges, which affected their ability to perform their role. Alternatively, participants experienced emotional growth, and learnt new ways of working through the difficulties encountered at end-of-life.

For some, using EL led to becoming detached, or desensitised, to end-of-life work (Bailey et al., 2011; Cain, 2012; Cricco-Lizza, 2014; Funk et al., 2017; Sorensen & Iedema, 2009). An oncology nurse described: “if you continually give, and give, and give, and give... I might be saying might be the right things... but they might not really mean anything to me anymore” (Gray & Smith, 2009, p.259).

For others, the work stayed with them, sometimes for long periods. Some participants struggled to find an appropriate emotional outlet, and one paper described this containment of

emotion as: “a growing pressure that required a vent, or else it might burst” (Brighton et al., 2019, p.498). Subsequently, some resorted to harmful coping mechanisms, as described by an emergency department nurse: “I have seen gambling... through to really bad jokes, again, just a coping mechanism to people who just cannot cope with it emotionally... [they] just reduce to tears” (Bailey et al., 2011, p.3366). Distancing strategies including avoidance were used, and some participants considered leaving end-of-life care. Some papers described how EL could lead to, ill-health, and burnout (Bailey et al., 2011; Cricco-Lizza, 2014; Gray & Smith, 2009).

Most papers considered EL to be skilled work, and highlighted the importance of training for HCPs (Bailey et al., 2011; Brighton et al., 2019). Age and level of experience might impact on coping ability, with some papers suggesting that younger, or less experienced, participants were at greater risk of distress (Funk et al., 2017; Li et al., 2014; Sorensen & Iedema, 2009). For some participants, resilience built over time, possibly due to encountering more difficult life events in their personal lives, or through the development and use of coping strategies (Li et al., 2014; Sorensen & Iedema, 2009). An ICU doctor described:

When you have been an ICU consultant for a reasonable length of time, you can afford to let it go a little bit more, and let the family see... your basic self is more secure than it was when you started. (Sorensen & Iedema, 2009, p.13)

The participant’s professional role could affect their personal lives, manifesting as a fear of losing loved ones. An oncology nurse described: “you think that you can die at any moment. Whenever someone in your family has any kind of pain, you are scared that they have cancer” (Tuna et al., 2017, p.933). Participants also reported difficulties including problems sleeping, relationship issues, anxiety, and irritability (Bailey et al., 2011; Tuna & Baykal, 2017; Vandrevalla et al., 2017).



Alternatively, EL could benefit participants. Some described a sense of purpose, and feeling they had made a difference to the patient and/or family (Cricco-Lizza, 2014; Funk et al., 2017; Msiska et al., 2014). How EL was perceived often depended on the culture within which the participant worked. In some contexts, participants were encouraged to express their emotions freely, which was described by one participant as “a good environment to work through sadness” (Cain, 2012, p.401). The suggestion that EL might provide a way of working through attitudes towards death and dying, leading to emotional growth, emerged within other papers also (Bailey et al., 2011; Funk et al., 2017; Sorensen & Iedema, 2009).

### **Building resilience**

As can be seen, participants had a range of emotional needs. Support could be through formal or informal mechanisms, and helped participants to build resilience, and greater self-awareness. Formal support included discussions with colleagues, reflective practice, attending funerals, and accessing to one-to-one support (Brighton et al., 2019; Cricco-Lizza, 2014; Funk et al., 2017; Pearson, 2013; Vandrevalla et al., 2017). Despite its perceived value, such mechanisms were limited. Even when formal support was available, participants faced barriers in accessing this (Brighton et al., 2019; Funk et al., 2017; Sorensen & Iedema, 2009). A palliative nurse described: “we have a regular slot for clinical reflection but it means leaving the ward. We are constantly busy, there is no one who comes to look after our patients while you are gone” (Pearson, 2013, p.203).

Several participants described how the organisation created barriers to coping. This included having limited “off stage” areas where they could take a break (Cricco-Lizza, 2014, p.620). This was important, as having opportunity to break from role helped participants to re-charge emotionally: “you get out of the room and calm your head, and then you come back and take a bit more of it” (Cricco-Lizza, 2014, p.623). Some organisations attempted to

support participants with the emotional aspects of their role (e.g. through rotating staff between patients or having mentors for new staff) (Cricco-Lizza, 2014; Raffi et al., 2015).

Accessing informal support in the absence of formal mechanisms was reported (Brighton et al., 2019; Brown et al., 2013; Pearson, 2013; Sorensen & Iedema, 2009; Vandrevalla et al., 2017). Co-worker support was considered essential, as it was felt to enhance emotional well-being, and increase the participant's ability to remain in their professional role (Brown et al., 2013). Sharing experiences with co-workers helped to normalise emotions, provide a sense of belonging, and of being understood by others. Several participants described that this was important within end-of-life, as they often felt different to others outside of this setting - including their own families, who did not want to hear about death and dying (Brown et al., 2013; Cricco-Lizza, 2014; Funk et al., 2017; Pearson, 2013).

Working within an environment that permitted, normalised, and acknowledged emotional expression was considered important (Brighton et al., 2019; Cricco-Lizza, 2014; Pearson, 2013; Vandrevalla et al., 2017). This type of organisational culture could provide realistic expectations for the range of ways participants could feel in response to death and dying. Managers were felt to have an important role in facilitating this (Brighton et al., 2019; Vandrevalla et al., 2017).

Opportunities for training could increase confidence and change how situations were appraised, helping participants to cope with the emotional aspects of their role. A paramedic described: "in the back of my mind, 'well, should I resuscitate? Is there any chance?' [That's] confidence, and only going to these sorts of things [training workshops] and understanding the process of dying in end-of-life care [will provide that]" (Brighton et al., 2019, p.497).

Additionally, training could develop the participant's self-awareness, helping them to understand their personal triggers while working at end-of-life. A hospice counsellor described how being aware of one's own triggers could help to reduce the possibility of over-

identification with the patient or family: “how to recognise what is my sadness and what is their sadness. I have sadness about what they’re going through, but my sadness is not the same as their sadness” (Cain, 2012, p.402).

### **Discussion**

This meta-synthesis considered the experience of EL for HCPs working within end-of-life care. Although previous reviews have considered this within other healthcare contexts, none have focused exclusively on end-of-life. As such, the results from the current review are two-fold: furthering our knowledge of EL, and addressing the literature gap relating to end-of-life. Furthermore, the current review considered the qualitative experiences of EL for HCPs within this context, which can add rich and detailed context to our understanding of this phenomenon. As supported by the findings of this review, increased awareness of EL is important within the context of death and dying, and may lead to the development of support mechanisms and relevant coping strategies.

#### **Relating the findings to previous literature**

The findings are largely consistent with previous research exploring EL within other healthcare contexts. Theodosius’s (2008) three types of EL also appear relevant to an end-of-life context, as EL occurred in response to interpersonal processes within the nurse-patient, family, and colleague relationships. Additionally, this review revealed triggers relevant to the use of EL that are unique to end-of-life. For example, the experience of grief in response to patient loss, and the existential impact of working with death and dying. Accordingly, EL was used to manage the emotional response. Being aware of the factors contributing to this within end-of-life care is important, and can inform relevant training needs.

The finding that a combination of both surface and deep acting strategies were used, is consistent with reviews undertaken in other healthcare contexts (Badolamenti et al., 2017; Delgado et al., 2017; Huynh et al., 2008; Riley & Weiss, 2015; Ryan & Seymour, 2013). In

the current review, such strategies could instill a sense of being cared for in the patient and/or family. Most participants wished to make a genuine connection within their professional relationships, and used deep acting to do so. Participants encountered barriers to this at times, and surface acting was used instead. This genuine desire to connect with patients and families supports the altruistic nature of the nurse, who derives satisfaction from providing care to others (Bolton, 2000). This supports the suggestion that some HCPs may perform EL because they wish to, rather than due to organisational demands (Mann, 2005).

In this review, EL strategies were dual-purpose, meaning they offered something to both the patient/family and the HCP. For the HCP, this was either the opportunity to connect with the patient (e.g., through intentional empathy) or disconnect (e.g., through emotional detachment or suppression). At times, strategies held a protective function, enabling participants to provide care, despite feeling their own distress. Considering the function of EL strategies for HCPs is important, and furthers our understanding of their experience.

The findings suggest that HCPs use different EL strategies depending on their professional role. This is based on the findings from two papers that doctors may respond differently to nurses, preferring to use surface (rather than deep) acting (Sorensen & Iedema, 2009; Szymczak et al., 2018). In this instance, surface acting allowed doctors to choose emotional distance from patients and families, rather than closeness. Huynh et al. (2008) reported similar findings, that nurses may seek to establish a genuine connection, while doctors may limit their emotional involvement. The doctor's response may be considered a form of self-protection, allowing them to avoid emotional distress. Such findings are important, as they suggest that support needs may differ, depending on profession.

Some papers referred to genuinely-felt emotion, rather than surface or deep acting. This is in line with Ashforth and Humphrey (1993), who suggested this is due to an individual's inclination to act a certain way, rather than the demands of the organisation. In

this review, this response occurred when the participant identified with the experience of the patient and/or family, or had developed an attachment. This appears to support the suggestion that this response can occur naturally for HCPs within an end-of-life context, when an experience holds personal significance. Again, this may be an important finding to consider, as HCPs working with death and dying are likely to experience personal loss at some point during their careers. Being aware of this response in advance may help to support these individuals.

The current research considered the impact on HCPs when using EL within end-of-life care. These results are consistent with previous findings that deep acting is associated with more positive outcomes (Golfenshtein & Drach-Zahavy, 2015). In this review, surface acting carried a risk for the participant of becoming desensitised, or emotionally detached. Dissonance was experienced by some, when their actions did not align with their perception of themselves as a caring individual, as described previously (Cheng et al., 2013; Karimi et al., 2014). Previous literature has been conflicted regarding the occurrence of dissonance – whether it is an antecedent to EL, or a consequence (Bono & Vey, 2005; Mann, 2005; Rubin et al., 2005). In the current review, it appeared as both, with dissonance occurring in response to the various triggers that made the HCP vulnerable to EL, and also as an implication of this.

Implications of EL included stress, ill-health, and burn-out, which is consistent with previous findings (Schmidt & Diestel, 2014). Subsequently, participants used distancing strategies and avoidance to cope. For some, this resulted in leaving the profession entirely. Interestingly, the age and experience level of the participant may be a protective factor, as several papers suggested that older participants or those with greater experience were more able to cope with EL. This finding supports suggestions that developing EL is skilled work and that HCPs may be able to learn how to use this with training and increased experience (Bailey et al., 2011).

Participants viewed EL positively when they worked within a supportive culture. In this context, EL could lead to emotional growth and increased resilience. This is an important finding, as it suggests that EL can be helpful for HCPs, providing it is supported by the organisational culture. In such a culture, participants felt able to share their emotional experiences with co-workers. This offered therapeutic benefit, through normalising experiences, and providing a means of working through attitudes towards death and dying. This is consistent with literature considering peer-support for other health conditions, suggesting it may lead to a feeling of belonging and connection with others (Richardson, Molyneaux & Murray, 2019). The opportunity to receive support from co-workers appears relevant within end-of-life, as HCPs may be unable to share their experiences outside of work. Thus, opportunities for discussion and reflection may hold greater importance in end-of-life care, than other healthcare contexts.

### **Clinical implications**

This review highlights the various challenges HCPs face when using EL within end-of-life. Subsequently, it is important to consider the emotional needs of HCPs. It is hoped that the findings of this review will increase awareness of EL, the implications of this within an end-of-life context, and provide organisations with recommendations for offering support.

Despite its emotional impact, there was limited formal support for HCPs. For participants in this meta-synthesis, formal support was considered a helpful but often luxury option; rather than a mandatory part of their role. The organisation was often considered a barrier to attending formal support (e.g., due to staff shortages or competing role demands). It is important that offering formal support (e.g., one-to-one sessions with a suitably trained individual, debrief opportunities, and team reflection) is understood at an organisational level. The important role for managers in encouraging, supporting, and facilitating HCPs

attendance to such support was highlighted across several papers included in the review (Brighton et al., 2019; Vandrevalla et al., 2017).

Managers and team leaders are also important in promoting a workplace culture that permits discussions about EL at end-of-life. Such discussions can hold therapeutic benefit for HCPs, through normalising and acknowledging difficult experiences. Within this culture, there should be opportunities for informal peer-support, as this was considered invaluable in the current review. Peer-support may enable HCPs to feel understood by others in a similar situation and reduce feelings of isolation. Within end-of-life, it may be particularly important as it could help to normalise the grief experienced in response to patient death, and provide opportunity to share difficult feelings.

Training and education are important, and should involve helping HCPs to understand the impact of their personal background on end-of-life care. Only three papers included in the current review mentioned training or education, and only one of these provided details of what this included (Cain, 2012). A similar training style to that of Cain (2012) could be considered, which would support HCPs to use EL within an end-of-life context.

### **Limitations and future research**

Papers published before 2004 were excluded from the review due to the publication of an important WHO (2004) document. Papers published before then may have contained information relevant to the research question, helping to provide a clearer picture of the target phenomenon.

As papers from multiple healthcare contexts were included, participants were from various professional backgrounds. Although this provided a broad overview of EL, focusing on the experiences of a smaller subset of professionals or on one profession only (e.g., nurses, doctors, or paramedics), might have allowed us to learn about a particular discipline in detail. This may have been useful, as differences did appear to exist across professions in their use

of EL (e.g., a preference for surface or deep acting, and specific support needs). Future research could try to explore such differences, building our understanding of the link between profession and EL.

Despite the presence of EL strategies across papers, it was not always clear how each author had categorised these (e.g., whether they were felt to demonstrate surface or deep acting). Additionally, discrepancy appeared between papers, with some considering a strategy to be an example of surface acting, and others considering the same strategy to be deep acting. It appeared to the LR that this was not always clear-cut, and that sometimes a strategy could be an example of both surface and deep acting. For example, changing an outward expression could be considered surface acting, but it might also result in a positive internal change, which would meet the criteria for deep acting. This interpretation is supported by Mann (2005), who commented “feelings are actively induced as the actor ‘psyches’ him/herself into the desired persona” (p.305).

Previous research has suggested that EL is largely “women’s work,” with females considered more likely to be employed in caring roles than males (Hochschild, 2003; Riley & Weiss, 2015, p.7). One paper considered the impact of gender for midwives, who were treated differently depending on their personal relationship with motherhood (Cricco-Lizza, 2014). Unfortunately, some papers provided incomplete information relating to the gender of participants, so it is difficult to draw firm conclusions from the current study. Future research could look to explore these links in greater detail.

EL is a complex concept, and as such, there has been a lack of consensus regarding its defining characteristics (Choi & Kim, 2005). The current review specified that all papers were consistent with the initial definition of EL, as suggested by Hochschild (1983). Although papers did not have to cite this definition to be included, they needed to demonstrate an understanding, or use, of EL that appeared consistent. This was determined



by the LR, through reading each paper thoroughly against this criterion. For papers that were less clearly defined, the project supervisors were consulted. A limitation of this approach however is that some papers claiming to explore EL may have been excluded, as they were considered incompatible with this definition. Additionally, EL had to be a main aim, focus, or key finding of the paper to be included. Determining this contained an element of subjectivity, and some papers may have been excluded that could have benefitted the review. For example, some papers may have briefly mentioned emotional labour, or concepts related to this (e.g., behaviours meeting the criteria for surface or deep acting). Such papers were excluded for not meeting the inclusion criterion, which could be considered a limitation.

Difficulties exist in determining when an individual is at end-of-life (Krau, 2016). This was addressed in the current review by reading all papers thoroughly, to ensure there was a focus on end-of-life care, rather than on individuals living with a chronic illness from which they may or may not die. Discussions with the project supervisors helped to guide this process.

Meta-ethnography has evolved since its initial development by Noblit & Hare (1988). Subsequently, the method for analysis differs considerably across papers, with researchers tailoring this to suit their data (France et al., 2019). In the current review, the analysis process was based on Atkins et al. (2008), who had a large number of accounts to synthesise, similar to the current review. It was also felt by the LR that this approach suited their style of working.

### **Conclusion**

This meta-synthesis explored the experiences of EL for HCPs working within end-of-life. The review highlights how HCPs use EL within this context to align themselves with the display rules of the organisation. The various situations in which HCPs find themselves vulnerable to EL have been discussed, and the impact of working within a context of death

and dying was explored. A main finding is the importance of support mechanisms, training, and for organisations to provide a culture in which EL is acknowledged, discussed, and normalised. Adopting such an approach may improve the resilience of HCPs working within this context, leading to emotional growth.

**Conflicts of Interest**

No conflict of interest has been declared by the author.

## References

Studies included in the meta-ethnography are marked \*

- Ablett, J. R., & Jones, R. S. P. (2006). Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experiences of work. *Psych-Oncology*, 16, 733–740. doi: 10.1002/pon.1130
- Ashforth, B. E., & Humphrey, R. H. (1993). Emotional labor in service roles: The influence of identity. *Academy of Management Review*, 18 (1), 88–115. doi: 10.2307/258824
- Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, 8 (21), 1-10. doi: 10.1186/1471-2288-8-21
- Badolamenti, S., Sili, A., Caruso, R., & Fida, R. (2017). What do we know about emotional labour in nursing? A narrative review. *British Journal of Nursing*, 26 (1), 48-55. doi: 10.12968/bjon.2017.26.1.48.
- \*Bailey, C., Murphy, R., & Porock, D. (2011). Professional tears: Developing emotional intelligence around death and dying in emergency work. *Journal of Clinical Nursing*, 20, 3364–3372. doi: 10.1111/j.1365-2702.2011.03860.x
- Bolton, S. C. (2000). Who cares? Offering emotional labour as a “gift” in the nursing labour process. *Journal of Advanced Nursing*, 32 (3), 580–586. doi: 10.1046/j.1365-2648.2000.01516.x
- Bono, J., E., & Vey, M. A. (2005). Toward understanding emotional management at work: A quantitative review of emotional labor research. In E. J. Hartel, W. J. Zerbe, & N. M. Ashkanasy (Eds.), *Emotions in Organizational Behavior* (pp. 213-235). Mahwah: Routledge.
- \*Brighton, L. J., Selman, L. E., Bristowe, K., Edwards, B., Koffman, J., & Evans, C. J. (2019). Emotional labour in palliative and end-of-life care communication: A qualitative study with generalist palliative care providers. *Patient Education and Counseling*, 102, 494–502. doi: 10.1016/j.pec.2018.10.013

- Browall, M., Henoch, I., Melin-Johansson, C., Strang, S., & Danielson, E. (2014). Existential encounters: Nurses' descriptions of critical incidents in end-of-life cancer care. *European Journal of Oncology Nursing*, 18, 636–644. doi: 10.1016/j.ejon.2014.06.001
- \*Brown, S., Bain, P., Broderick, P., & Sully, M. (2013). Emotional effort and perceived support in renal nursing: A comparative interview study. *Journal of Renal Care*, 39 (4), 246-255. doi: 10.1111/j.1755-6686.2013.12023.x.
- \*Cain, C. L. (2012). Emotions and the research interview: What hospice workers can teach us. *Health Sociology Review*, 21 (4), 396–405. doi: 10.5172/hesr.2012.21.4.396
- Cheng, C., Bartram, T., Karimi, L., & Leggat, S. G. (2013). The role of team climate in the management of emotional labour: Implications for nurse retention. *Journal of Advanced Nursing*, 69 (12), 2812–2825. doi: 10.1111/jan.12202
- Choi, Y., & Kim, K. (2015). A literature review of emotional labour and emotional labour strategies. *Universal Journal of Management*, 3 (7), 283–290. doi: 10.13189/ujm.2015.03070
- Chou, H. Y., Hecker, R. O. B., & Martin A. (2012). Predicting nurses' well-being from job demands and resources: A cross-sectional study of emotional labour. *Journal of Nursing Management*, 20 (4), 502-511. doi: 10.1111/j.1365-2834.2011.01305.x
- Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER Tool for Qualitative Evidence Synthesis. *Qualitative Health Research*, 22 (10), 1435-1443. doi:10.1177/1049732312452938
- \*Cricco-Lizza, R. (2014). The need to nurse the nurse: Emotional labor in neonatal intensive care. *Qualitative Health Research*, 24 (5), 615–628. doi: 10.1177/1049732314528810
- Croxon, L., Deravin, L., & Anderson, J. (2017). Dealing with end of life: New graduated nurse experiences. *Journal of Clinical Nursing*, 27, 337-344. doi:10.1111/jocn.13907.

- Debesay, J., Harsløf, I., Rechel, B., & Vike, H. (2014). Dispensing emotions: Norwegian community nurses' handling of diversity in a changing organizational context. *Social. Science & Medicine*, 119, 74-80. doi: 10.1016/j.socscimed.2014.08.025
- de Castro, A., B. (2004). Emotional vs physical labour: The demand of using emotions as a job duty. *American Journal of Nursing*, 104 (3), 120. doi: 10.1097/00000446-200403000-00033
- Delgado, C., Upton, D., Ranse, K., Furness, T., & Foster, K. (2017). Nurses' resilience and the emotional labour of nursing work: An integrative review of empirical literature. *International Journal of Nursing Studies*, 70, 71-88. doi: 10.1016/j.ijnurstu.2017.02.008
- Department of Health and Social Care. (2008). *End of life care strategy: Promoting high quality care for all adults at the end of their life*. London: Crown Copyright. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136431/End\\_of\\_life\\_strategy.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf)
- Diefendorff, J. M., Croyle, M. H., & Gosserand, R. H. (2005). The dimensionality and antecedents of emotional labor strategies. *Journal of Vocational Behavior*. 66, 339-357. doi: 10.1016/j.jvb.2004.02.001.
- Dixon-Woods, M., & Fitzpatrick, R. (2001). Qualitative research in systematic reviews: Has established a place for itself. *The BMJ*, 323, (7316), 765-766. doi: 10.1136/bmj.323.7316.765.
- Duggleby, W., Holtslander, L., Kylma, J., Duncan, V., Hammond, C., & Williams, A. (2010). Metasynthesis of the hope experience of family caregivers of persons with chronic illness. *Qualitative Health Research*, 20, 148-158. doi: 10.1177/1049732309358329.
- Festic, E., Wilson, M. E., Gajic, O., Divertie, G. D., & Rabatin, J. T. (2012). Perspectives of physicians and nurses regarding EoLC in the intensive care unit. *Journal of Intensive Care Medicine*, 27 (1), 45-54. doi: 10.1177/0885066610393465.

- France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A. S., Jepson, R. G., Roberts, R. J., & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC Medical Research Methodology*, 19 (35). doi: 10.1186/s12874-019-0670-7.
- \*Funk, L. M., Peters, S., & Stieber Roger, K. (2017). The emotional labor of personal grief in palliative care: Balancing caring and professional identities. *Qualitative Health Research*, 27 (14), 2211–2221. doi: 10.1177/1049732317729139.
- \*Funk, L. M., Peters, S., & Stieber Roger, K. (2018). Caring about dying persons and their families: Interpretation, practice and emotional labour. *Health and Social Care in the Community*, 1–8. doi: 10.1111/hsc.12559
- Gelinas, C., Fillion, L., Robitaille, M., & Truchon, M. (2012). Stressors experienced by nurses providing end-of-life palliative care in the intensive care unit. *The Canadian Journal of Nursing Research*, 44 (1), 18-39. Retrieved from [https://www.researchgate.net/profile/Marie\\_Anik\\_Robitaille/publication/225288054\\_Stressors\\_experienced\\_by\\_nurses\\_providing\\_end-of-life\\_palliative\\_care\\_in\\_the\\_intensive\\_care\\_unit/links/5c17b817a6fdcc494ffb3885/Stressors-experienced-by-nurses-providing-end-of-life-palliative-care-in-the-intensive-care-unit.pdf](https://www.researchgate.net/profile/Marie_Anik_Robitaille/publication/225288054_Stressors_experienced_by_nurses_providing_end-of-life_palliative_care_in_the_intensive_care_unit/links/5c17b817a6fdcc494ffb3885/Stressors-experienced-by-nurses-providing-end-of-life-palliative-care-in-the-intensive-care-unit.pdf)
- Grandey, A. A., Fisk, G. M., Mattila, A. S., Jansen, K. J., & Sideman, L. A. (2005). Is “service with a smile” enough? Authenticity of positive displays during service encounters. *Organizational Behavior and Human Decision Processes*, 96, 38–55. doi: 10.1016/j.obhdp.2004.08.002
- \*Gray, B., & Smith, P. (2009). Emotional labour and the clinical settings of nursing care: The perspectives of nurses in East London. *Nurse Education in Practice*, 9, 253–261. doi: 10.1016/j.nepr.2008.08.009

- Golfenshtein, N., & Drach-Zahavy, A. (2015). An attribution theory perspective on emotional labour in nurse-patient encounters: A nested cross-sectional study in paediatric settings. *Journal of Advanced Nursing*, 71 (5), 1123–1134. doi: 10.1111/jan.12612
- Henderson, A. (2001). Emotional labour and nursing: An under-appreciated aspect of caring work. *Nursing Inquiry*, 8 (2), 130–138. doi: 10.1046/j.1440-1800.2001.00097.x
- Hochschild, A. R. (1983). *The Managed Heart: Commercialization of human feeling*. Berkeley: University of California Press.
- Hochschild, A. R. (2003). *The Managed Heart: Commercialization of human feeling*. (Twentieth Anniversary ed.). Berkeley: University of California Press.
- \*Huang, C., Chen, J., & Chaing, H. (2016). The transformation process in nurses caring for dying patients. *The Journal of Nursing Research*, 24 (2), 109–117. doi: 10.1097/jnr.000000000000160.
- Humphrey, R. H., Ashforth, B. E., & Diefendorff, J. M. (2015). The bright side of emotional labor. *Journal of Organizational Behavior*, 36, 749-769. doi: 10.1002/job.2019.
- Hunter, B. (2004). Conflicting ideologies as a source of emotional labour in midwifery. *Midwifery*, 20 (3), 261–272. doi: 10.1016/j.midw.2003.12.004.
- Hunter, B. (2005). Emotional labour and boundary maintenance in hospital-based midwifery. *Midwifery*, 21 (3), 253–266. doi: 10.1016/j.midw.2004.12.007.
- Huynh, T., Alderson, M., & Thompson, M. (2008). Emotional labour underlying caring: An evolutionary concept analysis. *Journal of Advanced Nursing*, 64 (2), 195–208. doi: 10.1111/j.1365-2648.2008.04780.x
- James, N. (1989). Emotional labour: Skill and work in the social regulation of feelings. *The Sociological Review*, 37 (1), 15-42. doi:10.1111/j.1467-954X.1989.tb00019.x

- Karimi, L., Leggat, S. G., Donohue, L., Farrell, G., & Couper, G. E. (2014). Emotional rescue: The role of emotional intelligence and emotional labour on well-being and job-stress among community nurses. *Journal of Advanced Nursing*, 70 (1), 176–186. doi: 10.1111/jan.12185
- Krau, S. D. (2016). The difference between palliative care and end of life care: More than semantics. *Nursing Clinics*, 51 (3), 4-5. doi: 10.1016/j.cnur.2016.07.002.
- Kruml, S. M., & Geddes, D. (2000). Exploring the dimensions of emotional labour: The heart of Hochschild's work. *Management Communication Quarterly*, 14 (1), 8-49. doi:10.1177/0893318900141002.
- Leadership Alliance for the Care of Dying People. (2014). *One chance to get it right: Improving people's experience of care in the last few days and hours of life*. Retrieved from [http://wales.pallcare.info/files/One\\_chance\\_to\\_get\\_it\\_right.pdf](http://wales.pallcare.info/files/One_chance_to_get_it_right.pdf)
- \*Li, J. H., Gao, P., Shen, X. Y., & Liu, X. (2014). A process model of emotional labor of nursing: A case study of two Chinese public hospitals. *International Journal of Public Administration*, 37 (10), 695–707. doi: 10.1080/01900692.2014.907310
- \*Lovatt, M., Nanton, V., Roberts, J., Ingleton, C., Noble, B., Pitt, E., Seers, K., & Munday, D. (2015). The provision of emotional labour by health care assistants caring for dying cancer patients in the community: A qualitative study into the experiences of health care assistants and bereaved family carers. *International Journal of Nursing Studies*, 52, 271–279. doi: 10.1016/j.ijnurstu.2014.10.013
- Luxardo, N., Padros, C. V., & Tripodoro, V. (2014). Palliative care staff perspectives: The challenges of end-of-life care on their professional practices and everyday lives. *Journal of Hospice & Palliative Nursing*, 16 (3), 165-172. doi: 10.1097/NJH.0000000000000036.
- Mann, S. (2005). A health-care model of emotional labour: An evaluation of the literature and development of a model. *Journal of Health Organization and Management*, 19 (4/5), 304–317. doi: 10.1108/14777260510615369.



- Mann, S., & Cowburn, J. (2005). Emotional labour and stress within mental health nursing. *Journal of Psychiatric and Mental Health*, 12, 154–162. doi: 10.1111/j.1365.2850.2004.00807.x
- McQueen, A. (2004). Emotional intelligence in nursing work. *Journal of Advanced Nursing*, 47 (1), 101–108. doi:10.1111/j.1365-2648.2004.03069.x
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *BMJ*, 339. doi: 10.1136/bmi.b2535
- \*Msiska, G., Smith, P., & Fawcett, T. (2014). Exposing emotional labour experiences by nursing students during their clinical learning experience: A Malawian perspective. *International Journal of Africa Nursing Sciences*, 1, 43–50. doi: 10.1016/j.ijans.2014.07.001.
- Murray, C. D., & Forshaw, M. J. (2013). The experience of amputation and prosthesis use for adults: A metasynthesis. *Disability & Rehabilitation*, 35 (14), 1133-1142. doi: 10.3109/09638288.2012.723790.
- National Institute for Health and Care Excellence. (2019). End of life care for adults: service delivery. (NICE Publication No. 142). Retrieved from <https://www.nice.org.uk/guidance/ng142/resources/end-of-life-care-for-adults-service-delivery-pdf-66141776457925>
- Noblit, G., & Hare, R. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA: Sage Publications Ltd.
- Papadatou, D. (2000). A proposed model of health professionals' grieving process. *OMEGA Journal of Death and Dying*, 41 (1), 59-77. doi: 10.2190/TV6M-8YNA-5DYW-3C1E.
- Parola, V., Coelho, A., Sandgren, A., Fernandes, O., & Apostolo, J. (2018). Caring in palliative care: A phenomenological study of nurses' lived experiences. *Journal of Hospice & Palliative Nursing*, 20 (2), 180-186. doi: 10.1097/NJH.0000000000000428.

- \*Pearson, H. N. (2013). “You’ve only got one chance to get it right”: children’s cancer nurses’ experiences of providing palliative care in the acute hospital setting. *Issues in Comprehensive Pediatric Nursing*, 36 (3), 188–211. doi: 10.3109/01460862.2013.797520
- Phillips, S. (1996). Labouring the emotions: Expanding the remit of nursing work? *Journal of Advanced Nursing*, 24, 139–143. doi: 1-0.1046/j.1365-2648.1996.17419.x
- Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice*. Philadelphia: Lippincott Williams & Wilkins.
- Public Health Resource Unit. *Critical Appraisal Skills Programme (CASP): Making sense of evidence*. England: Public Health Resource Unit. Retrieved from <https://casp-uk.net/casp-tools-checklists/>
- \*Raffi, F., Nasrabadi, A. N., & Karim, M. A. (2015). End-of-life care provision: experiences of intensive care nurses in Iraq. *British Association of Critical Care Nurses*, 21 (2), 105–111. doi: 10.1111/nicc.12219
- Richardson, L., Molyneaux, V., & Murray, C. (2019). Being a peer-support mentor for individuals who have had a lower limb amputation: An interpretative phenomenological analysis. *Disability and Rehabilitation*. doi: 10.1080/09638288.2019.1611954
- Riley, R., & Weiss, M. C. (2015). A qualitative thematic review: Emotional labour in healthcare settings. *Journal of Advanced Nursing*, 72 (1), 6–17. doi: 10.1111/jan.12738
- Rodriguez, J. (2011). “It’s a dignity thing”: Nursing home care workers use of emotions. *Sociological Forum*, 26 (2), 265–286. doi: 10.1111/j.1573-7861.2011.01240.x
- Rubin, R. S., Staebler-Tardino, V. M., Daus, C. S., & Munz, D. C. (2005). A reconceptualization of the emotional labor construct: On the development of an integrated theory of perceived emotional dissonance and emotional labor. In E. J. Hartel, W. J. Zerbe, & N. M. Ashkanasy (Eds.), *Emotions in Organizational Behavior* (pp. 189-213). Mahwah: Routledge.

- Ryan, L., & Seymour, J. (2013). Death and dying in intensive care: Emotional labour of nurses. *End of Life Journal*, 3 (2), 1-9.
- Schmidt, K. H., & Diestel, S. (2014). Are emotional labour strategies by nurses associated with psychological costs? A cross-sectional survey. *International Journal of Nursing Studies*, 51, 1450–1461. doi: 10.1016/j.ijnurstu.2014.03.003
- Smith, P., & Gray, B. (2000). *The emotional labour of nursing: How student and qualified nurses learn to care*. London: South Bank University.
- \*Sorensen, R., & Iedema, R. (2009). Emotional labour: Clinicians' attitudes to death and dying. *Journal of Health Organization and Management*, 23 (1), 5–22. doi: 10.1108/14777260910942524
- Spencer, L., & Richie, J. (2012). In pursuit of quality. In D. Harper, & A. R. Thompson, (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 227-242). West Sussex, United Kingdom: John Wiley & Sons.
- \*Szymczak, J. E., Schall, T., Hill, D. L., Walter, J. K., Parikh, S., DiDomenico, C., & Feudtner, C. (2018). Pediatric oncology providers' perceptions of a palliative care service: The influence of emotional esteem and emotional labour. *Journal of Pain and Symptom Management*, 55 (5), 1260–1268. doi: 10.1016/j.jpainsymman.2018.01.019
- Theodosius, C. (2008). *Emotional Labour in Healthcare: The Unmanaged Heart of Nursing*. New York, NY: Routledge.
- Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology*, 12 (181). doi:10.1186/1471-2288-12-181.
- \*Tuna, R., & Baykal, R. (2017). A qualitative study on emotional labor behaviour of oncology nurses and its effects. *International Journal of Caring Sciences*, 10 (2), 929–936. Retrieved from [http://www.internationaljournalofcaringsciences.org/docs/31\\_tuna\\_original\\_10\\_2.pdf](http://www.internationaljournalofcaringsciences.org/docs/31_tuna_original_10_2.pdf)

- \*Vandrevala, T., Samsi, K., Rose, C., Adenrele, C., Barnes, C., & Manthorpe, J. (2017). Perceived needs for support among care home staff providing end of life care for people with dementia: A qualitative study. *International Journal of Geriatric Psychiatry*, 32, 155–163. doi: 10.1002/gps.4451
- Williams, A. (2013). The strategies used to deal with emotion work in student paramedic practice. *Nurse Education in Practice*, 13, 207–212. doi: 10.1016/j.nepr.2012.09.010
- World Health Organisation. (2004a). *The solid facts: Palliative care*. Retrieved from [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/98418/E82931.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0003/98418/E82931.pdf?ua=1)
- World Health Organisation. (2014). *Global atlas of palliative care at the end of life*. Retrieved from [https://www.who.int/nmh/Global\\_Atlas\\_of\\_Palliative\\_Care.pdf](https://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf)
- World Health Organisation. (2019). WHO definition of palliative care. Retrieved from <https://www.who.int/cancer/palliative/definition/en/>

Figure 1

*Flow diagram for inclusion of papers in the meta-synthesis*

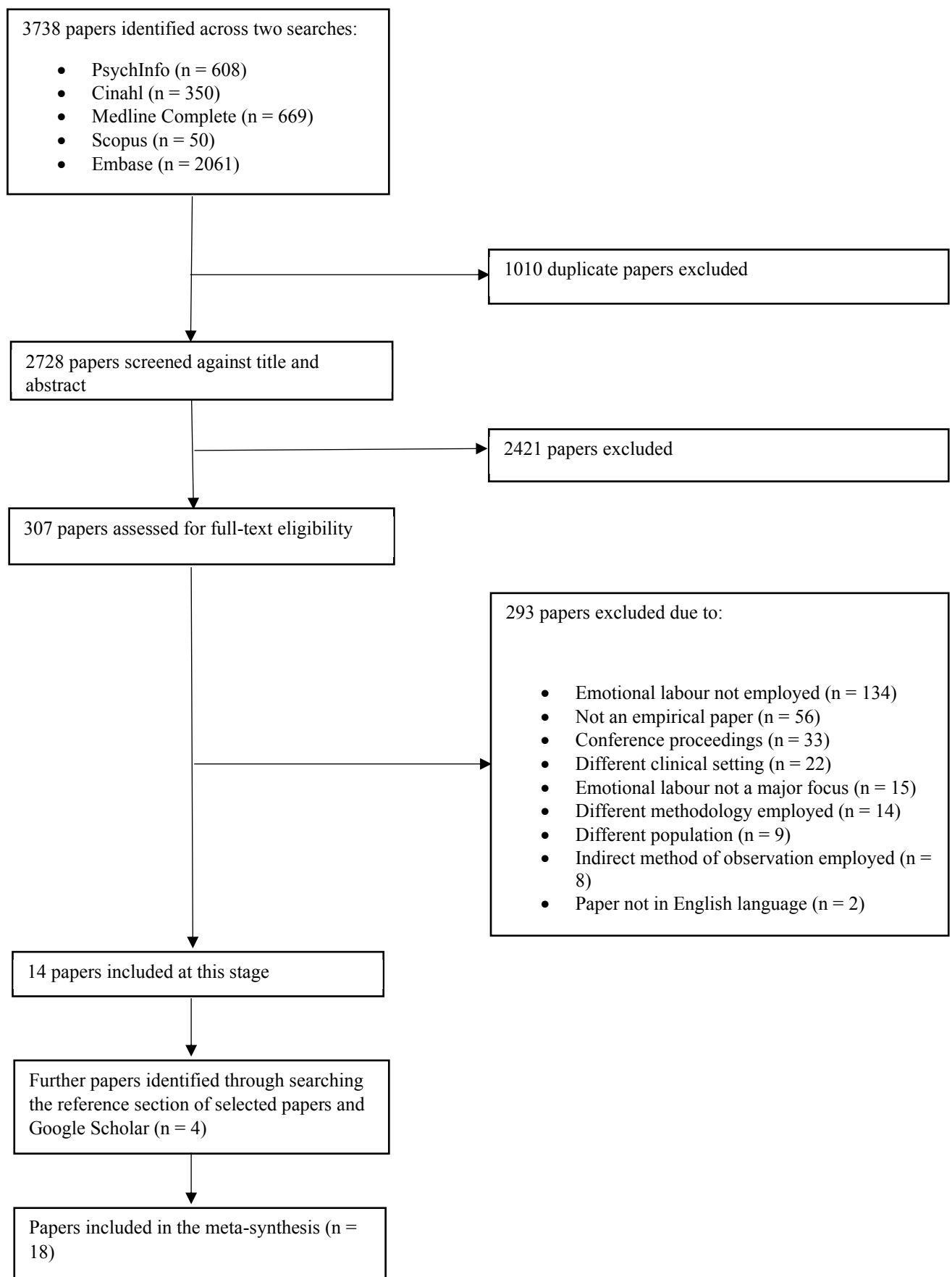


Table 1

*Hochschild's (1983) criteria for emotional labour*

Number	Criterion
1	Face-to-face or voice-to-voice contact with another individual must occur
2	The interaction must induce an emotional state in another individual
3	It occurs within a work context meaning that the organisation must have a degree of control over the emotional activities of the employee (e.g., through the use of supervision or training mechanisms)

Table 2

*The three types of emotional labour proposed by Theodosius (2008)*

Type	Description
Therapeutic	Therapeutic refers to the interpersonal relationships occurring between nurses, patients, and families
Instrumental	Instrumental relates to the interpersonal communication skills of the nurse, their confidence in their role (e.g., when performing clinical tasks), and when supporting the patient and/or family
Collegial	Collegial refers to the relationships and interactions that may occur between the nurse and their colleagues

Table 3

*Previous reviews considering emotional labour within a health-related context*

Author/date	Research question/aims	Search dates	Sample	Design	Results/themes
Badolamenti et al. (2017)	To synthesise and critically analyse emotional labour occurring within a nursing context	1990 - 2014	27 papers were included in the review (12 quantitative and 15 qualitative)	Papers were analysed using a narrative approach	2 themes emerged: Emotional labour strategies; and emotional labour antecedents and consequences
Delgado et al. (2017)	To consider what is known about resilience, and how this relates to emotional labour, within a nursing context	2005 - 2015	27 papers were included in the review (4 quantitative, 22 qualitative and 1 mixed-method study)	An integrative literature review approach was used	Emotional labour is linked to all aspects of nursing work. Resilience is suggested as an intervention that may support nurses in response to the emotional labour encountered within their role
Huynh et al. (2008)	To analyse the concept of emotional labour as described in four disciplines (nursing, medicine, psychology and management)	1990 - 2007	72 papers were included. It was not stated whether these were quantitative, qualitative or mixed-method papers	Papers were analysed using evolutionary concept analysis	Emotional labour is a process whereby nurses adopt a work persona to regulate their emotions. Antecedents to this work persona were events based on three elements: the organisation; the nurse; and



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					related to aspects of the role
Riley & Weiss (2015)	To identify the emotional labour employed by healthcare professionals across various healthcare settings, and the impact of this for the worker and organisation	1979 - 2014	13 qualitative papers were included in the review	A thematic synthesis of qualitative studies	4 themes emerged: the professionalism of emotion and gendered aspects of emotional labour; intrapersonal aspects of emotional labour; collegial and organisational sources of emotional labour; and support and training needs of professionals
Ryan & Seymour (2013)	To explore the emotional labour of intensive care unit nurses when caring for dying patients and their relatives. In particular, focusing on managing the transition from curative to end-of-life care	1990 - 2012	Quantitative and qualitative papers, literature reviews, and systematic reviews of the literature, were included in the review. An exact number of each was not provided by the authors	The type of review was not explicitly stated	The results considered the emotional reactions of intensive care unit nurses, and the coping strategies they used for their grief

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Table 4

*The research question as identified using the SPIDER tool*

Study components	Key elements
Sample	Healthcare professionals working directly with individuals approaching end-of-life
Phenomenon of Interest	The role of emotional labour and how this was experienced
Design	Direct accounts of experience (e.g., semi-structured interviews, focus groups)
Evaluation	Psychological experience, phenomenology
Research type	Qualitative methods

Table 5

*Inclusion and exclusion criteria*

Inclusion	Exclusion
Qualitative studies. Mixed-method studies could be included providing qualitative data could be easily extracted	Quantitative studies or mixed-method research where extracts could not be separated
Healthcare professionals working directly with patients and families approaching end-of-life, across the lifespan. Papers considering the perspectives of other individuals (e.g., patient, family or carers) were included, providing the professional's experience could be separated	Experiences of the patient, family or carers
Emotional labour was cited as a main aim, research question, or focus of the study (e.g., appearing throughout the paper in the introduction, findings, and discussion sections). Emotional labour emerged as a key finding or a clearly defined theme in the paper	Emotional labour was not a main aim, finding or theme to emerge from the paper
The definition of emotional labour was consistent with Hochschild's (1983) definition. Although papers did not have to cite Hochschild (1983), the use of emotional labour theory needed to be consistent with this initial understanding of the concept	The definition of emotional labour was inconsistent with Hochschild (1983)
Only direct accounts of experience were included (e.g., via semi-structured interview, diary, or focus group research)	Methods of data collection were used that did not gather direct accounts of experience
Papers were peer-reviewed	Not in English language
	Research published before 2004

Table 6

*Summary information of all papers included in the meta-synthesis*

Study	Location	Research question / aim(s)	Design	Analysis	Sample	Setting
Bailey et al. (2011)	United Kingdom	To explore how nurses working in an emergency department manage the emotional impact of death and dying	Observations, natural interviews with emergency staff, in-depth interviews with emergency staff, patients and relatives	Thematic analysis	Sample size: n = 28 Participants: Nurses (n = 10), doctors (n = 2), student nurse (n = 1), emergency department assistants (n = 2), patients (n = 6) and relatives (n = 7) Age: Not provided Sex: Not provided	A large Emergency Department, UK
Brighton et al. (2019)	United Kingdom	To explore how generalist palliative care providers' experience emotional labour during conversations around palliative and end-of-life	Semi-structured interviews	The framework approach	Sample size: n = 10 Participants: Generalist palliative care staff (E.g., working within a general care setting rather than specialist	Participants were sampled from a communication skills workshop run in London, UK

		care with patients and families			palliative care) including ambulance staff (n = 4), community nurses (n = 2), student nurses (n = 1), speech and language therapists (n = 2) and therapy assistants (n = 1) Age: 26 – 52 years (mean age of 39.2 years) Sex: 7 females, 3 males	
Brown et al. (2013)	Australia	To consider differences between renal, emergency and palliative nurses in terms of emotional labour	Semi-structured interviews	Thematic analysis	Sample size: n = 16 Participants: Renal (n = 5), emergency (n = 5) and palliative care (n = 6) nurses Age: Not provided Sex: 14 females, 2 males	Renal, emergency and palliative care nurses in Perth, Australia
Cain (2012)	United States of America	To consider the emotional experiences of	Observations, informal interviews with hospice workers,	Grounded theory	Sample size: n = 34	Hospice setting, USA

		hospice workers in regards to death and dying	and semi-structured interviews		Participants: Hospice workers including nurses (n = 8), nursing assistants (n = 5), social support workers (n = 9), medical directors (n = 2), volunteers (n = 2), managers (n = 8). Age: Not provided Sex: Not provided	
Cricco-Lizza (2014)	United States of America	To examine the nature of the nurses' emotional labour and explore coping strategies used	A combination of participant observations, informal and formal interviews	Ethnographic analysis	Sample size: n= 114 (18 of these completed formal interviews) Participants: Neonatal intensive care unit nurses Age range: 22 – 51 years (mean age of 33 years) Sex: 17 female, 1 male	Neonatal Intensive Care Unit in a children's hospital, North-eastern, USA
*Funk et al. (2017)	Canada	To consider the emotional labour of paid care	In-depth interviews	Inductive, interpretive	Sample size: n = 25	A multi-unit health care facility in

		providers when working with dying individuals and their families, and how they understand and make sense of their grief		thematic coding approach	Participants: Health care assistants (n = 12) and registered nurses (n = 13) Age: 19 – 59 years (mean age of 44 years) Sex: 19 females, 6 males	Winnipeg, Canada. Participants were recruited from palliative care (n = 11) and other non-palliative units (n = 14) where patient deaths occur including long-term residential, complex chronic care, respiratory, and dementia care
*Funk et al. (2018)	Canada	To explore how healthcare workers interpret and respond to the emotional needs of dying individuals and their families	In-depth interviews	Inductive, interpretive thematic coding approach	Sample size: n = 26 Participants: Nurses (n = 14) and healthcare aides (n = 12) Age: 19 – 59 years Sex: 20 females, 6 males	Non-profit healthcare facility in Western Canada. Participants were recruited from palliative care (n = 11) and other non-palliative units (n = 15) where deaths occur including long-term, complex chronic care, respiratory,

						specialised dementia care
Gray & Smith (2009)	United Kingdom	To consider the role of emotional labour and how this is impacted by different clinical settings	Semi-structured interviews	Ethnographical approach	Sample size: n = 16 Participants: Nurses Age: Not provided Sex: 12 females, 4 males	An urban and multi-racial location in East London, UK. Participants worked across three settings: primary care, mental health, and children's oncology
Huang et al. (2016)	Taiwan	To explore the transformative process that may occur in nurses when experiencing the spiritual suffering and conflict that can be associated with caring for dying individuals	Semi-structured interviews	Phenomenological thematic analysis, reflective analysis	Sample size: n = 8 Participants: Hospice care nurses Age: 27 – 40 years (mean age of 33.4 years) Sex: Not provided	Hospice wards of a medical centre in Northern Taiwan
Li et al. (2014)	China	To develop a process model to outline the antecedents and consequences of	Searching for information on the hospital website and semi-structured interviews	Information not clearly stated	Sample size: n = 8 Participants: Doctors (n = 1), nurses (n = 5),	Two hospitals in China: intensive care unit and an obstetrics department



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		emotional labour in nursing care			and ward sisters (n = 2) Age: Not provided Sex: Not provided	
Lovatt et al. (2015)	United Kingdom	To explore the emotional labour undertaken by health care assistants working in community palliative care settings	Semi-structured interviews	Grounded theory	Sample size: n = 8 Participants: Health care assistants Age: Not provided Sex: Not provided	Health care assistants working across three different community palliative care settings in England, UK: a hospice (n = 2), an NHS service (n = 4), and a supportive care at home service (n = 2)
Msiska et al. (2014)	Malawi	To investigate the clinical learning experience of undergraduate nursing students in Malawi	Conversational interviews	Phenomenological thematic analysis	Sample size: n = 30 Participants: Third and fourth- year undergraduate nursing students Age: Not provided Sex: Not provided	A University Nursing College in Malawi

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Pearson (2013)	United Kingdom	To understand children's cancer nurses' experiences of providing palliative care in an acute hospital setting	Semi-structured interviews	Phenomenological thematic analysis	Sample size: n = 7 Participants: Children's oncology nurses providing palliative care Age range: 22 – 25 years (mean age not provided) Sex: Female	Three primary treatment centres, UK
Raffi et al. (2015)	Iraq	To explore the perspective of Kurdish Intensive Care Unit nurses when caring for terminally ill individuals	Semi-structured interviews	Phenomenological thematic analysis	Sample size: n = 10 Participants: Intensive Care Unit nurses Age: 26 – 35 years (mean age of 30 years) Sex: 5 females, 5 males	Kurdish registered nurses working in hospital Intensive Care Units in Erbil City / Kurdistan region
Sorensen & Iedema (2009)	Australia	To understand the impact of emotional labour in specific health care settings and its potential effect on patient care	Open-ended interviews, focus groups, observation from patient case studies, ward rounds, and family conferences	Grounded theory	Sample size: n = 55 Participants: Medical and nursing clinicians, managers and nurses Age: Not provided Sex: Not provided	Intensive Care Unit in a Sydney hospital

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Szymczak et al. (2018)	United States of America	To explore how paediatric oncology providers, perceive the hospital's paediatric palliative care service and the way these perceptions influence the consultation process	Semi-structured interviews	Grounded theory	Sample size: n = 16 Participants: Paediatric oncology providers including physicians (n = 10), nurse practitioners (n = 1), social workers (n = 2), psychologists (n = 2) and child life specialists (n = 1) Age: Not provided Sex: 12 females, 4 males	Paediatric oncology providers at a large children's hospital in Philadelphia, USA
Tuna & Baykal (2017)	Istanbul	To identify how nurses working in an oncology setting perceive emotional labour and its use. Also, to establish the individual and organisational	Semi-structured interviews	Qualitative content analysis	Sample size: n = 25 Participants: Oncology nursing staff (60% of the sample held a degree in nursing) Age: Mean age was 33.40 +/- 8.27 years.	Oncology centre in Istanbul

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		impacts of emotional labour			Sex: 90% female	
Vandrevala et al. (2017)	United Kingdom	To investigate the impact for care home staff when working with individuals with dementia approaching end-of-life, and to explore their coping strategies	Semi-structured interviews	Thematic analysis	Sample size: n = 20 Participants: Frontline care home workers (registered nurses were excluded from the study) Age: Not provided Sex: 18 females, 2 males	Five care homes for people with dementia in Southern England

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*Note.* \* = a possibility of being from the same sample.

Table 7

*Quality ratings for all papers included in the meta-synthesis*

Paper	Research design	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total score
Bailey et al. (2011)	2	3	2	1	1	1	3	2	15
Brighton et al. (2019)	2	3	3	2	1	2	3	2	18
Brown et al. (2013)	2	2	3	2	2	3	3	3	20
Cain (2012)	3	2	3	3	2	2	2	2	19
Cricco-Lizza (2014)	3	2	3	2	2	3	3	3	21
Funk et al. (2017)	1	2	2	1	1	2	2	3	14

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Funk et al. (2018)	3	3	2	1	2	3	3	2	19
Gray & Smith (2009)	3	2	2	1	3	2	2	3	18
Huang et al. (2016)	2	2	3	2	1	3	2	2	17
Li et al. (2014)	1	2	2	1	1	3	2	2	14
Lovatt et al. (2015)	3	3	2	1	3	3	3	2	20
Msiska et al. (2014)	3	3	3	3	3	3	2	2	22
Pearson (2013)	3	3	3	3	2	2	2	2	20

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Raffi et al. (2015)	3	2	3	2	3	3	2	2	20
Sorensen & Iedema (2009)	2	2	3	1	2	2	2	3	17
Szymczak et al. (2018)	1	2	3	1	1	2	3	2	15
Tuna & Baykal (2017)	3	2	3	1	2	2	2	1	16
Vandrevala et al. (2017)	1	2	3	1	2	3	3	3	18

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Table 8

*Analytical stages for completing a meta-ethnography and illustrative examples of the process for the development of two concepts*

Stage	Description of process	Illustrative examples from the current review*
1. Getting started	This stage involved deciding on the focus of the synthesis including the research questions and aims	This review aimed to address the following research question: “what are the experiences of emotional labour for healthcare professionals working within end-of-life care?”
2. Deciding what is relevant to the initial interest	The second stage involved identifying and selecting studies to synthesise in the review	Inclusion and exclusion criteria were applied to papers retrieved from the literature search, as described in the method section of this review
3. Reading the studies	Repeated and careful reading of each study was undertaken, to become familiar with the content. This helped to identify the main concepts (both first and second order constructs) considered relevant to the research question. Concepts were recorded in a table alongside details of the study, setting, and participant information	This process was followed for each paper. For example, for Cricco-Lizza (2014), participants’ accounts or understandings of an experience were recorded (e.g., “you get out of the room and calm your head and then you come back and take a little more of it”). The original authors’ interpretation of the participant’s account was also documented (e.g., “the nurses spoke of the importance of taking breaks during their work days to cope with the strain... [they] described the emotional demands on the bedside nurse, and the need for a break” p.623)



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4. Determining how the studies are related	A thematic analysis of the concepts identified in Stage 3 was undertaken	<p>Concepts were summarised (ensuring the participants and original author's language was preserved), and compared across studies to highlight similarities and differences</p> <p>This process identified 14 initial broad categories of themes (e.g., "the emotional toll of working at end of life," "the emotional impact," "the consequence of emotional labour," "emotional labour as a skill / offering benefit," "support - current support, limitations / barriers to support," "support - what helps / their needs," etc.,)</p> <p>These categories were later revised, with some concepts being merged, and others discarded. Concepts relating to the emotional impact were merged, producing one category which included both the positive and negative aspects of this. Some aspects of the emotional impact appeared connected to coping strategies, although it was felt that this warranted separate categories. For example, the concept of being misunderstood at home emerged for several papers, and was felt to fall under the category of the emotional impact. It was closely linked however to coping strategies, as participants described how shared experience at work and seeking</p>
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5. Translating the studies into one another	<p>Concepts from one study were compared with concepts from another. This process matched themes across papers, ensuring concepts captured similar themes from different papers</p>	<p>support from colleagues was beneficial for emotional wellbeing</p> <p>For support mechanisms, two categories were kept at this point: one that focused on the barriers to accessing support (e.g., having limited time, lack of formal support), and one exploring helpful sources of support (e.g., support from colleagues, culture, having shared experience)</p> <p>This resulted in eight categories that formed the basis for the reciprocal translation, as described in stage 5</p> <p>This involved comparing concepts from one paper with concepts from another in chronological order (e.g., comparing concepts from paper 1, with concepts from paper 2 etc.,)</p> <p>Through this method of comparison, the eight theme groups were again reduced and refined, with some merging into others, and some being dropped from the synthesis</p> <p>For example, the two categories relating to support remained separate at this time, but some concepts from within these moved to other categories (e.g., some of the barriers to coping were actually felt to be triggers for</p>
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6. Synthesising translations	During this stage, it was important to look beyond the findings of each individual study, to create a higher order interpretation – or line of argument synthesis. In this way, new concepts and interpretation were developed	emotional labour, and were grouped within this category instead)  This occurred through considering how concepts linked together, and what the overall narrative revealed about the experiences of emotional labour for healthcare professionals working at end-of-life. For example, the concept “the emotional impact” considered the various ways that emotional labour impacted on the participant – in particular the suggestion that emotional labour could lead to personal growth and skill development. Alongside this, the two categories considering coping and support systems merged to form one concept: “building resilience.” This explored the more practical strategies / support offered that helped participants to cope with their work
7. Expressing the synthesis	The final stage involved communicating the synthesis in written format	This part of the synthesis can be seen in the results section of the current review

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\*Illustrative examples for two of the five concepts to emerge from the synthesis process

Table 9

*Summary of first and second order constructs for each paper, and their contribution to overall concept development*

Paper	CASP score*	The continuum of emotional expression	Being vulnerable to triggers	The dual-purpose of emotional labour	The emotional impact	Building resilience
Bailey et al. (2011)	15		Intense and emotionally demanding interactions; length of time providing care; and the impact of own experience	Surface acting (e.g., distancing self, avoidance); deep acting (e.g., thinking about the loss, putting themselves in the shoes of the patient and family)	Lack of support leading to ineffective/harmful coping strategies (e.g., stress, ill-health, withdrawal from practice); emotional labour as skilled work leading to emotional growth	
Brighton et al. (2019)	18	A controlled expression of some (but not all) emotion; emotion as tailored to suit need of patient or family; importance of finding a balance between being professional (non-	The worker's perceived abilities; in response to the situation at hand; and an accumulation of emotional experiences	Surface acting (e.g., preparing in advance, conducting background work, focusing on clinical tasks, avoidance, adopting a persona or becoming "robotic"); deep acting (e.g., intentional efforts to	Struggling to find an outlet for emotions	Reflective practice (to re-visit, re-appraise experiences); limited time and increasing demand as a barrier to formal support (ambulance staff in particular); request for normalising workplace culture; informal support valued; training as a way

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		emotional) and human (emotional)		empathise); an unintentional empathic response experienced by some participants		of coping with emotional aspects of role; and use of cathartic activities (both related and unrelated) to role
Brown et al. (2013)	20			Deep acting (e.g., acknowledge the importance of the role, helping to be alongside)		Lack of formal support; feeling misunderstood by others (both within and outside of organisation); the importance of support from co-workers (assisted well-being and ability to remain in role)
Cain (2012)	19	Emotion as appropriate but constrained via “the moderated cry”; explicit feeling rules as acceptable in hospice setting; emotional expression as a way of understanding,	Challenged by worker’s own vulnerability (due to personal loss, or a lack of experience in sharing sadness)	Deep acting used to modify emotions and prevent over-identification (e.g., drawing a distinction between the worker’s emotions and others)	Sharing emotions as important for work satisfaction; and a method of working through sadness at loss; culture as important (providing “a good environment to work through sadness”)	Feeling rules shared through training; training contained explicit rules regarding appropriate emotional expression; culture of openly discussing emotions

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		normalising and responding to grief				
Cricco-Lizza (2014)	21	Emotions controlled to appear competent and professional; becoming too close as threatening role performance	Being alongside the dying process; sadness at death; balancing organisational demands with providing care, and the impact of personal background on professional role	Surface acting (e.g., maintaining a “happy face persona,” suppressing emotion and using distancing strategies); deep acting (e.g., focusing on patients they can help, “banking successes” to offer sustenance during difficult times, balancing joyful and sad experiences, re-framing experience to find meaning, humour, and use of “transitional time”)	Use of distancing strategies (including avoidance); feeling worthwhile/making a difference	Limited “off stage” areas; emotional labour not acknowledged in training; use of personal strategies (e.g., exercise, taking a break, rest, work life balance, transitional time); use of professional strategies (e.g., co-worker support, restructuring thinking with others); organisational support (e.g., staff rotations, flexible aid, keeping unit well-staffed); formal support mechanisms (e.g., attendance at memorial services, funerals, one-to-one support)
Funk et al. (2017)	14	Public (and private) grief expression inhibited by	Perceived similarities; death as unfair or sudden;	Surface acting helped detached workers to convey	A sense of purpose (compensating for emotional	Limited time and space to grieve; strained workloads as a barrier to

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	<p>professional norms; emotional expression appropriate only in limited ways; grief expression suggests inexperience, fear of death, unprofessionalism and lack of natural aptitude to work in death and dying; expression demonstrated humanity, care, and empathy; for some; conflict present between professional norms and caring identity</p>	<p>being unable to say goodbye; being unable to facilitate a good death; an accumulation of death and dying; having an attachment to patient or family; younger and less experienced workers at greater risk</p>	<p>caring, closeness and empathy; grief suppressed until after the clinical interaction; humour as “an antidote to grief”; avoidance of patients in anticipation of strong emotional response; avoidance to reduce caring or closeness</p>	<p>exhaustion); age as risk factor for distress</p>	<p>support; concern about sharing emotions with co-workers and loved ones; work/life boundaries as protective; some formal opportunities for support (e.g., memorials, life reviews)</p>
Funk et al. 19 (2018)	<p>Portraying “caring about” as challenged by organisational norms of professional detachment; finding a balance between</p>	<p>Coping with anxiety, fear, distress and displaced emotions of patients/families; emotional labour used when workers disliked someone or did not feel</p>	<p>Avoidance of emotional attachment to minimise grief at death; surface acting (e.g., smiling, being friendly, cheerful, making light</p>		

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		showing care and remaining detached	authentically cheerful; offering honesty about prognosis as challenging; time constraints and availability of team members; the struggle to maintain caring commitments and good care	conversation, and humour); surface acting often used when workers were distressed, time-pressed, disliked a patient or relative, and not authentically cheerful; deep acting to cope with displaced emotions of relatives (through trying to understand their emotional experience)	
Gray & Smith (2009)	18	Having to “sit on anger” and other difficult emotions (to remain in role); the dissonance between genuinely felt and displayed emotions as linked to the formation of the “hard nurse”; “getting on with		Becoming desensitised to end-of-life work over time	Support systems acknowledged as important (no description of these provided however)

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		things” regardless of feelings				
Huang et al. (2016)	17		Emotional labour occurring in response to recollection of own loss	Surface acting (e.g., evasion strategies to avoid grief; and emotional suppression to appear professional; helps to cope with rejection by patients and families.) Deep acting (e.g., using recollection of own loss to increase understanding and empathy)		
Li et al. (2014)	14	Emotional detachment as resulting in high quality care; limited emotional expression as demonstrating care	Level of experience as important (less-experienced nurses as feeling greater sadness than more-experienced nurses)	Deep acting as preferred by ICU nurses (resonates with values); surface acting only used when deep acting does not work; surface acting as holding a protective function for nurses;	Emotional labour can be developed; strategies to cope with the emotional impact can be learnt; age as a risk factor for distress	More experienced nurses as sharing feelings with co-workers; sharing feelings as a way of overcoming sadness, modifying internal experience, and learning new ways to cope

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			surface acting (e.g., distancing self, showing a “professional face”); deep acting (e.g., situation modification, attention deployment and cognitive change)	
Lovatt et al. (2015)	20	Developing and maintaining relationships on the professional/personal boundary; the ambiguity of the “insider-outsider” status	Surface acting as helping workers to fit in; to perform their role in line with professional expectations	
Msiska et al. (2014)	22	Emotional labour in response to patient death; preparing a body and confirming death; being afraid of performing certain tasks; risk of failing	Deep acting to meet professional values such as compassion and empathy; being able to see the impact of care as a coping mechanism	Emotional labour in caring-learning relationships; emotional labour as learnt/a skill that can be developed

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Pearson (2013)	20	Familiarity with patient or family as trigger	Various barriers to formal support (e.g., a busy clinical environment, staffing issues, lack of confidence); co-worker support as essential; opportunity for clinical reflection; access to formal support provided (e.g., counsellor, debrief sessions)
Raffi et al. (2015)	20	Caring for younger patients as more difficult (than older patients); caring for patients who could not be saved; withdrawing treatment and an awareness that this would lead to death; family reactions	

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Sorensen & Iedema (2009)	17	Display rules modify nurse's behaviour contrary to emotions; some emotional expression as therapeutic; important for skill development	Feeling unsupported with caring responsibilities; struggling with role accountability; when caring efforts are unacknowledged; fast turnover as against moral/ethics values of nurses; A "fracture line" between doctors and nurses (differences in approach to death and dying)	Deep acting as leading to greater engagement and empathy; avoidance/detachment to avoid feelings; some open displays of feelings; emotional involvement as challenging for doctors (surface acting used to cope); doctors used emotional suppression, detached concern, and avoidance of feelings (self/other); a genuine connection experienced by some participants	Difficult death experiences as impacting on emotional growth/skill development; "a good death" linked to attitude/comfort level with death; expressing emotion as important for wellbeing; emotional labour as a means of working through attitudes to death and dying; experience level as linked to distress	Lack of organisational support (in particular, for doctors); co-worker support as essential; use of strategies (e.g., humour, unit social worker); unit organisation could assist coping after death (e.g., slow turnover, increased staffing); limited opportunity to grieve patient death
Szymczak et al. (2018)	15			Outsourcing emotional labour to PACT (increases emotional distance)		

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Tuna & Baykal (2017)	16	Emotions controlled (to keep in line with organisational demands); emotions (including crying) may demonstrate understanding/support	Emotional labour in response to deep feelings of care for the patient/family	Surface acting to provide support (attention, love, compassion) when tired; offering a smile/touch when thought beneficial; deep acting (e.g., putting self “in the patient’s shoes”); a “genuinely felt empathic response” triggered by patient loss	Impact of professional role on personal self (leading to anxiety and relationship difficulties)	
Vandrevala et al. (2017)	18	Importance of being professional, remaining detached; holding own sadness/discomfort at death	Dying as a source of emotional labour; sadness/powerlessness in response to death; intimate nature of the role as impacting on grief experienced; risk of over-identification; confrontation of own and loved one’s mortality; coping of unrealistic expectation of role	Deep acting in response to sadness at death; taking “comfort from a good death” (a form of deep acting); knowing they worked in line with best interests	Coping with emotional labour; managing stress and anxiety at end-of-life	Sense of “team spirit”; managers as crucial (to develop sharing culture); supportive culture as reducing anxiety/rumination; co-worker sharing/support as important; emotional support as increasing coping ability (reducing anxiety/uncertainty/helplessness); increased space to grieve as beneficial; raising awareness of self-care

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strategies (e.g., physical exercise/meditation); promoting a workplace culture that enabled discussions around death and dying as important

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\*CASP scores provided to demonstrate the contribution of papers scoring across the quality range

## Appendix 1-A

*Detailed search terms for each database*

Medline	
Free text search terms (applied to Title / Abstract)	<p>emotion* work OR emotion* labo#r OR emotion* suppress* OR emotion* dissonance</p> <p>AND</p> <p>“end-of-life” OR palliative OR terminal OR cancer OR neoplasm* OR life-limiting OR death OR dying</p> <p>AND</p> <p>Doctor* OR nurs* OR physician* OR healthcare OR worker* OR staff OR “health personnel” OR paramedic*</p>
MeSH terms	<p>Emotional Adjustment OR Emotions OR Emotional Intelligence</p> <p>AND</p> <p>Neoplasms OR Death OR Palliative Care OR Terminal Care OR Terminally Ill</p> <p>AND</p> <p>Health Personnel OR Caregivers OR Nurses OR Physicians</p>
PsychINFO	
Free text search terms (applied to Title / Abstract)	<p>emotion* work OR emotion* labo#r OR emotion* suppress* OR emotion* dissonance</p> <p>AND</p> <p>“end-of-life” OR palliative OR terminal OR cancer OR neoplasm* OR life-limiting OR death OR dying</p> <p>AND</p>

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Subject terms

Doctor\* OR nurs\* OR physician\* OR  
healthcare OR worker\* OR staff OR “health  
personnel” OR paramedic\*

Emotional Adjustment OR Emotional  
Control OR Emotional Intelligence OR  
Emotions

AND

Terminally Ill Patients OR Terminal Cancer  
OR Palliative Care OR Death and Dying  
OR Neoplasms OR Oncology

AND

Physicians OR Nurses OR Caregivers OR  
Health Personnel

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CINAHL

Free text search terms (applied to Title /  
Abstract)

emotion\* work OR emotion\* labo#r OR  
emotion\* suppress\* OR emotion\*  
dissonance

AND

“end-of-life” OR palliative OR terminal OR  
cancer OR neoplasm\* OR life-limiting OR  
death OR dying

AND

Doctor\* OR nurs\* OR physician\* OR  
healthcare OR worker\* OR staff OR “health  
personnel” OR paramedic\*

Subject terms

Emotional Adjustment OR Emotions OR  
Emotional Intelligence

AND

Terminally Ill OR Terminal Care OR  
Palliative Care OR Death OR Neoplasms  
OR Oncology

AND

Physicians OR Nurses OR Caregivers OR  
Health Personnel



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 EMBASE
 

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Free text search terms (applied to Title / Abstract)

 emotion\* work OR emotion\* labo#r OR  
 emotion\* suppress\* OR emotion\*  
 dissonance

AND

 “end-of-life” OR palliative OR terminal OR  
 cancer OR neoplasm\* OR life-limiting OR  
 death OR dying

AND

 Doctor\* OR nurs\* OR physician\* OR  
 healthcare OR worker\* OR staff OR “health  
 personnel” OR paramedic\*

Search terms

 Emotion OR Psychological Adjustment OR  
 Emotionality OR Emotional Intelligence

AND

 Terminally Ill Patient OR Terminal Care  
 OR Terminal Disease OR Palliative  
 Therapy OR Death OR Neoplasm OR  
 Oncology

AND

 Physicians OR Nurses OR Caregivers OR  
 Health Care Personnel

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 Scopus
 

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Free text search terms (applied to Title / Abstract / Keywords)

 emotion\* work OR emotion\* labo#r OR  
 emotion\* suppress\* OR emotion\*  
 dissonance

AND

 “end-of-life” OR palliative OR terminal OR  
 cancer OR neoplasm\* OR life-limiting OR  
 death OR dying

AND

 Doctor\* OR nurs\* OR physician\* OR  
 healthcare OR worker\* OR staff OR “health  
 personnel” OR paramedic\*

## Appendix 1-B

*Journal of Advanced Nursing's guide for writing systematic reviews***Systematic review or other type of review paper**

*JAN* publishes high quality qualitative, quantitative and mixed method systematic reviews, systematic methodological, economic and policy reviews, realist and integrative reviews, of relevance to nursing. Authors should demonstrate the appropriate choice and use of methodology for a specific review question or context. *JAN* does not normally publish scoping reviews; we suggest authors of scoping reviews consider submitting to our sister journal, Nursing Open, instead of *JAN*.

Manuscripts should not exceed 5,000 words for the main text, excluding the abstract, tables and references. However, at the discretion of the Editor-in-Chief, a more flexible approach to the word limit may be approved for reviews of exceptional quality and importance. Authors who anticipate that their review requires more than 5,000 words to adhere to international reporting standards should first make maximum use of supplemental online files (see **Supporting Information**), and then outline the reason for requiring additional words in the main text in the 'Relevant Information' submission question on ScholarOne. Additional flexibility with the word count will be considered on a case by case basis.

Authors should also consider page length even if the text of their paper is under 5,000 words. Very long or numerous tables and figures are not compatible with the page allowance that is available for any single issue of the print journal. Please make maximum use of supplemental online files (see **Supporting Information**). Look at some examples of review papers in recent issues of *JAN* to see how tables can be formatted using space economically. If appropriate contact the Editor for advice about designing tables of included studies for the print journal.

We encourage the registration of appropriate systematic reviews that have 'a health-related outcome relevant to human health in the broadest sense' on the **PROSPERO** website.

**Organising your manuscript:**

We suggest that you use our templates for the **title page** and the **main manuscript file**. Please see below for what should be included under each heading and sub-heading.

Separate files to be created and uploaded onto **ScholarOne Manuscripts**:

**Title Page**

Your title page should include the following information:

- Full title (maximum 20 words; in general we do not include country names in published articles and therefore encourage you to omit these from your manuscript title).
- Running head
- Author details: names (please put last names in CAPITALS) and affiliations (maximum of 3 per author)
- Acknowledgements (if applicable)

- **Funding Statement**

The title should begin with a descriptor that best describes the type of review, such as: 'Systematic review:', 'Quantitative Systematic review:', 'Qualitative Systematic Review', 'Meta-analysis', 'Integrative review'.

**Main file, to include:**

**Abstract:** 300 words. The abstract should include the following headings: Aims (of the paper, should simply state 'To...'), Design, Data Sources (include search dates), Review Methods, Results, Conclusion, Impact (addressing the below):

- What problem did the study address?
- What were the main findings?
- Where and on whom will the research have an impact?

**Tables and figures** should be uploaded separately.

**Keywords:** A maximum of 10. Should include 'literature review' and other MeSH headings appropriate for the specific review, such as 'systematic review', as well as nurses/midwives/nursing and subject-specific keywords.

**Main Text:** To include the headings below and references.

The main text of your paper should include the following headings and sub-headings:

**INTRODUCTION**

Include rationale, conceptual or theoretical context, and international relevance of topic.

**BACKGROUND**

Present the scientific, conceptual or theoretical framework that guided the review, identifying and providing an overview of the conceptual model and/or theory where appropriate. Identify key concepts or variables.

For advice on writing an Introduction and Background please **see this article** by Roger Watson.

**THE REVIEW**

**Aim/s**

Include research topic/objectives/questions/hypothesis(es): for example, 'The aim of the (type) review was to...'.  
Structure the review question(s) as appropriate for the review type.

**Design**

The review design should be the most appropriate for the review question. Identify type of review and describe design and methods used in detail (e.g. meta-ethnography, Cochrane intervention review, realist synthesis etc). Report original methodological sources of reference for the review design and methods. Report processes and steps used and any methodological adaptations/deviations (if any) with supporting rationale.

**Search methods**

Include: Development, testing and choice of search strategies (consider using a supplemental information file to report searches), inclusion/exclusion criteria, databases searched, keywords, languages and inclusive dates of the literature searched

**Search outcome**

Search outcome and audit trail - application of inclusion/exclusion criteria, retrieval and selection of references and handling. Summarise included studies (and, if appropriate, excluded studies) in separate tables.

**Quality appraisal**

Please note that for most systematic review approaches quality appraisal is mandatory and considered the primary marker of a systematic review. Include a description of approaches used, outcome of appraisal process and audit of discarded studies. Make clear the criteria that were used for discarding studies. If quality appraisal was not undertaken provide a convincing and robust explanation, and in the limitations section outline the potential impact on the credibility of the review findings. *JAN* is less likely to publish reviews where quality appraisal of evidence is considered important but was not undertaken.

**Data abstraction**

Describe the methods and process(es).

**Synthesis**

Include clear description of process(es) used.

**RESULTS**

Present the results of your review using appropriate subheadings outlined here and adhere to relevant standard(s) of reporting (e.g. **PRISMA** for systematic review of RCTs, or RAMESES publication standards for **realist syntheses** and **meta-narrative reviews**). Include a flow diagram illustrating the flow of literature through the review. Review methods that involve multiple methodological stages/processes should report the outcome of each stage/process. If appropriate, identify the conceptual or theoretical context of each definition or discussion of the concept found in the literature.

**DISCUSSION**

Draw out the applicability, theoretical and practical implications of the review findings. End with limitations and strength and generalisability/transferability of the evidence.

**CONCLUSION**

This should not be a summary/repetition of the findings. Clarify the contribution of the review to existing knowledge, highlight gaps in knowledge and understanding, outline future research, report implications/recommendations for practice/research/education/management as appropriate, and consistent with the limitations. If appropriate, consider whether one or more theoretical frameworks could guide future research about the topic of the review.

**Conflict of interest**

Authors are required to disclose any possible conflict of interest when submitting a paper. These can include financial conflicts of interest e.g. patent ownership, stock ownership, consultancies, speaker's fee. All conflict of interest (or information specifying the absence of conflict of interest) should be included at the end of the article under 'Conflicts of Interest'. This information will be included in the published article. If the author does not have any conflict of interest the following statement should be included: "No conflict of interest has been declared by the author(s)."

**Section Two: Research Paper**

**Crying with Patients at End-of-Life: The Experiences of Psychological Therapists**

Word count: 7997

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### Abstract

Although relatively neglected within the literature, research suggests the majority of psychological therapists have cried with a client during therapy (Blume-Marcovici, Stolberg & Khademi, 2013). To date, two qualitative anecdotal studies have considered therapist crying in relation to end-of-life. Further explorative research considering the experiences of a larger group of participants was considered necessary, to further our understanding of this phenomenon.

This qualitative study explored the experiences of therapist crying in therapy (TCIT) for 10 psychological therapists working within a palliative/end-of-life context. Five clinical psychologists and five counsellors participated in semi-structured interviews. Interpretative phenomenological analysis (IPA) was used to analyse these accounts.

Three superordinate themes emerged: The role of the therapist; Being struck by emotion; and The balancing act. Participants described that their role as a therapist was to provide a space that was both therapeutic and professional. This was challenged however by various triggers that could result in crying. Participants were put at risk by over-empathising with the client's account, their own personal background, and the nature of end-of-life work. Subsequently, participants attempted to find a balance between appropriate and inappropriate emotion.

Participants used various strategies to manage their tears.

The findings indicate that increasing the awareness of triggers may help reduce over-empathising. Raising the awareness and understanding of TCIT is important, as it is often unacknowledged in discussions with colleagues or in supervision.

**Keywords:** therapist crying, tears, crying in therapy, end-of-life, palliative care

### **Clinical Impact Statement**

- **Question:** How do psychological therapists working at end-of-life experience their own tears in therapy with a client?
- **Findings:** Under the right conditions, crying can offer therapeutic benefits including demonstrating therapist authenticity, helping the client to realise the significance of an experience, and showing a healthy response to emotion.
- **Meaning:** Increasing awareness of therapist crying in therapy may help to normalise the experience and encourage psychological therapists to develop an understanding of their own tears and why these occur.
- **Next Steps:** Further research considering the therapist's tears with other samples within a palliative/end-of-life context would be helpful, alongside considering the experience of the client, and issues of gender and culture.

### Crying with Patients at End-of-Life: The Experiences of Psychological Therapists

Approximately 500,000 people die in England and Wales each year, with this figure anticipated to reach over 574,000 by 2030 (National Institute for Health and Care Excellence [NICE], 2011; Office for National Statistics [ONS], 2017). Often, individuals do not die suddenly, requiring specialist end-of-life care (Hughes-Hallet, Craft, Davies, Mackay & Nielsson, 2011; Hunter & Orlovic, 2018). NICE (2011) considers an individual at end-of-life when death is anticipated within 12 months, although this varies across the literature (Krau, 2016; Leadership Alliance for the Care of Dying People [LACDP], 2014). Individuals at end-of-life may receive palliative treatment, which involves caring for those with a serious illness where a cure is no longer possible (DHSC, 2008).

Individuals approaching end-of-life may experience psychological problems including anxiety and depression, social, and spiritual difficulties (NICE, 2011; World Health Organisation [WHO], 2004). Distress can occur in response to the trauma associated with dying (NICE, 2004). Therefore, accessing psychological support and the opportunity to ask questions, is recommended (NICE, 2004; NICE, 2011, WHO, 2004).

Caring for such individuals is often considered important and rewarding work (LACDP, 2014). Despite this, healthcare professionals can experience challenges associated with the emotional labour of providing such care including anxiety, helplessness, a sense of failure, and loss (Hochschild, 1983; Browall, Henoch, Melin-Johansson, Strang & Danielson 2014; Wilson, 2014). Emotions can occur for many reasons including identifying strongly with the patient, or where death appears unjust (Ablett & Jones, 2006). Crying may be one possible response to the emotional demands of working at end-of-life.

### **The Role of Crying**

Crying is thought to be intrapersonal (affecting the person) or interpersonal (affecting others) (Vingerhoets & Bylsma, 2015). Intrapersonal effects include catharsis, emotional



recovery, and removing tension (Bylsma, Gracanin & Vingerhoets, 2018; t'Lam, Vingerhoets & Bylsma, 2018). Interpersonally, crying can communicate vulnerability, the need for assistance, and care (Cornelius & Labott, 2001). Although criers can appear warmer, they may be considered less competent (van de Ven, Meijs & Vingerhoets, 2017). Furthermore, crying can result in discomfort for others, leading to emotional and physical withdrawal (Hendriks, Nelson, Cornelius & Vingerhoets, 2008).

Tears stem from both negative and positive emotions, and in response to difficult life events and positive ones (Hendricks, Nelson, et al., 2008). Crying can occur out of empathy for others: through identifying with their experience, or imagining what it would feel like in their position (Ioannou et al., 2016). Various factors influence how crying is perceived including the type (whether tears or sobbing), cultural beliefs, and gender (Becht & Vingerhoets, 2002; Gracanin et al., 2018; Vingerhoets, 2013). The social environment may influence or regulate crying (e.g., crying at work can be considered inappropriate depending on professional role and context) (Hochschild, 1983; Vingerhoets, Cornelius, van Heck & Becht, 2000). Tears may therefore be suppressed until considered acceptable (Frey, 1985; Vingerhoets, van Geleuken, van Tilburg & van Heck, 1997). As such, the perceived appropriateness of crying may be relevant when considering the likelihood of tears occurring in certain contexts (Hendriks, Croon et al., 2008).

### **Therapist Crying in Therapy Literature**

Although relatively neglected within the literature, research suggests the majority of psychological therapists have cried with a client during therapy (Blume-Marcovici, Stolberg & Khademi, 2013). Despite this, no professional guidelines exist advising therapists how to respond to their tears (t'Lam et al, 2018). Matise (2015) considered therapist crying in therapy (TCIT) from the client's perspective, suggesting the therapist's tears can have a positive effect on the therapeutic relationship, with crying evidencing a strong empathic

connection. Similarly, Knox et al. (2007) described how crying may be considered “visible proof” that the therapist was affected by the client’s story (p.300).

Tritt, Kelly and Waller (2015) also considered the client’s perspective, asking 105 individuals who had therapy for an eating disorder to complete a quantitative survey. Results indicated tears can be beneficial, depending on how the client perceives the therapist’s demeanor (whether viewed positively or negatively), and the client’s understanding of the reasons for TCIT. This appears similar to self-disclosure literature, that clients consider psychotherapy more effective when therapists appropriately self-disclose (Barrett & Berman, 2001). This suggests that crying, if used similarly to appropriate self-disclosure, could enhance therapy from the client’s perspective.

In a mixed-method survey of 684 participants, Blume-Marcovici et al. (2013) reported that 72% of therapists cried in therapy with a client. Factors including gender, personality, and empathy did not influence crying. Instead, contextual factors were important (e.g., clinical experience, theoretical orientation, affective tone, and emotional tone). Furthermore, tears did not appear to have a negative impact overall, but could assist the therapeutic relationship. A follow-up survey supported this, suggesting TCIT could increase rapport (Blume-Marcovici, Stolberg & Khademi, 2015). In this study, crying often occurred in response to the clients’ tears, or topics touching on sadness or grief.

Recently, t’Lam et al., (2018) asked 819 Dutch mental-health professionals to complete a questionnaire exploring attitudes toward TCIT. Crying was relatively common, with some professionals using tears as a therapeutic “tool” to role model crying for the client (p.214). Crying often occurred when professionals empathised with a client’s story; usually as it held similarities to an experience of their own. Similarly, to Blume-Marcovici et al., (2013), being an experienced therapist, and adopting a client-centred therapeutic approach

were positively associated with crying. Despite beliefs about gender (that males do not cry), male professionals were found to be more open to TCIT than females.

Limited research has considered the qualitative experiences of therapists who cry with a client (British Psychological Society, 2013). To date, four anecdotal accounts of TCIT exist, suggesting crying can be therapeutically appropriate and beneficial (Alden, 2001; Counselman, 1997; Owens, 2005; Rhue, 2001). Owens (2005) described working with a 13-year-old client with acquired quadriplegia. They allowed their tears within the therapeutic encounter, where they would not ordinarily, in response to sadness at the client's story. They described identifying as a mother, and experiencing a countertransference reaction. Their tears were viewed positively by the client, helping them to experience something they could not otherwise, by "creating a meeting place for therapist and patient" (p.298). Alden (2001) reported similar findings, sharing their crying experience while working with a client who was paralysed. Feeling moved by their story, and experiencing a sense of tragedy on their behalf, resulted in crying. As Alden had a physical disability similar to the client, a countertransference reaction may have occurred (Alden, 2001; Knox et al., 2017).

Two of these anecdotal accounts hold particular relevance to the current study, with a focus on the therapist's tears in relation to end-of-life. Rhue (2001) described working with a young adult following a sibling's death. Rhue initially fought their tears, fearing they might overwhelm the client. They later chose to allow these to emerge as therapy progressed and their relationship deepened. Their tears were viewed positively by the client, as a demonstration of authenticity.

Finally, Counselman (1997) considered their own experience of providing therapy to a couple when one partner had a terminal illness. In this instance, they changed their therapeutic approach to allow tears and more frequent self-disclosure, "in service of greater connection with the clients" (p.233). Counselman (1997) altered their usual way of working,

based on the client's illness, sharing more of themselves within the therapeutic relationship, and re-considering previously established boundaries. As these accounts only consider the experiences of two individuals within this context, further research would provide greater insight.

Although some qualitative papers have explored TCIT, this has not been within end-of-life. Maise (2015) conducted a study with 11 therapists working within a university counselling setting. Factors including the degree and timing of tears, cultural acceptability, and therapist gender were important, if crying was to be perceived as therapeutically useful to the client. Additionally, tears needed to appear genuine and relevant, as opposed to the unresolved difficulties of the therapist. The study found a lack of clarity as to how therapists experience intense emotions (including crying) within the therapeutic encounter. Further qualitative research was recommended, to provide a greater insight of how therapists experience TCIT.

More recently, the experiences of 18 doctoral students working across various clinical (non-palliative/end-of-life) settings were considered (Knox et al., 2017). TCIT was felt to strengthen the therapeutic relationship, providing tears were "minimal" (ranging from "welling-up" to "a few tears," p.297). Tears occurred in response to the client's distress, terminating therapy, and an empathic connection. Countertransference also placed the therapist at risk of crying. Crying could be viewed as positive or negative, depending on the perceived appropriateness of the tears. For example, crying that resulted in the focus being taken away from the client, was inappropriate. It was viewed positively however when it demonstrated that the therapist understood the client, and in this instance, could deepen the therapeutic connection. Although acknowledged in supervision, tears were rarely discussed with clients, and some participants suggested this may have been therapeutic. Although these

studies consider the qualitative experiences of TCIT, they were not within a palliative/end-of-life context.

### **The Current Research**

Limited qualitative research has considered therapists' experiences of crying in therapy. Gaps in our understanding of the factors that contribute to TCIT, and the impact this may have on the therapeutic encounter, are likely to exist (Matise, 2015; Knox et al., 2017). TCIT may be more likely within a palliative/end-of-life context, given the challenges professionals face when working within this setting. For example, the focus of the therapeutic work being on end-of-life, instead of recovery (Gelinias, Fillion, Robitaille & Truchon, 2012).

Although the two anecdotal accounts provided by Counselman (1997) and Rhue (2001) indicate that TCIT may be experienced differently within an end-of-life context, further qualitative research would increase our understanding of this experience. Therefore, this study aims to expand on the literature relating to TCIT within a palliative/end-of-life context, by addressing the following research question: "how do psychological therapists working with individuals who have been given a palliative diagnosis, or who are approaching the end of their lives, view or experience crying in the therapeutic encounter?"

## **Method**

### **Design**

Qualitative methodology was selected to explore the subjective experiences of a particular phenomenon (e.g., therapist's crying in therapy with clients) (Willig, 2008). To access experience, semi-structured interviews were completed, based on the research question/aims. An open-ended interviewing style allowed participants to share rich and detailed life stories, revealing their thoughts about a particular experience (Reid, Flowers & Larkin, 2005). Data was analysed using Interpretative Phenomenological Analysis (IPA), which focuses on "how people perceive an experience, or rather, what any particular

experience means for them” (Langridge, 2007, p.107).

### **Inclusion/Exclusion Criteria**

Inclusion and exclusion criteria can be seen in Table 1.

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### **Participants**

Purposive sampling ensured the sample remained homogenous, meaning participants shared an underlying experience, but did not differ largely in demographics (Langridge, 2007; Smith, Flowers & Larkin, 2009). A relatively small sample size is recommended, due to IPA’s time-consuming, detailed, and idiographic (case-by-case) nature (Eatough & Smith, 2017; Willig, 2008).

In total, 16 individuals expressed interest in participating. Participants were recruited on a first-come, first-served, basis where possible. Individuals who did not meet the criteria were thanked for their interest and informed they could have a summary of findings on completion. Of these, three met the inclusion criteria and were invited to take part, but did not respond. Other reasons for exclusion included: not receiving clinical supervision ( $n=1$ ), working in palliative care for less than six months ( $n=1$ ), and not currently working within this context ( $n=1$ ).

In total, 10 individuals participated. A definition of crying was provided to participants prior to the interview: “tearing up, as in the eyes filling with tears, or running over” (Matisse, 2015, p.28). Based on this definition, all participants had experienced TCIT. For most

participants, welling-up was the extreme of their crying behaviour, although one described an experience of tears running down their cheeks.

Demographic information was collected (age, gender, professional role, therapeutic orientation, and time working within context). Six participants were female and four were male. Ages ranged from 32 to 60 years. Five clinical psychologists and five counsellors participated. Therapeutic orientation varied. Participants had worked within a palliative/end-of-life context for various time periods, ranging from one to 20 years. See Table 2 for a portrait of participants.

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Insert Table 2 here  
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### **Ethical Considerations**

Ethical approval was obtained from Lancaster University Research Ethics Committee (FHMREC Reference: FHMREC16148). See Section Four for ethics documentation.

### **Recruitment**

Recruitment took place via five healthcare related organisations commonly used by psychological therapists working in palliative/end-of-life care. Written information about the study was shared by these organisations, on behalf of the Lead Researcher (LR) The method of sharing differed depending on the requirements of the organisation. Snowball sampling assisted recruitment, and communication stated that all documentation could be forwarded to potential participants. Individuals were encouraged to contact the LR directly to take part.

### **Data Collection**

Participants were asked to complete a semi-structured interview lasting approximately one hour. They were offered face-to-face, telephone, or Skype interviews. Seven participants completed face-to-face interviews at their work. Due to location restrictions, three chose telephone interviews. See Table 3 for details relating to interviews.

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Insert Table 3 here  
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Interviews were audio recorded and transcribed verbatim by the LR. Transcripts were anonymised to protect participants' identities and pseudonyms were used.

An interview schedule was decided in advance based on discussions with the project supervisors and consultation of relevant TCIT literature. Questions were open-ended to ensure no assumptions were made about an individual's experience.

All participants signed the Consent Form prior to taking part (see Section Four, Appendix 4-E). Following the interview, participants were provided with the Debrief Sheet (either directly when meeting face-to-face or via email for telephone interviews to avoid delay) (see Section Four, Appendix 4-H).

### **Data Analysis**

IPA is a qualitative approach to analysis based on three theoretical foundations: phenomenology, idiography, and hermeneutics (Smith et al., 2009). In IPA, an individual's experience is considered in isolation before combining accounts during the later stages of analysis (Willig, 2008). A double hermeneutic is employed, during which the researcher adopts an active and dual-role in the analysis process. Although they consider the



participant's account, they also involve their own interpretation of this experience (Smith & Eatough, 2007).

IPA felt an appropriate choice for the study, given its ability to explore and consider the significant and transformative events that can occur in a participant's life including health-related topics, existential matters, issues of identity, and major life transitions (Eatough & Smith, 2007; Eatough & Smith, 2017).

**Epistemological position.** In IPA, although aspects of the participant's experience may be accessed through data collection methods (e.g., interviews, focus groups), the researcher also occupies an active role in interpreting such accounts. This suited the LR's epistemological position of Critical Realism, described as: "combining the Realist ambition to gain a better understanding of what is 'really' going on in the world, with the acknowledgement that the data the researcher gathers may not provide direct access to this reality" (Willig, 2008, p.13).

To complete the analysis, Smith et al.'s, (2009) six-stage process was followed. To check validity, emergent themes were discussed with the project supervisors, and the LR also attended an IPA study group at a local university. Remaining focused on the research question was helpful, ensuring the analysis remained relevant. Table 4 details this process.

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Insert Table 4 here  
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Table 5 details how each participant contributed to the overarching themes and subthemes.

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An example of coded transcript can be seen in Appendix 2-A.

### **Reflexivity**

Mason (2002) defined reflexivity as “recognising the extent to which your thoughts, actions, and decisions shape how you research and what you see” (p.5). This is relevant in IPA where the analysis is considered a joint process between the analyst and participant. Smith et al., (2009) wrote: “the end result is always an account of how the analyst thinks the participant is thinking” (p.80). Using reflective practice can assist the researcher in becoming aware of their preconceptions and reduce bias (Shaw, 2010; Willig, 2008). In the current study, this was through supervision and a reflective diary.

It was important for the LR to “bracket” their assumptions during the research process (Smith et al, 2009, p.100). For example, they noticed a desire for the research to reveal that participants viewed crying positively. Being aware of such preconceptions was important, as it enabled the LR to carefully consider their questions (both prior to, and during) the interviews. Had this not been addressed, questions could have been phrased in a way that led participants to certain responses, instead of allowing their genuine experience to emerge.

Adopting a transparent approach to the researcher’s social, cultural, and historical contexts can assist the reader’s comprehension of the research (Shaw, 2010). The LR is a trainee psychologist in her thirties. She completed a placement in a psycho-oncology service where she encountered individuals receiving palliative care or approaching end-of-life. She was struck by the emotional challenges’ professionals faced when working with such issues. This prompted her to consider her own relationship with tears in therapy. To date, she has not

had personal experience of crying in therapy when with a client, although she had noticed tears in her eyes when feeling particularly touched or saddened.

### **Results**

Three superordinate themes emerged: The role of the therapist; Being struck by emotion; and The balancing act. These, and their subthemes, are described below.

#### **Superordinate Theme One: The Role of the Therapist**

For all participants, it was important to be therapeutic in their relationships with clients. Tears were considered both therapeutic and non-therapeutic, depending on the type of crying (e.g., whether welling-up or sobbing), and the meaning the tears were felt to have. Alongside this, participants wished to appear professional, demonstrating that they could cope emotionally with the client's story. It was the therapist's role to manage these two qualities in the context of crying in therapy.

**Being therapeutic.** For most participants, crying had the potential to demonstrate authenticity or genuineness. As such, it could be considered a therapeutic tool, which could show care towards the client, and position the therapist as a collaborative companion. Kathryn described: "It's probably improved... trust between us... they know [that] I'm... genuine... I'm not putting on an act... it feels... more like you're coming alongside that person and you're walking with them... as a collaborator rather than a detached expert."

Several participants felt crying could demonstrate the significance of the client's story. Acknowledging this through tears could help to validate the client's pain, and show that the participant was moved by their experience. Sheila described her personal experience of receiving therapy, and noticing tears in her therapist's eyes: "It... affirmed... what I was saying... it was a very familiar experience to me... and... seeing his... being moved... helped me to... accept the significance of it."

For some, crying was an opportunity to model a healthy response to emotion. Through crying, participants could help the client to acknowledge and accept difficult experiences. For example, James spoke about how it would be wrong to give clients the message of “let’s just ignore” emotions. Instead, acknowledging his emotional response and tearfulness during the therapy session, communicated an alternative message of “let’s be okay with emotions.” Interestingly, in several of the male participant’s accounts, gender appeared as a factor influencing crying. As a male therapist, James indicated it was important for him to share a message of acceptability: “men... aren’t encouraged to let their emotions out... I’m... inviting them... it’s okay to be with your emotions.”

For some participants, acknowledging their tears could enhance the therapeutic connection between themselves and the client. Kathryn, who often shared her tearfulness with clients, and believed this strengthened the therapeutic relationship, described:

I’ll say... “that’s so touching to hear” ...point to my eyes... I might say, “I’ve welled-up listening to that” ...if they’re crying they might just smile and nod... in a way that your eyes connect... it feels like there’s something unspoken but really meaningful that has... clicked between you.

For others, a less direct approach was preferred, instead referring to a more general sense of feeling moved by the client’s account. How participants acknowledged crying varied, depending on how comfortable they were with their tears.

Alternatively, some participants considered crying to be non-therapeutic, and in some cases, risky. In this instance, crying could take something away from the client, or unhelpfully shift the focus of the session towards the therapist. Some participants expressed concerns that this might result in the client feeling responsible for them. This could damage the therapeutic connection, and impact on the client’s ability to trust the therapist. Charlie described:

They'll want to protect you, they'll... hold back, not trust themselves, so their emotions run full force... that... risks damaging... not necessarily their relationship with you, they may still care about you very much, but their ability to be secure and safe in a therapeutic relationship.

**Appearing professional.** For most participants, appearing professional within the therapeutic encounter was important. This appeared synonymous with being strong, and in dealing with emotions outside of the therapy session. When crying was felt to show weakness, this was considered inappropriate and unprofessional. Sonya described: "It's a belief of mine that I cannot crumble in this room... I would be letting my client down." She drew comparison between her role as a therapist and that of a nurse:

Nurses don't go around crying either. My role [as a therapist] ... is to be there to help others... there's almost a uniform that goes on... I guess the uniform is this room. I step into this room... I step into counsellor role and that... has to be a strong position. Subsequently, most participants described "shelving," or suppressing, their tears until they left the therapeutic encounter. This carried risks however, as their tears could emerge elsewhere - often when they least expected it. Harvey described: "It... leaks out in other scenarios... you might be really upset about the patient, but... actually get upset in a meeting (laughs), it's... displaced... it comes out at silly things."

Although participants wished to appear professional, for some, this conflicted with their desire to also appear human. Being human meant that crying might occur, as Max described:

To be human is to sometimes cry... I am human when I am doing my practice [so] I have to accept that maybe I don't necessarily think we should cry, but if it does happen, then it's not a bad thing.

**Superordinate Theme Two: Being Struck by Emotion**

Although participants wanted to be both therapeutic and professional, this was challenged by various triggers which could result in crying. Subsequently, participants described teetering on the edge between emotion that felt appropriate and containable, and emotion that felt inappropriate and out of control.

**Teetering on the edge.** Some participants described “over-empathising,” or identifying with, the client’s experience. There was a point where empathising with the client’s experience became risky, although the moment of over-empathising was not always predictable.

Over-empathising consisted of two processes, sometimes occurring simultaneously. The first, was when the participant put themselves in the client’s shoes, and imagined the emotions the client was experiencing. The second, was being struck by what an experience would be like, should the events that happened to the client, also happen to the participant. James described this:

There [are] two reasons... we might feel emotions ourselves. Either... we have really felt touched... that empathy we have... for someone... [because of] something they... shared with us. Or... we have identified with something of our own... it’s stirred something of our own.

The first process seemed easier to pull back from and contain. The second appeared more difficult and created greater challenge for the participant. The latter is highlighted in Sooty’s account, in which she describes identifying with a client’s story: “she talked about... her son, going from a well-teen... to suddenly... very poorly, and not knowing whether they are going to survive... even now I can feel myself welling-up... I’ve got children, how awful must that experience be?” For Sooty, it appeared that she was still experiencing a sense of identification during the interview, as evidenced by her welling-up while sharing this story.

Some participants appeared to panic when they became aware of their emotions. Often, this response appeared unexpected and surprising for the participant. For example, Kathryn said: “[there has been] a little jolt... you have gone too far with over-empathising... a split second of ‘oh God.’ You don’t actually want to fully burst out crying.”

**Experiencing vulnerability.** Participants shared various triggers that led to the experience of teetering on the edge including disbelief, sadness, helplessness, joy, privilege, being moved, and loss. Triggers made participants vulnerable to crying and threatened their ability to remain in control.

Triggers could be specific to certain individuals depending on their personal experiences or backgrounds (e.g., feeling sadness or hopelessness) and others were common across accounts (e.g., questions relating to existentiality). For Katie, struggling to comprehend her clients were dying left her vulnerable to welling-up:

They’re saying... “I have six weeks before I die” ...it doesn’t register in your mind.

You want to say, “no way... you can’t be dying... you’re beautiful, you’re well, you’re healthy.” It’s really hard to get your head around... that disbelief.

Disbelief appeared to be a personal trigger for Katie because of her background and rules about what was fair and unfair, and what should and should not happen: “It’s my rules of... that’s unfair, that’s so rubbish, that doesn’t feel right... my thoughts of how life should be.”

It was not just sadness, helplessness, and disbelief that acted as triggers, but also positive experiences. For Kathryn, seeing her clients hit milestones and overcome adversity was powerful, and at times, moved her to tears:

[It’s] when they start coming out of [distressing experiences] and they tell me that about something that’s a massive milestone or achievement... there’s just something really touching that probably is... connecting really strongly with my values as a

therapist and why I do what I do... [it] really, really touches me hearing about people that manage to triumph over adversity.

For some, questions relating to existentiality were raised, and acted as a trigger for tears. Several participants felt that the end-of-life context presented unique challenges in comparison to other settings, as it was impossible to avoid the reality of your own, and others, mortality. Charlie described: “we face our own... death, or the death of people we love... It’s difficult to empathise [with others] without imagining... frequently, what it might feel like to know you were dying... or a loved one was dying.”

For others, the end-of-life context affected how they worked therapeutically, with a person-centred approach often being favoured over more directive or goal-orientated therapies. Sooty reflected that the goals were often different in this role, in comparison to other settings in which she had worked:

It’s about you being with those people at the possible worst time of their lives when they are facing death, or loss... their goal might be just to... see you support them through... until they die... it’s a lot tougher.

Working in a more person-centred way exposed participants to instances where tears might occur within the therapeutic encounter, as Kathryn described:

I was more technique based before... now, I am definitely more to the, really just being alongside that person, empathising, the non-specifics of therapy. So that’s almost led to more teary moments. I guess because I am truly present with them rather than thinking about [my] technique.

### **Superordinate Theme Three: The Balancing Act**

All participants described welling-up within the therapeutic encounter, which was generally considered appropriate. However, participants expressed needing to be cautious with their emotional expression, as more extreme types of crying (e.g., sobbing), were



unacceptable. This appeared a balancing act for participants, between experiencing some acceptable emotion, but not teetering over the edge into unacceptable. Some described being more able to manage or contain emotion as their careers progressed and their self-awareness increased.

**A dance between showing and managing.** Participants described creating a balance between showing some emotion which might be considered therapeutic, and too much emotion, that was considered inappropriate.

For Harvey, although it was important to demonstrate that the client's story had impacted on him, it was important to contain any overwhelming emotion:

I would be open to... showing some of the impact of their story. But I would definitely be cautious about... showing... unrestrained emotion ... because that's actually why [clients] come to me. They ... want someone who could contain their distress, and hear it... It's a bit of a dance between showing it and managing it.

Although participants felt there was a line of acceptability to be kept to, this was context-dependent, with certain settings lending themselves to showing more emotion than others. Working in palliative care was considered different to other contexts, with the boundaries being loosened. Sheila explained how the expectations placed on the therapist were unique in this setting: “[Crying is] perhaps helpful or acceptable... if you're in that ending. There isn't an expectation... that they're going to need you as a therapist again. It's different... your role [has changed].”

Not only was working in palliative care thought to influence the boundaries of showing emotion and crying, but being with clients at end-of-life was felt to further impact these. For example, Katie talked about her experience of crying tears with a client who was dying:

I was with her... before she died. It was really difficult and I cried... I don't usually cry... that was very different, because I had made a lot of connections with her... more frequently it's welling up, that's the extreme... she knew she was dying and I knew she was dying... we acknowledged this was our goodbye.

**Learning to surf.** For most participants, crying was rarely eluded to during training, or in their professional role. Thus, participants increased their self-awareness and understanding of their personal triggers through working as a therapist. Through increasing self-awareness, participants reduced the risk of over-empathising, or identifying too strongly, with a client's story. Several participants used strategies to manage their emotional response, to ensure the balance between showing and managing emotion was maintained.

All participants described that TCIT had not been considered in detail during training. For Renna, this appeared particularly important, to reduce the fears of newly qualified therapists who might believe that crying was abnormal or unacceptable: "It's really important to normalise... not make them afraid of what might happen." Similarly, conversations with other therapists regarding crying, rarely occurred. Kathryn described that on the few occasions that crying had been discussed, this was with therapists who held similar beliefs to her own, and were therefore more likely to see tears positively: "[They think] ...that's really good, that's helpful, that's normalising it... I don't... have contact with people that are psychodynamic therapists or... a lot older... trained in different models... I wonder if they would have a different perspective."

Only a few participants described sharing experiences of crying within supervision, which appeared dependent upon the nature of the relationship they had with their supervisor. Katie shared how although she felt comfortable sharing her emotional experiences with her current supervisor, this had not always been the case: "In some organisations I've worked...

there was always that risk it was *supervision* rather than supervision, so I'd be less inclined to be very open about how I felt in case I looked as if I wasn't managing."

Subsequently, participants often learnt about crying in therapy through their clinical practice. Being a more experienced therapist appeared helpful when developing ways to manage tears within the therapeutic encounter. Charlie described how his resilience towards crying increased over his career, with the inclination to cry becoming less over time:

They say in mindfulness that "you can't stop the waves but you can learn to surf."

...waves of emotion will be part of your session. If you're doing the work right, they'll be manageable waves that you are practiced at surfing.

Furthermore, over time the experience of welling-up could be considered helpful, as a way of providing reassurance to participants that they were truly understanding the client's account. Charlie summarised: "when I feel the prickling behind the eyes... that's just recognising that I'm in tune with this person and we're on the right wave-length... like the sound of a radio clicking into play."

Increasing self-awareness was important to most participants, as it helped to reduce the risk of over-empathising, or identifying too strongly with the client's story. Often, this meant becoming aware of their triggers, and considering why they felt affected by certain accounts. James described:

[I feel that] it's something that is mirrored of our own... has stirred something of ours. [And] we need that honestly then with ourselves of... what's that? ...I need to acknowledge [that emotion is] present [and] put it to one side while I stay with that person and return to it when I can. [It is something] I've become more aware of over the last few years.

Several participants described using strategies to maintain the therapeutic balance and avoid falling into uncontrollable emotion. Charlie described a system of disconnecting from the client's story:

If... the emotions are getting... very big... I use mindfulness of the breath... of the body. I may say gently to myself, "this isn't your pain" ... "this isn't your story"... [I will] step back... [and] disconnect for... a few seconds... while my emotions settle and then reconnect.

For Sooty, a firm approach to crying was adopted: "I give myself a good telling off... there's a bit of a battle, I really tell myself not to cry." Alternatively, Katie described a physical strategy that she used to move her attention away from the emotional pain of the client's story: "I'll ...pinch (pinches fingers). To... feel... physical pain, to remove the emotional pain. I do that... with my fingernails... to divert ...attention... I'm going to cry, so... to stop it."

Strategies were also used to control crying when tears were considered unacceptable or inappropriate. Although Kathryn often felt acknowledging welling-up within the therapeutic encounter was acceptable, she described an example of a client sharing information relating to their prognosis. In this instance, Kathryn chose to blink her tears down, sensing that welling-up could reveal something unhelpful for the client: "I was thinking a thought that I didn't want to share... [I] quickly tried to blink that away... that wouldn't be appropriate... basically, I have just had a thought about you dying and it has upset me."

Although they may have developed strategies and ways to manage their tearfulness, some participants felt that their understanding, awareness, and relationship with crying in therapy would continue to develop and change over their career. For example, although Max described reaching "a good place" in regards to his emotions, he reflected that this may yet evolve further.

## **Discussion**

Limited qualitative research has considered TCIT. This is despite literature suggesting that the majority of therapists have cried with a client (Blume-Marcovici et al, 2013). All participants in the current study reported welling-up when working therapeutically. For most, this was the extreme of their crying behaviour, however one individual described more intense crying (having visible tears on their face) while working with a client who was close to death.

The findings considered how participants managed their emotions, so that welling-up did not lead to more intense crying. The boundaries at end-of-life felt looser for several participants, in comparison to other contexts they had worked. For some, crying felt more acceptable, given the changing role of the therapist, and the intensity of the emotions experienced. Participants referred to the use of strategies and in developing their self-awareness of triggers that might make them vulnerable to crying.

### **Relating Findings to Existing Research**

Crying could possess both therapeutic and non-therapeutic qualities, supporting the suggestion that under the right conditions, crying can be considered a useful “therapeutic tool” (Blume-Marcovici, Stolberg & Khademi, 2015; t’Lam et al., 2018, p.214). In the current study, crying could demonstrate therapist authenticity and care towards the client. Additionally, it could validate the client’s pain, helping them to realise an experience was significant. These findings are synonymous with previous research relating to the therapeutic nature of crying, suggesting this may also be relevant within end-of-life (Blume-Marcovici et al, 2013; Matise, 2015).

The finding that therapists may use their tears to model a healthy response to emotion has also been documented previously (Matise, 2015; t’Lam et al., 2018). In the current study, this was particularly important for male participants, who described the therapeutic value of

sharing their tears with male clients. Levant (1992) suggested the Normative Male Alexithymia Hypothesis to explain the notion that males may experience greater difficulty in expressing emotions than females. This difference may result from cultural norms relating to masculinity, as males can be discouraged from expressing emotions when young.

Subsequently, Levant (2009) highlighted the importance of therapists in encouraging male clients to explore the impact of gender within therapy. How male participants chose to model their tears in the current study might be one way of achieving this.

Although previous research has suggested that therapists may acknowledge their tears within the therapeutic encounter, there was limited understanding of how they chose to do this (Blume-Marcovici, Stolberg & Khademi, 2015; Knox et al., 2018). Learning how participants in the current study shared their tears may be helpful for other therapists considering how to disclose crying to clients. This may be particularly relevant, as several participants in the current study felt that their disclosure enhanced the therapeutic connection.

Tears were considered non-therapeutic when they shifted the focus from the client to the therapist, a finding in line with Matisse (2015). This could result in the client becoming concerned about the therapist, which might damage trust within the relationship, and impact negatively on the client's ability to feel safe.

Alongside being therapeutic, it was important for participants to appear professional and strong. The suggestion that crying could demonstrate incompetence or an inability to cope has been described in the general crying literature (van de Ven et al., 2017). Subsequently, some participants described suppressing emotions. This is often considered unhelpful, with research suggesting suppression is linked to poor physical and psychological health, stress, and burn-out (Schmidt & Diestel, 2014). This highlights the importance of raising awareness of TCIT, and normalising this experience, so participants feel able to share their experience

with colleagues. Such conversations often do not occur, as highlighted by several participants in the current study.

Various triggers threatened the participant's ability to stay in control of crying. Previous TCIT literature has addressed some of these, but the current research sheds light on specific triggers relevant to end-of-life. In the current study, participants adopted various therapeutic orientations, but all utilised approaches that emphasised the importance of the therapeutic relationship. For several participants, end-of-life meant altering their usual way of working, choosing to let go of techniques or goal-directed therapies in favour of being alongside the client. This is in line with findings by Counselman (1997). When the therapist becomes overly concerned with technique and appearing competent, they become less authentic, and subsequently less focused on the client. This can stand in the way of meeting the client at the level of relational depth (Rogers, 1973; Stern, 2003). In the current study, working in this person-centred way appeared to naturally lend itself to more tearful moments. This finding supports previous research suggesting that therapeutic orientation may impact on whether tears are shed (Blume-Marcovici et al., 2013; t'Lam et al., 2018).

Previous literature suggested that therapist crying becomes more likely with increased clinical experience (Blume-Marcovici et al, 2013; t'Lam et al., 2018). In contrast, participants in the current study described that resilience towards crying increased over their career, with the inclination to cry becoming less over time. The amount of time participants worked within palliative/end-of-life care may be relevant, rather than the general experience level of the therapist. For example, although the participant that described crying tears with a client was a very experienced therapist, they had only worked within palliative care for one year.

Over-empathising, or identifying too strongly, also placed participants at risk of crying. This is consistent with literature suggesting that although empathy can benefit the therapist's understanding of the client, it can place them at risk of over-identification

(Iosifidis & Iosifidis, 2002; t'Lam et al., 2018). Risk was greater when the client's experience held personal significance for the participant. Lamm, Batson and Decety (2007) suggested that focusing on the feelings of another (e.g., using imagination to consider how it might be for them) can evoke empathic concern, however putting oneself into the shoes of another (e.g., imagining the self in that same position) induces both empathic concern and personal distress. Personal distress, considered a component of affective empathy, is thought to occur when confusion exists between the experience of the self and the other (Davis, 1983; Decety & Lamm, 2006). Personal distress can be problematic, as it may lead to the therapist withdrawing from the client, which can impact on their ability to be present within the encounter (Jackson, 2001). Thus, it is important for therapists to increase their own sense of self, to reduce the risk of falling into personal distress as opposed to empathic concern (Lamm et al., 2007).

Participants reported using various strategies to manage their tears. To the authors knowledge, previous studies have not considered in depth the ways in which therapists manage their tears. Sharing such strategies can be helpful for other therapists, who wish to manage their emotional response within therapy, and may also help to normalise this process. Emotional labour theory may help to explain this finding, by suggesting that employees align themselves with the display rules of their organisation through strategies of deep and surface acting (Hochschild, 1983). Participants in the current study described suppressing emotions and blinking away tears which appears consistent with the criteria for surface acting. Alternatively, using mindfulness or giving yourself a "telling off," appears to be deep acting. For participants in the current study, this enabled them fulfil their professional role.

### **Clinical Implications**

Crying was rarely eluded to during teaching or within clinical practice. This is consistent with research suggesting that TCIT is often not discussed (Blume-Marcovici,



Stolberg, Khademi & Luciano, 2015). Talking about crying was considered important however, particularly for trainee therapists. This might reduce the likelihood that trainees perceive tears as a sign of failure or an inability to cope. Previous research suggests that trainees are unlikely to disclose TCIT to supervisors (Ledany, 2004). Normalising tears during training could help to reduce stigma, and allow trainees to consider how they might respond to experiences of crying, when they occur.

Participants emphasised the importance of developing self-awareness during their careers. This allowed them to become aware of their personal triggers, thus, reducing the likelihood that these would lead to uncontrolled crying that might be non-therapeutic. Gelso and Hayes (2007) suggested it is critical that the therapist's own wounds are healed, or at least understood, to prevent these from adversely impacting on therapy. In the current study, undergoing personal therapy helped several participants to develop self-awareness, which may have increased their resilience to tears. Therefore, a recommendation is that therapists increase their awareness of the triggers that make them vulnerable to crying, which may include accessing personal therapy.

### **Limitations and Future Research**

Participants were required to currently work within palliative/end-of-life care to increase the likelihood that details regarding TCIT would be accurately recalled. Despite this, participants described experiences from various time-points of their careers. Vingerhoets (2000) suggested that challenges exist when considering qualitative experiences of tears. Often, crying is delayed until a more appropriate time, making identifying the emotions behind tears difficult. Furthermore, various factors are thought to contribute to why we cry, making it challenging to determine an exact cause. Unless participants reflected on their tears immediately after they occurred, through supervision or personal therapy, parts of the

experience may have been forgotten or overlooked. Therefore, excluding individuals no longer working in this context could be considered a limitation.

Participants worked within end-of-life for six-months minimum to ensure they had sufficient experience. The amount of time spent working within this context may not relate to the quality or quantity of the participant's experience however. This may be relevant, as based on the findings of this study, less experience working at end-of-life may result in more tearful moments. Therefore, having no restrictions regarding time spent working within this setting may have provided different experiences of crying.

As mentioned previously, participants were provided with a definition of crying prior to their interview. Some expressed that they had not previously considered welling-up to be an example of crying. This demonstrates that their own perception of whether they had cried or not may differ from the definition provided, and highlights the subjective nature of tears (Vingerhoets, 2000). Participants with experiences of welling-up may not have applied to participate, believing this not to be an experience of crying.

Both face-to-face and telephone interviews were completed. The LR anticipated that face-to-face interviews may be advantageous, as participants could be monitored for signs of distress, and it would be easier to establish rapport (Birks & Mills, 2011). Despite this, face-to-face and telephone interviews did not appear to differ greatly in content or quality. An explanation for this may be that some participants found it easier to discuss sensitive topics over the telephone than face-to-face (Mathias & Harcourt, 2014). Additionally, participants that opted to complete telephone interviews were the last individuals to be interviewed. At this point, the LR was very familiar with the interview schedule, and felt confident asking questions about TCIT. This could have contributed to the relaxed and open nature of the telephone interviews.

A limitation of the current research, is the limited cultural diversity within the sample. The British culture of a “stiff upper lip” emerged for several participants, particularly in relation to gender. Although one participant grew-up in the United Kingdom, they were raised within another culture. Their views of TCIT appeared congruent with other participants, however they described how their background enriched their understanding of grief and loss, demonstrating the impact culture may have on our tears (van Hemert, van de Vijver & Vingerhoets, 2011). Subsequently, recruiting participants from different cultural backgrounds may be important for future research, to gain a clearer picture of how this may influence TCIT.

### **Conclusion**

This study explored the experiences of psychological therapists who cried in therapy within a palliative/end-of-life context. All participants described experiences of crying within the therapeutic encounter. Three superordinate themes emerged which considered the participants experience of this, the triggers that made them vulnerable, and how they managed this response. Recommendations have been provided based on these findings, the limitations of the study, and areas for future research have been considered.

### References

- Ablett, J. R., & Jones, R. S. P. (2006). Resilience and well-being in palliative care staff: a qualitative study of hospice nurses' experiences of work. *Psych-Oncology*, 16, 733–740. doi: 10.1002/pon.1130
- Alden, P. A. (2001). Gently wiping her tears away. In S. Kahn, & E. Fromm (Eds.), *Changes in the therapist* (pp. 117-131). Mahwah, NJ: Erlbaum.
- Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Counselling and Clinical Psychology*, 69 (4), 597–603. doi: 10.1037//0022-006X.69.4.597
- Becht, M. C., & Vingerhoets, A. J. J. M. (2002). Crying and mood change: A cross-cultural study. *Cognitive Emotion*, 16, 87-101. doi: 10.1080/02699930143000149
- Blume-Marcovici, A. C., Stolberg, R. A., & Khademi, M. (2013). Do therapists cry in therapy? The role of experience and other factors in therapists' tears. *Psychotherapy*, 50 (2), 224-234. doi: 10.1037/a0031384.
- Blume-Marcovici, A. C., Stolberg, R. A., & Khademi, M. (2015). Examining our tears: Therapists' accounts of crying in therapy. *American Journal of Psychotherapy*, 69 (4), 399-421. doi: 10.1176/appi.psychotherapy.2015.69.4.399
- Blume-Marcovici, A. C., Stolberg, R. A., Khademi, M., & Luciano, G. (2015). When therapists cry: Implications for supervision and training. *The Clinical Supervisor*, 34 (2), 164-183. doi: 10.1080/07325223.2015.1048556.
- British Psychological Society. (2013). *The tears of a therapist*. BPS Digest. Retrieved from <http://digest.bps.org.uk/2013/older-more-experienced-therapists-cry.html>
- Browall, M., Henoeh, I., Melin-Johansson, C., Strang, S., & Danielson, E. (2014). Existential encounters: Nurses' descriptions of critical incidents in end-of-life cancer care. *European Journal of Oncology Nursing*, 18, 636–644. doi: 10.1016/j.ejon.2014.06.001

- Bylsma, L. M., Gracanin, A., & Vingerhoets, A. J. J. M. (2018). The neurobiology of human crying. *Clinical Autonomic Research*, 29, 63–73. doi: 10.1007/s10286-018-0526-y.
- Cornelius, R. R., & Labott, S. M. (2001). The social psychological aspects of crying. In A. J. J. M. Vingerhoets, & R. R. Cornelius (Eds.), *Adult crying: A biopsychosocial approach* (pp. 159-176). Hove: Brunner-Routledge.
- Counselman, E. F. (1997). Self-disclosure, tears, and the dying client. *Psychotherapy*, 34, 233-237. doi: 10.1037/h0087715
- Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology*, 44 (1), 113–126. doi:10.1037/0022-3514.44.1.113
- Decety, J., & Lamm, C. (2006). Human empathy through the lens of social neuroscience. *The Scientific World Journal*, 6, 1146–1163. doi:10.1100/tsw.2006.221
- Department of Health and Social Care. (2008). *End of life care strategy: Promoting high quality care for adults at the end of their life*. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136431/End\\_of\\_life\\_strategy.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf)
- Eatough, V., & Smith, J. A. (2007). Interpretative Phenomenological Analysis. In C. Willig, & W. Stainton-Rogers Denzin, & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research in Psychology*. (pp. 179-193). London: Sage Publications Ltd.
- Eatough, V., & Smith, J. A. (2017). Interpretative Phenomenological Analysis. In C. Willig, & W. Stainton-Rogers Denzin, & Y. S. Lincoln (2nd ed.), *The SAGE Handbook of Qualitative Research in Psychology*. (pp. 193-211). London: Sage Publications Ltd.
- Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, 19 (4-5), 583-590. doi: 10.1080/10503300902798375.
- Frey, W. H. (1985). *Crying: The mystery of tears*. Minneapolis: Winston Press.

- Frey, W. H., Hoffman-Ahern, C., Johnson, R. A., Lykken, D. T., & Tuason, V. B. (1983). Crying Behavior in the human adult. *Integrative Psychiatry*, 1(3), 94-98. Retrieved from <https://psycnet.apa.org/record/1984-19574-001>
- Gelinas, C., Fillion, L., Robitaille, M., & Truchon, M. (2012). Stressors experienced by nurses providing end-of-life palliative care in the intensive care unit. *The Canadian Journal of Nursing Research*, 44 (1), 18-39. Retrieved from [https://www.researchgate.net/profile/Marie\\_Anik\\_Robitaille/publication/225288054\\_Stressors\\_experienced\\_by\\_nurses\\_providing\\_end-of-life\\_palliative\\_care\\_in\\_the\\_intensive\\_care\\_unit/links/5c17b817a6fdcc494ffb3885/Stressors-experienced-by-nurses-providing-end-of-life-palliative-care-in-the-intensive-care-unit.pdf](https://www.researchgate.net/profile/Marie_Anik_Robitaille/publication/225288054_Stressors_experienced_by_nurses_providing_end-of-life_palliative_care_in_the_intensive_care_unit/links/5c17b817a6fdcc494ffb3885/Stressors-experienced-by-nurses-providing-end-of-life-palliative-care-in-the-intensive-care-unit.pdf)
- Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Mahwah, NJ: Erlbaum.
- Gracanin, A., Bylsma, L. M., & Vingerhoets, A. J. J. M. (2014). Is crying a self-soothing behavior? *Frontiers in Psychology*, 5 (502), 1-15. doi: 10.3389/fpsyg.2014.00502
- Gracanin, A., Bylsma, L. M., & Vingerhoets, A. J. J. M. (2018). Why only humans shed emotional tears: Evolutionary and cultural perspectives. *Human Nature*, 29 (2), 104-133. doi: 10.1007/s12110-018-9312-8.
- Hendriks, M. C. P., Croon, M. A., & Vingerhoets, A. J. J. M. (2008). Social reactions to adult crying: The help-soliciting function of tears. *The Journal of Social Psychology*, 148 (1), 22-42. doi: 10.3200/SOCP.148.1.22-42
- Hendriks, M. C. P., Nelson, J. K., Cornelius, R. R., & Vingerhoets, A. J. J. M. (2008). Why crying improves our well-being: An attachment-theory perspective on the functions of adult crying. In A. J. J. M. Vingerhoets, I. Nyklicek, & J. Denollet (Eds.), *Emotional regulation: Conceptual and clinical issues* (pp. 87-96). New York: Springer.

- Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling*. London: University of California Press.
- Hughes-Hallett, T., Craft, A., Davies, C., Mackay, I., & Nielsson, T. (2011). Funding the right care and support for everyone: Creating a fair and transparent funding system. *Journal of Pain and Palliative Care Pharmacotherapy*, 25 (4), 362-364. doi: 10.3109/15360288.2011.621020
- Hunter, J., & Orlovic, M. (2018). *End of life care in England: A briefing paper*. Retrieved from <https://www.ippr.org/files/2018-05/end-of-life-care-in-england-may18.pdf>
- Ioannou, S., Morris, P., Terry, S., Baker, M., Gallese, V., & Reddy, V. (2016). Sympathy crying: Insights from infrared thermal imaging on a female sample. *PLoS ONE*, 11 (10), doi: 10.1371/journal.pone.0162749.
- Iosifidou, P. & Iosifidis, J. (2002). Carl Rogers, In Potaminos (Eds.), *Theories of personality and clinical practice*. Athens: Hellinika Grammata
- Jackson, S. W. (2001). Presidential address: The wounded healer. *Bulletin of the History of Medicine*. 75 (1), 1-36. doi: 10.1353/bhm.2001.0025
- Knox, S., Knowlton, G., Pruitt, N., Hill, C. E., Chui, H., & Tate, K. (2017). Crying in psychotherapy: The perspective of therapists and clients. *Psychotherapy*, 54 (3), 292-306. doi: 10.1037/pst0000123
- Lamm, C., Batson, C. D., & Decety, J. (2007). The neural substrate of human empathy: Effects of perspective-taking and cognitive appraisal. *Journal of Cognitive Neuroscience*, 19 (1), 42-58. doi: 10.1162/jocn.2007.19.1.42
- Langridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Essex: Pearson Education Limited.
- Leadership Alliance for the Care of Dying People. (2014). *One chance to get it right: Improving people's experience of care in the last few days and hours of life*. Retrieved from [http://wales.pallcare.info/files/One\\_chance\\_to\\_get\\_it\\_right.pdf](http://wales.pallcare.info/files/One_chance_to_get_it_right.pdf)

- Ledany, N. (2004). Psychotherapy supervision: What lies beneath. *Psychotherapy Research*, 14 (1), 1-19. doi: 10.1093/ptr/kph001
- Levant, R. (1992). Toward the reconstruction of masculinity. *Journal of Family Psychology*, 5, 379-402. doi:10.1037/0893-3200.5.3-4.379
- Levant, R. F., Hall, R. J., Williams, C. M., & Hasan, N. T. (2009). Gender differences in alexithymia. *Psychology of Men & Masculinity*, 10 (3), 190-203. doi: 10.1037/a0015652
- Mason, J. (2002). *Qualitative Researching*. London: Sage Publications Ltd.
- Matise, M. J. (2015). An exploration of the personal experiences and effects of counselors' crying in session. *The Professional Counselor*, 5 (1), 28–38. doi: 10.15241/mm.5.1.28
- National Institute for Health and Care Excellence. (2004). *Improving supportive and palliative care for adults with cancer: The manual* (NICE Publication No. 4). Retrieved from <https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-pdf-773375005>
- National Institute for Health and Care Excellence. (2011). *End of life care for adults* (NICE Publication No. 13). Retrieved from <https://www.nice.org.uk/guidance/qs13/resources/end-of-life-care-for-adults-pdf-2098483631557>
- Office for National Statistics. (2017). *Deaths registered in England and Wales: 2016*. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2016>
- Owens, C. (2005). Moved to tears: Technical considerations and dilemmas encountered when working with a 13 year-old boy with acquired quadriplegia. *Journal of Child Psychotherapy*, 31, 284-302. doi: 10.1080/00754170500370753



- Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience: An introduction to Interpretative Phenomenological Analysis. *The Psychologist*, 18, 20–12. Retrieved from: [https://is.muni.cz/el/1423/jaro2009/PSY118/um/exploring\\_lived\\_experience.pdf](https://is.muni.cz/el/1423/jaro2009/PSY118/um/exploring_lived_experience.pdf)
- Rhue, J. W. (2001). Death, bereavement, and the therapist. In S. Kahn, & E. Fromm (Eds.), *Changes in the therapist* (pp. 117-131). Mahwah: Erlbaum Publishers.
- Rogers, C. R. (1973). The interpersonal relationship: The core of guidance. In C. R. Rogers, & B. Stevens (Eds.), *Person to person: The problem of being human* (pp. 98-103). London: Souvenir Press.
- Rogers, C. R. (1975). Empathic: An unappreciated way of being. *The Counseling Psychologist*, 5, 2–10. doi:10.1177/001100007500500202
- Schmidt, K. H., & Diestel, S. (2014). Are emotional labour strategies by nurses associated with psychological costs? A cross-sectional survey. *International Journal of Nursing Studies*, 51, 1450–1461. doi: 10.1016/j.ijnurstu.2014.03.003
- Shaw, R. L. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, 7 (3), 233–243, doi:10.1080/14780880802699092
- Singer, P. A., & Bowman, K. W. (2002). Quality end-of-life care: A global perspective. *BMC Palliative Care*, 1 (4), 1-10. doi: 10.1186/1472-684X-1-4
- Smith, J. A., & V. Eatough. (2007). Interpretative Phenomenological Analysis. In E. Lyons, & A. Coyle (Eds.), *Analysing qualitative data in psychology*. (pp. 35–50). London: Sage Publications Ltd.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage Publications Ltd: London.
- Stern, D. N. (2003). *The interpersonal world of the infant: A view from psychoanalysis and developmental theory*. London: Karnac.

- t'Lam, C., Vingerhoets, A. J. J. M., & Bylsma, L. (2018). Tears in therapy: A pilot study about experiences and perceptions of therapist and client crying. *European Journal of Psychotherapy & Counselling*, 20 (2), 199-219. doi: 10.1080/13642537.2018.1459767.
- Tritt, A., Kelly, J., & Waller, G. (2015). Patients' experiences of clinicians' crying during psychotherapy for eating disorders. *Psychotherapy*, 52 (3), 373-380. doi: 10.1037/a0038711
- van de Ven, N., Meijs, M. H. J., & Vingerhoets, A. (2017). What emotional tears convey: Tearful individuals are seen as warmer, but also less competent. *British Journal of Social Psychology*, 56, 146–160. doi: 10.1111/bjso.12162
- van Hemert, D. A., van de Vijver, F. J. R., & Vingerhoets, A. J. J. M. (2011). Culture and crying: Prevalences and gender differences. *Cross-cultural Research*, 45 (4), 399-431. doi: 10.1177/1069397111404519.
- Vingerhoets, A. J. J. M. (2013). *Why only humans weep: Unraveling the mysteries of tears*. Oxford: Oxford University Press.
- Vingerhoets, A. J. J. M., & Bylsma, L. M. (2015). The riddle of human emotional crying: A challenge for emotion researchers. *Emotion Review*, 8 (3), 1-11. doi: 10.1177//1754073915586226
- Vingerhoets, A. J. J. M., Cornelius, R. R., Van Heck, G. L., & Becht, M. C. (2000). Adult crying: A model and review of the literature. *Review of General Psychology*, 4 (4), 354–377. doi:10.1037//1089-2680.4.4.354
- Vingerhoets, A. J. J. M., van Geleuken, A. J. M. L., van Tilburg, M. A. L., & van Heck, G. L. (1997). The psychological context of crying episodes: Towards a model of adult crying. In A. J. J. M. Vingerhoets, F. van Bussel, & A. Boelhouwer (Eds.), *The (non)expression of emotions in health and disease* (pp. 323-336). Tilburg: Tilburg University Press.
- Willig, C. (2008). *Introducing Qualitative Research in Psychology*. Open University Press: Berkshire.

Wilson, J. (2014). Ward staff experiences of patient death in an acute hospital setting. *Nursing Standard*, 28 (37), 37-45. doi: 10.7748/ns.28.37.37.e7949

World Health Organisation. (2004a). *The solid facts: Palliative care*. Retrieved from [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/98418/E82931.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0003/98418/E82931.pdf?ua=1)

Table 1

*Inclusion and exclusion criteria*

Inclusion	Exclusion
<p>Participants were psychological therapists working within a palliative or end-of-life context. The term “psychological therapist” referred to any clinician providing one-to-one psychological interventions, or therapeutic work, for which they received clinical supervision (e.g., qualified clinical or counselling psychologists, psychotherapists or counsellors)</p>	<p>Participants were unable to take part if they did not provide one-to-one psychological interventions or therapeutic work for which they received clinical supervision</p>
<p>Participants had to be currently working within an end-of-life or palliative context</p>	<p>Participants were unable to take part if they did not currently work within an end-of-life or palliative context</p>
<p>Participants were required to have six-months minimum experience working within this context. This was specified to ensure participants had a detailed view of the target phenomenon that they could discuss in an interview</p>	<p>Participants were unable to take part if they had less than six-months experience working within this context</p>

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Participants had to be at least 18 years old. No upper age limit was specified	Participants were unable to take part if they were under 18 years old
Both males and females were able to take part	Participants were not excluded based on gender
Participants were required to speak English Language well enough to participate in an interview lasting approximately one hour. This was due to funding and being unable to afford an interpreter	Participants were excluded if they did not speak English Language well enough to participate in the study

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Table 2

*Details of participants*

Pseudonym	Description
Renna	Renna is a clinical psychologist. They described their therapeutic orientation as “Social Constructionist.” They have worked within a palliative or end-of-life context for 20 years.
Max	Max is a clinical psychologist. They described their therapeutic orientation as “Cognitive Analytic Therapy, Cognitive Behavioural Therapy and Eclectic.” They have worked within a palliative or end-of-life context for 16 years.
Sheila	Sheila is a counsellor. They described their therapeutic orientation as “Psychodynamic.” They have worked within a palliative or end-of-life context for 15 years.
Sonya	Sonya is a counsellor. They described their therapeutic orientation as “Integrative.” They have worked within a palliative or end-of-life context for 13 years.
James	James is a counsellor. They described their therapeutic orientation as “Integrative.” They have worked in a palliative or end-of-life context for 13 years.
Sooty	Sooty is a counsellor. They described their therapeutic orientation as “person-Centred and Integrative.” They have worked in a palliative or end-of-life context for eight years.
Katie	Katie is a counsellor. They described their therapeutic orientation as “Systemic, Person-Centred and Psychodynamic.” They have worked within a palliative or end-of-life context for one year.

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Charlie	Charlie is a clinical psychologist. They described their therapeutic orientation as “Integrative.” They have worked within a palliative or end-of-life context for 10.5 years.
Harvey	Harvey is a clinical psychologist. They described their therapeutic orientation as “Acceptance and Commitment Therapy, Compassion Focused Therapy and Cognitive Behavioural Therapy.” They have worked within a palliative or end-of-life context for 10 years.
Kathryn	Kathryn is a clinical psychologist. They described their therapeutic orientation as “Systemic and Acceptance and Commitment Therapy.” They have worked within a palliative or end-of-life context for two and a half years.

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Table 3

*Duration of face-to-face and telephone interviews*

Type of interview	Shortest time	Longest time	Average
Face-to-face	40 minutes 39 seconds	95 minutes 28 seconds	54 minutes 31 seconds
Telephone	47 minutes 37 seconds	60 minutes 41 seconds	52 minutes 33 seconds
Total (all interviews)	40 minutes 39 seconds	95 minutes 28 seconds	53 minutes 32 seconds



Table 4

*The six stages of IPA research*

1	<p>Reading and re-reading</p> <p>To become familiar with the data, the first transcript was read several times. Initial notes were made on one margin.</p>
2	<p>Making initial notes</p> <p>Next, more in-depth notes were made, in light of the research question (“How do psychological therapists working with individuals who have a palliative diagnosis, or are approaching the end of their lives, view or experience crying in the therapeutic encounter?”).</p>
3	<p>Developing emergent themes</p> <p>Next, the initial notes were considered in greater detail, and themes began to emerge from the data. These themes were a combination of the researcher’s interpretation of the data, and the participants account of the experience.</p>
4	<p>Searching for connections across emergent themes</p> <p>Themes were written on post-it notes and grouped based on their similarities and differences. The purpose of this was to consider the relationship between themes and make sense of how they fit together. Themes considered irrelevant to the research question were discarded at this point.</p>
5	<p>Moving to the next case</p> <p>The same process was repeated for each participant’s account. Each transcript was considered separately before moving on to the next.</p>
6	<p>Looking for patterns across cases</p> <p>The final stage involved looking across the complete data to find patterns and connections. An overall list of themes was produced.</p>

Table 5

*The contribution for each participant to overarching themes and subthemes*

Overarching theme	Subtheme	Participants contributing to subtheme	Selected illustrative quotes for each participant*
The role of the therapist	Being therapeutic	Charlie, Harvey, Renna, James, Kathryn, Katie, Max, Sheila, Sonya, Sooty	<p data-bbox="1263 392 2002 536">“I think to know that we were... resonating, that the story [she told] ...mattered to me... she would have been aware [of the welling-up] ...and [I felt] that it facilitated her telling [her story]” (Charlie)</p> <p data-bbox="1263 576 2024 791">“It can enhance [the relationship] because they see you as a human being who’s real and kind and has made a connection and they value that... that they feel important and that they are not just a number, not just a patient, they’re not just somebody who’s in and out of your therapy room and didn’t mean anything” (Katie)</p> <p data-bbox="1263 831 2024 935">“People feel validated... that this is an enormous amount of suffering [and] that anyone hearing this would be... rendered... tearful, or upset” (Renna)</p> <p data-bbox="1263 975 2024 1126">“It gives them positive messages about “it is okay to cry,” “it is okay to express yourself,” [and] that this... suffering is normal, and the expected behavioural response is to cry” (Renna)</p> <p data-bbox="1263 1166 2024 1383">“It shows that you’ve heard them, either you have felt something really strongly about what they have shared, [or] you have really felt their emotion, you have really connected with them... rather than just going through the motions, that you have really connected with them” (James)</p>

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“[It’s] possible that the client feels heard, listened to, understood, and that... an empathic stance... exists even more strongly because of the evidence of the emotion of my face, and I have really understood their difficulty or their pain, or their suffering” (Max)

“I saw some very experienced therapist, and... there was one time that I was telling him... a sad story of my own, and I could see tears in his eyes, and I still hold on to that to this day that I could see that... he was visibly moved... I didn't feel any less contained at all... it affirmed... what I was saying... because it was a very familiar experience to me... albeit distressing, and actually sort of seeing his ...being moved... helped me to accept the significance of it” (Sheila)

“It just feels helpful in terms of normalising emotions... a lot of people feel embarrassed of crying, or... that they are abnormal or damaged in some way because they're emotional, and [I think] it really helps to just normalise that emotions are... normal and safe and... fine” (Kathryn)

“[Crying] was taking away from her really because it is her grief not mine, but the grief was because she was dying, I felt sad that she was dying” (Katie)

“I suppose my fear would be that it means that they shut down and feel unsafe to continue, that they're... worried about upsetting me, or maybe they're a bit annoyed at me, or angry that I have become upset” (Max)

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		<p>“The connection between us would be lost... my client might then be worried about me, and it's not about me in this room... it is about my client, so I think it would stop the therapeutic process... they may not be able to trust me again because they wouldn't know if it was going to happen again ...I would feel that I had let my client down and myself down” (Sonya)</p>
Appearing professional	Charlie, Renna, James, Katie, Max, Sheila, Sonya, Sooty	<p>“I am a professional and professionals don't go around crying” (Sonya)</p> <p>“I like to know, okay, this is me... I am the therapist here... and this is [what it is like] being a therapist... and [that means] offering a containing space” (Sheila)</p> <p>“If your shoulders start going... it is pretty likely at that point that the patient is going to feel the need to comfort you, and if a patient ever feels [that]... you're not doing your job for them” (Charlie)</p> <p>“I don't like crying in front of people, and if I do, I feel very vulnerable, and then I feel I have got to somehow redeem myself and become professional again, certainly in the work place” (Katie)</p> <p>“I don't think that I have physically cried [tears]... but I have been able to hopefully sit with that emotion, talk about what it raises for me, being with them, and how that impacts on them... retained my... own level of professional... overview” (Renna)</p>

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“Would they feel that, oh, he can’t manage this, or he can’t cope with this? ...Very often, people describe [that] I was doing okay, or I was being strong... and then the implication is because they have got upset they are not doing as well, or they are not as strong” (James)

“There is something very conscious of taking it off, putting it on at the beginning... some people wear their badge going home, I always take mine off in the office it goes in my bag and then I arrive and it comes out of the bag” (Sheila)

“I think to be human is to sometimes cry without... controlling it... I am a human when I am doing my practice, so I think sometimes I have to accept that maybe I don’t necessarily think we should cry, but if it does happen it is not a bad thing, because it is just being human” (Max)

“I am aware that we are human beings at the end of the day, so... if I said, you shouldn’t cry at all, that feels a little bit harsh” (Sooty)

Being struck by emotion    Teetering on the edge

Charlie, Harvey, James,  
Kathryn, Katie, Sheila,  
Sonya, Sooty

“[Uncontrolled crying] begins to sound and feel to me like somebody not in control of their emotions, being overwhelmed by their emotions, beginning to find their patient’s grief... in their grief” (Charlie)

“[After a relative’s death] I was very ambivalent about... when to return [to work], and... what the impact of the work would be like, because I think actually, you want to be in touch with your emotions and others emotions, but... too much, and you might not be able to function... I have

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definitely been quite mindful about... some of the narratives I hear around loss and the impact of my own experiences... I kind of have to remind myself of who I am here for” (Harvey)

“If tears are emerging, emotion is stirred clearly... and it’s a question of what is that emotion about? ...is it something that I felt either deeply connected with, or have I stepped too close to a client... have I moved more towards sympathising as opposed to empathising? ...What is it about that particular client that has really touched me? And it might be that just something they said is incredibly sad and I just feel that sadness... but more often, I feel... it’s something that is mirrored of our own, it has stirred something of our [and then] we need that honesty with ourselves of... what is that?” (James)

“It’s the... lump in my throat or, “oh, God, I am going to cry” feeling when you have that, “oh shit, if, if she carries on I am going to cry here, that’s so sad” (Katie)

“She wasn’t... particularly much older than me... her life story was very different to mine, but there were lots of connections in her story... the amount of children was similar, she had the same job... there were a few things that I think resonated with me, sort of got deeper into my emotions” (Katie)

“It was just this heavy, heavy sadness... that felt like my own sadness mixed with hers... [it] was overwhelming, whereas more often than not, it’s that person’s sadness might feel heavy, but it’s not where I am at as well, but

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that... was too much... and I was taken by surprise by it because... I knew seeing frail little old ladies in wheelchairs around the hospital would set me off and I would feel like crying because they reminded me of my mum, but I wasn't really expecting it here, it was a different situation"  
(Sheila)

"I think there is something about that the second lady I've just spoken to you about, with her childlike experiences, in some ways there were similarities between what she was describing and my... childhood... which I have had work with, but as I was saying to my supervisor yesterday, you never un-experience something ...you can... you can work with it, but it is still a part of you, so maybe for that second lady it was... a connection... because it was something similar to myself" (Sonya)

"I suppose it depends on whether... it touches on some of your own stuff at the time, if there's any... familiarity, familiar things that have happened in your own life, with loss, or with... people that you have lost, of experiences of the illness, and sometimes it is just people of a similar age... Somebody sits opposite me, my age, and... has only got six months to live... I really feel, they are my age, and that... that does get me sometimes, and if it is somebody that is my husband's age or my daughter's age" (Sooty)

Experiencing  
vulnerability

Charlie, Harvey, Renna,  
James, Kathryn, Max,  
Sonya, Sooty

"I think I am... really touched and overwhelmed... by people's strength, their resilience... against awful adversity and challenge... that human spirit and... in awe [of them] ... just thinking, wow, you have had all this shit to deal with and look at you, you have actually, you have come through

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it... I find that really heartening, I think that's what gets me" (Harvey)

"It just felt like such a powerful experience and he was so... delighted to be able to do that... it felt like such a privilege to be there and to have helped him... [to] do something so... important... that was a time when ...I could have properly cried" (Kathryn)

"They come to me... to tell me some of the most distressing stuff they probably ever say to anybody, because... you are on a journey with them, aren't you... I feel so privileged to be part of it" (Sooty)

"She is known to other members of the team, and we have a lot of affection for her because of who she is - her personality, she is just... really joyful to be around, so there is an additional dimension to that sense of sadness that this person isn't going to be able to thrive beyond maybe a year, maybe six months" (Renna)

"The tears I feel is when it is an overwhelming sense of sadness, and when it feels very unfair, and when I say very unfair, it's my rules of that's unfair... my thoughts of how life should be and it seems unfair... and obviously patients say that all the time, 'it is so unfair,' but you can't help but think as a bystander sometimes, oh that really is unfair" (Katie)

"At that point, when she was telling me this, it was incredibly sad, she had young children [and] she didn't want to die, she was almost like going down there to beg..."

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but everybody on the transplant list everyone has a story to tell, and it was very, very, sad and there was an occasion when I did fill up but I held onto it” (Sonya)

“It is more intense in this situation, it just feels heavier... it is a lot, a lot sadder... a lot heavier... [it] just feels a lot tougher... it’s awful, you see and hear some awful things” (Sooty)

“Working with the clients... that I do... you do turn towards those themes a lot more than you might... [and it’s] a question I have been left with myself in the past, of how much does my own losses and experience potentially ...help you know me as a practitioner... or does coming doing this work... make it evermore increasingly difficult for me? [So] if I had a job where the themes weren’t around illness, cancer, death, dying, bereavement... my emotions might not be stirred as much on a daily basis” (James)

“It was the intenseness of the death that was happening in front of me... I think he died a few hours after I had left, so it was very... imminent his death, and so I think it was the proximity to the death... and the... helplessness that as a therapist I couldn’t... reach him” (Max)

“It is something about human beings and... us having people that we love around us... maybe... there’s a part of you that maps other people’s experience on to your own... their talking about not seeing so and so grow-up, and I’m thinking of my nephews or... they’re talking about... dying, and leaving their husbands on their own, and I’m doing the

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The balancing act	A dance between showing and managing	Charlie, Harvey, Renna, James, Kathryn, Max, Sonya	same, I'm thinking, well, how would he cope without me?" (Charlie)
			"I would be open to... showing some of the impact of their story, but I would definitely be cautious about... showing ... unrestrained emotion... because I think that's actually why they come to me, because they want someone who could contain their distress, and hear it, they know it is emotive, they know it's moving, and that's why they are not telling, talking, to other people, because that is too much for them to manage... so it is a bit of a dance between really showing it and managing it" (Harvey)
			"I'd be very careful with maybe not over-expressing that [emotional response]" (Charlie)
			"I think it will probably stay the same, there will still be a bit of default setting, where I always will feel uncomfortable about doing it, I wouldn't actively ...seek to let myself cry, I think I would always try and hold it back" (Katie)
			"I prefer to... tell, not show... I will communicate my level of ...emotionality to someone, but it wouldn't be something that I would want them to necessarily witness" (Renna)
			"I was very able and willing as my emotions came up, especially if I was at home, to just let them flow, let them be, but then the irony is in returning back to work and then faced with lots of situations that might stir my own emotions... I can't just let them come as freely as I would. So, for all that I am saying I want to validate and

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acknowledge the emotions, there is probably an extent of... containing it as much as you can, which does again almost... go against my own philosophy (laughs) of wanting to allow emotions to be felt and expressed” (James)

“If I do fully cry, which I haven’t done in front of a client... I am someone that if I do fully cry, it’s not like a little elegant tear down the cheek (laughs), it’s proper snot and sobbing, so I know that... would feel really inappropriate in front of a client, but I think the sort of welling-up... that’s as much as I have sort of cried in front of someone” (Kathryn)

“I was very aware that it didn’t feel right to... fully cry, if indeed that was going to happen, but there was definitely emotion there” (Max)

‘I don’t remember crying with a patient although I have felt upset and emotional... but haven’t lost it, if you like” (Sheila)

“If people can see that, yes... I have tears in my eyes, they know that there is a connection there, that I am really listening to and empathising [with] what they’re experiencing, but I have to manage it, I can’t let it spill over into crying like they are crying” (Sonya)

Learning to surf

Charlie, Renna, James,  
Kathryn, Katie, Max,  
Sooty

“Over the years actually I find... any inclination [to cry] is actually there far less... it’s more when I get the prickling behind the eyes, and for me, that’s just recognising that I’m

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in tune with this person and we're on the right wave length" (Charlie)

"[I feel that] it's something that is mirrored of our own... has stirred something of ours. [And] we need that honesty then with ourselves of... what's that? I need to acknowledge [the emotion is] present [and] put it to one side while I stay with that person and return to it when I can. [It is something] I've become more aware of over the last few years" (James)

"There was still always that risk it was supervision rather than supervision, so I would be less inclined to be very open about how I felt in case I looked as if I wasn't managing" (Katie)

"With newer therapists they are learning aren't they, so it is really important, I really want to normalise quite a lot about what might happen, and not make them afraid of [that]... it's more about how they manage what happens" (Renna)

"When I know I am at the point when I go, oh God, I could cry, I will try and ...divert myself" (Katie)

"I suppose it does momentarily... switch off the empathising just for a second, for me anyway, to allow me to just compose myself and breathe... [and] not try and sort of blink away the tears but just so that I am back in... professional mode rather than getting into, almost like, over-empathising..." (Kathryn)

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“I give myself s good telling off (laughs)... I think, oh, I can't do this, I can't start crying because... they are going to be worried they have upset me, so there is a bit of a... battle... I think I mustn't cry, I mustn't cry...I probably have to really tell myself not to cry” (Sooty)

“I think it's very hard to say that I shouldn't evolve further, I think there must be better ways, there must be more ways I can help people, there must be variation of reasons for why people make me feel... that way... I think I have a lot more to learn because there are many more clients who'll probably come into my room and... surprise me, or test me... so I hope there is still an evolution to happen with understanding how to ... deal with crying... but I think where I am at, at the moment, is a strong enough place to help me do that next bit, if and when it happens, I have evolved... my awareness” (Max)

“I will still work as I do, but... maybe it's... not saying... never? Now I have done this interview and thought a bit more about it, because I don't think I have ever discussed it as in depth, there are possibilities that it might not always be a bad thing, but be cautious, I still think there is a cautiousness in me about it” (Sooty)

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\*Some quotes differ from those included in the results section. This is to provide further detail relating to the interviews and the analysis process

## Appendix 2-A

*Example of a coded transcript for Kathryn*

Initial notes	Transcript	Emergent themes
Crying as due to positive things	Interviewer: Yeah... So, you have mentioned there about regularly welling-up. Do you mind telling me a bit about those experiences?	
Less to do with awful experiences	Participant: Yeah, so, erm... well funnily enough I find that it happens more often when someone's, erm... describing something really ...positive. When you feel less that they have been through awful things, erm... It seems to be for me when they start coming out of that and they tell me that about something that's a massive milestone or achievement for them. There's just something really touching that probably is... maybe	"Something positive" as a pre-cursor to tears
Coming out / moving on from awful experiences	erm... It seems to be for me when they start coming out of that and they tell me that about something that's a massive milestone or achievement for them. There's just something really touching that probably is... maybe	Overcoming awful experiences
Crying at a milestone or achievement	connecting really strongly with my values as a therapist and why I do what I do... That just really, really, touches me hearing about people that manage to triumph over adversity in some way. Erm... I mean, I can give a couple of examples, like it happened today... but I don't know... if that's worth doing... I guess you can't really report that in the...research?	Connecting with values
Really touched by triumphing over adversity	erm... I mean, I can give a couple of examples, like it happened today... but I don't know... if that's worth doing... I guess you can't really report that in the...research?	"Triumphing over adversity" as a trigger for crying
Happened today (frequent?)		

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	Interviewer: No, it is fine to give examples. Anything you say that gives someone away, I will just anonymise anything... It might be helpful to see the context?	
Importance of role / Sense of privilege?	Participant: So... I have got three examples springing to mind. So, one is I was working with a dad whose baby was dying... it just felt like such a powerful experience ...it was... yeah, it was just, it felt like such a privilege to be there and to have helped him... do something so, so, important as such a, at an important time. Erm, that was time when I could have, I could have properly cried. And I felt myself welling up, erm, and I kind of deliberately held it in so it was just a welling, but it just felt like such a powerful experience. Erm, like another one, I had a woman this morning who has got, who had, a PTSD kind of reaction... and again, just hearing that, erm... was just really touching that she'd overcome, you know, it was just this sign that she has really overcome this. And... so similarly, it was a similar reason really for welling up as the other one... sorry, tell me to stop if I am doing too many examples-	Context: Experiencing loss of baby
Experience as powerful		Crying as "welling-up" (crying as having levels?)
Deliberately "held in" tears ("could have properly cried" – Levels of acceptability?) / Self at risk of tears		Crying as "held in" (a deliberate choice)
		"Powerful experience" as trigger
		Feeling "really touched"
Really touched by client overcoming difficulties		Client "overcoming" experience (as trigger)
	Interviewer: -No, no, I am happy to-	
Recurring theme / Overcoming adversity again	Participant: -So, the first one that springs to mind, again, it is the same theme for me, I	Overcoming adversity as trigger

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Distinction between palliative and end-of-life – relevant?	<p>think, of, erm, people overcoming adversity. It was the woman who, she had... we see people here who aren't, erm... palliative, as in end-of-life, but palliative as in months to live of the disease. And, erm, she had had her cancer treatment... so, to hear that... was just so moving, and again, to be privilege to be party to that information and ...being on that journey with the woman... just, it was a really... powerful moment. And, with all three of them, well there are many more examples, but those just spring to mind. With all three of them.... I definitely, definitely, feel that the client has noticed. And I sometimes do comment on it like... "oh gosh, I am really touched by that, I have got a, you know, that has brought a tear to my eye." And we talk about it that and it has definitely strengthened the therapeutic relationship on every single occasion. And then some people have commented on it at the time, just that it's nice for them to see that I care so much, or that I am invested in what is going on for them. That... it's provoked an emotional reaction in me. So... there's never been a time when it's, well, when anyone's said that they think bad, or reacted badly to it.</p>	<p>Self as "moved"</p> <p>Self as "privileged" (to be alongside)</p> <p>Moment as "powerful" (when tears occurred)</p> <p>Crying as "noticed"</p> <p>Crying as acknowledged (acceptable?)</p> <p>(Acknowledging) crying as strengthening relationship</p> <p>Crying as expression of "care"</p> <p>Crying as positive (therapeutic?)</p>
Self as moved / Sense of privilege		
Being alongside client ("on that journey") / Powerful moment		
Crying as noticed		
Tears as discussed, acknowledged		
Relationship as strengthened (through discussing tears)		
"Nice" to see she cares / is invested (crying demonstrates this)		
Response as positive		
	<p>Interviewer: That is really interesting... There are a few things that I have scribbled down that I would like to come back to, if that is okay.... Any examples you want to provide</p>	

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	<p>are fine, I am happy to let you talk and just ask some questions... So, you said at the beginning - I am going to come back to the particular examples - but you said there was this sense of privilege, or feeling touched by something that someone was sharing, erm... And you said about it perhaps touching on your values as a therapist... Do you mind saying a bit more about that?</p>	
Questions what has caused her tears	<p>Participant: Yeah... I think, I mean, I don't know. I think initially, when I think about why, what it is about that, that's... provoked an emotional reaction? Well, I don't really know if it is necessarily that, because I think anyone would struggle not to be really moved in that situation hearing those things because they are just... they just show the human spirit that... that... erm, so maybe... maybe it's not actually, I am probably over... analysing it (laughs) ...I guess a lot of the work we do is hard and you don't always get... success that's as obvious or... So, when you do have those moments, not necessarily that you've, you know... caused that good thing to happen, but hopefully you have played some small role in enabling the person to get to that point... it just really, I don't know. It reinforces why I do this job, and it's just a real sort of feel good.</p>	
Universal trigger, would make anyone cry		Being moved as unavoidable (in this context?)
Showing the human spirit		Emotion (to deny) as "struggle"
Questions herself		"The human spirit" as trigger (for being moved)
Work as hard / Not always as obvious success (makes you appreciate it more?)		Work as "hard" (tears as different in this context?)
Self as playing a role in client's achievement		Context: Self as helper?
Feels good to help client		Context: A "feel good" (sense of pride / achievement?)

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	Interviewer: Yeah... I suppose, yeah. And do you think that is different from... because it sounds like you are more likely to get the reaction to those sorts of things, than when it is something... that's not so positive that has happened for the person. Or, you know, something that has been upsetting or... Is that right? So, it is more likely to be something-	
Crying also due to awful things (E.g., abuse)	Participant: -Yeah... I think so. Or maybe they are just the ones that spring to mind because there's been... I have definitely welled up when people have been talking about awful things as well, like abuse. Erm... so maybe my mind is a bit biased towards remembering the good (laughs). The times when my tears have been for, you know, something lovely. Because no, I think... I think, probably as a person, maybe I am a little bit of an over-empathiser because to see someone crying on the TV that will often make me well-up, so maybe I am a bit, erm... a bit too in-tune with other people's emotions sometimes. So... yeah, I have welled-up when I am, I guess at the times I am really, really, present with people. Like in the moment, listening to someone, and sort of, you know, trying to imagine what that must have been like what they are describing, you know. And like awful... erm, abuse in childhood, or, erm, I don't know, the disappointment of being told about a	Welling-up due to "awful things"
Biased towards remembering the good?		
Crying due to "something lovely"		"Something lovely" as trigger
Self as "a bit of an over-empathiser" (wells-up quite easily)		Self as "over-empathiser"
Being "too in-tune" (puts her at risk?)		Self as vulnerable ("too in-tune")
Being really present led to tears		Being "present" as trigger
Imagining another's experience (empathy)		Putting herself in their shoes (empathy)

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Empathy and connecting with values as different	recurrence of cancer or something. Erm... I have actually welled-up at those times as well. That would have nothing to do with, erm... values about my job, and I guess just more... erm, really, really... being with the person and hearing them say, erm, and imagining... how they must be feeling. Erm... and there's definitely a thing your kind of teetering on the edge. You don't want to shut that off one hundred percent because, you know, it is important to be with that person, erm. Equally, you don't want to burst out, you wouldn't want to burst out crying in an uncontrolled way, because that would feel more about me. I don't know, that probably wouldn't feel very containing for the person, erm... Yeah, it's like you're teetering on the edge of remaining professional but being really empathic...	"Being with the person" (trigger)
Teetering on the edge (of something dangerous / risky?)		"Teetering on the edge" (vulnerable?)
Not wanting to shut off empathy		Empathy as being "shut off"
Important to not cry in an uncontrolled way (risks containment)		Crying as "bursting out" (uncontrolled?)
Important to get the right balance (between professional and empathic)		Uncontrolled crying as unacceptable? (not containing / "more about me")
	Interviewer: Yeah... yeah, because... I have written something else down you mentioned before about deliberately holding it in. I think there was one example you shared where you said, erm... you actually felt at that time that you possibly could cry. It was something that was really emotional, it may have been the first example you shared, you described being aware that you were deliberately holding it in, erm ... how do you do that? What's that... how does that happen for you?	Being on an "edge" (balancing being professional and empathic)
		Important to be professional / Important to be empathic (therapeutic?)

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A process of detachment? “A jolt” - shock, surprise?	Participant: I think there is, I think there is like almost a little moment of checking yourself, of erm... detachment... you almost get like a little jolt of “oh, God, I could,” you know, pull it back... you have gone too (laughs). You have gone too far with over-empathising, and just in a split, a split second of, “oh, God,” you don't want to actually fully burst out crying. So, I think I just control...almost you get a little jolt of just noticing that has happened. ... It does, I suppose, it does momentarily ...switch off the empathising just for a second, for me anyway, to allow me to just compose myself and breathe and, erm... not try and sort of blink away the tears but just so that I am back in ...professional mode rather than getting into, almost like, over-empathising. Erm... but also, I know about myself that if, if I do fully cry, which I haven't done in front a client, that I am someone that if I do fully cry, it's not like a little elegant tear down the cheek (laughs). It's proper snot and sobbing. So, I know that that for me would be, that would feel really inappropriate in front of a client	Needing to “detach”
Crying as unpredictable, unexpected		“Pull it back” (regain control)
Over-empathising as “going too far” (dangerous?)		Self as “gone too far” (with empathising)
Needing to compose self / Fully crying as unacceptable Control		“A little jolt’ of realization (crying as unexpected?)
Switches empathy off (to compose self)		Vulnerable to crying (at risk)
Tears as not blinked away (tears as okay?)		Tears as “blinked away” (concealed?)
Over-empathising as unprofessional (cannot be professional and over-empathise)		Empathy as “switched off”
		Fully crying as unprofessional (inappropriate)
		Acceptability of tears (levels)

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## Appendix 2-B

*Summary of guide for authors for Psychotherapy*

Psychotherapy publishes a wide variety of articles relevant to the field of psychotherapy. We strive to foster interactions among training, practice, theory, and research since all are essential to psychotherapy.

We welcome the widest scope of orientations to inform our readers. Authors are asked to submit theoretical contributions, research studies, novel ideas, the controversial, as well as examples of practice-relevant issues that would stimulate other theorists, researchers, and/or practitioners.

Manuscripts submitted to this Journal must have a very clear statement on the implications for psychotherapy, as well as use psychotherapy terminology. Thus, we are most interested in manuscripts that are specifically related to the therapeutic setting and treatment interventions in an applied manner. As such, papers would need to have very clear and accessible implications for therapists in applied clinical practice.

Directly related to the main aims of this Journal we also encourage submission of articles to a pair of ongoing special series. The first being Practice Review articles that summarize extant research in a clinically accessible manner. The second, parallel in purpose to the Practice Review articles, are Evidence-Based Case Studies that integrate verbatim clinical case material with standardized measures of process and outcome evaluated at different times across treatment.

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<http://dx.doi.org/10.1037/a0028566>
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- Chapter in an Edited Book:  
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

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### **Section Three: Critical Appraisal**

#### **Becoming A Critically Reflective Researcher within an End-of-Life Context**

Word count: 3780 words

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### Becoming A Critically Reflective Researcher within an End-of-Life Context

This critical appraisal provides a reflective account of my research journey. It considers decisions made at various time-points during the research process, and the rationale for these. The key challenges encountered are described and critically considered. In addition, my experience of completing qualitative research within an end-of-life context is addressed, the possible impact of this on the participants and myself, and how the research has shaped, and continues to influence, the way I work within my clinical practice.

#### **Why Study Crying at End-of-Life?**

Heaven knows we need never be ashamed of our tears, for they are rain upon the blinding dust of earth, overlying our hard hearts. I was better after I had cried than before – more sorry, more aware of my own ingratitude, more gentle (Dickens, 1890/2016, p.116).

I first considered the topic of therapist crying in therapy (TCIT) during my first year of the Clinical Psychology Doctorate. At this time, I was planning a different assignment, which required an exploration of a professional issue that psychologists might face during their clinical practice. Despite my interest in the therapist's tears, the literature was limited.

My interest in the topic led to me consider my own position in relation to crying within the therapeutic encounter, and my relationship with tears more generally. I decided to explore this phenomenon within an end-of-life context based on a conversation I instigated with a colleague. During this discussion, we shared our mutual discomfort with the concept of shedding tears in therapy with a client. My colleague provided an example of a psychologist they trained with who regularly cried with individuals approaching end-of-life. This led me to question whether crying might be experienced differently within this context. A search of the literature suggested that this might be the case, and that aspects of this

context may impact on how crying is experienced by the therapist (Counselman, 1997; Rhue, 2001).

### **The Importance of Knowing Oneself**

Hockey (2007) suggested that researchers studying death and dying are likely to be asked why they chose this topic. They argue that working within this context means a deliberate exposure to the loss and pain of others. Katz and Genevay (2002) stated that individuals are drawn to end-of-life work for various reasons, but often due to their personal background or life experience. Thus, in the interest of reflexivity, it is important to consider this in relation to myself, and why I chose the topic of therapist crying at end-of-life.

Shaw (2010) defined reflexivity as the “explicit evaluation of the self” (p.235). Thus, any preconceptions of the researcher should be explored, including the impact of social, historical, and cultural contexts. Reflexivity is important within qualitative research, as the researcher occupies a position in which they are trying to make sense of the subjective experience of another individual. This is particularly relevant for interpretative phenomenological analysis (IPA), as the presuppositions of the research can “both hinder and enhance the therapeutic interpretation of another’s lived experience” (Shaw, 2010, p.235).

Within my career, I have always felt drawn to working within physical health settings. For my final placement on the doctorate, I elected to work in psycho-oncology. Prior to this placement, many individuals in my personal life commented on how upsetting this role was likely to be, and asked how I would cope. Subsequently, I noticed anxiety and apprehension within myself, and worried that working with cancer might feel unmanageable.

Several participants from the research paper considered their own choice to work within end-of-life during our interview. For example, Max described:

It has been very helpful to think about... why am I drawn to working in end-of-life... knowing full well that it’s a very emotional place at times for everyone concerned,

but particularly for the person who's preparing, and knowing that you can't stop death and dying... there is no cure... there is no... fixing that person, so that they don't die, the thing that they would want most, I can't help them achieve... instead we have to think "well what can we do instead to help this be a meaningful experience?"...I am drawn to the area... I don't know if I fully understand why.

From Max's account, he questions why he is drawn to this context, despite the emotional challenges that can occur. He acknowledges being unable to change the outcome for the client, but hopes that his contribution as a therapist might make their experience meaningful in some way, a sentiment that was shared by several participants. Similarly, another participant from the research study, Kathryn, addressed her choice to work within this context, suggesting that it connected with her values: "[When] they tell me about something that's a massive milestone or achievement for them and there's just something really touching that probably is... connecting really strongly with my values as a therapist, and why I do what I do."

Reflecting on the responses of participants in the research paper was a helpful starting point for me to consider my own interest in death and dying, and my ability to work within this context, both as a researcher and a therapist. Despite the concerns of my loved ones, I enjoyed working within a cancer context, and have since started a paid position in this field. Like Max and Kathryn, I wonder whether this is due to the role connecting with my values, and my own desire to make an experience meaningful for the client and their family – even when the outcome cannot be altered.

Considering my professional and personal relationship with crying was also important. As described previously, I have not always felt comfortable with my tears. Perhaps this was what led me to explore the topic of therapist crying in therapy – noticing my

own internal reaction, and my attempts to suppress the welling in my eyes that can occur during the therapeutic encounter.

### **Getting Started**

This section of the critical appraisal considers some of the challenges I faced and my decision-making process throughout my research journey.

### **An Ethical Dilemma**

The first challenge I encountered was regarding ethical approval. I experienced a lot of uncertainty as to what type of approval was required for my research project. The nature of the project meant that participants were likely to work for the National Health Service (NHS), which could possibly mean that I required Health Research Authority (HRA) approval. Additionally, participants might wish to be interviewed at their place of work, or within working hours.

To clarify this, I contacted several individuals at the University who were involved with the ethics process. I was informed that if I used any NHS resource at all, for example, to advertise, recruit, use of a phone number or email address, or interviewing someone in a capacity in which they also work within the NHS, then I would need HRA approval. This would be via the Integrated Research Application System (IRAS). Subsequently, I completed an IRAS form and also applied to Faculty of Health and Medicine Research Ethics Committee (FHMREC) at the University.

Despite my application, I continued to feel unsure whether I had needed to complete an IRAS form (based on the response from the two decision making tools available on the HRA website). Although I had previously queried their results with the HRA, I felt confused by their response, which did not really address my question. Thus, I made contact on two other occasions, before finally receiving a response stating: “from the information you have provided, we would not consider this project to involve the NHS, so it should not come under



HRA approval.” This decision was based on the argument that I would not be recruiting through an NHS employer, and as such, they could not be held accountable for any participants that may choose to take part in the project. If participants chose to use their professional email or time for non-work purposes, this was considered a matter for the employer and employee, not the HRA.

I contacted the FHMREC to let them know the outcome of this. I was concerned that I would have to complete different ethics documents, but I was assured that I did not. It felt important to share this experience with the ethics committee and my supervisors, so that future trainees would not have to experience this uncertainty and confusion. Additionally, this caused delays to starting my research. Ethics documentation can be seen in Section Four of the thesis.

### **Becoming Familiar with Terminology**

The terminology at end-of-life is often described as inconsistent and confusing, with a lack of understanding regarding the differences between “palliative care” and “end-of-life” (Department of Health and Social Care [DHSC], 2008; Krau, 2016). As someone who was unfamiliar with the language surrounding death and dying, I experienced challenges in the early stages of my research. In particular, when considering the sample of participants that would be eligible to take part.

To clarify this, I first consulted relevant literature, and also met with my field supervisors to discuss the difference between the two terms. Although some suggest end-of-life care is provided in the last 12 months of life, this varies considerably within the literature, and has led to great debate (Krau, 2016; NHS England, 2014). Additionally, individuals might receive palliative care, which involves caring for those with a serious illness when a cure is not possible (DHSC, 2008).

My research focused on palliative care when it occurred at end-of-life, as opposed to the management of long-term conditions. Drawing this distinction was helpful, and led to an ethics amendment. In my first ethics application, I had specified that participants had to work within a palliative care service. Changing my inclusion criteria to include psychological therapists working with individuals with a palliative or terminal diagnosis that were approaching end-of-life, felt more relevant to the focus of the research.

### **Feeling Guilty**

Once ethical approval was received, I was able to start recruitment. An initial concern was that I would not have enough interest in the project. Looking at this retrospectively, I wonder whether this was based on my own sense of anxiety in relation to the topic, and feeling fearful that it might be perceived as controversial by some therapists. My fears could be supported by the limited literature consider TCIT and the acknowledgement that crying is not often discussed (Blume-Marcovici, Stolberg & Khademi, 2013). I was also apprehensive that through studying this topic, some individuals might believe that I was an advocate for the therapist's tears, and that I would be judged negatively for this.

Despite my worries, I had a positive response to my study, and recruitment took place quickly. I experienced guilt however at being unable to interview all individuals that expressed an interest in participating. For two individuals, this was because they did not meet the inclusion criteria (e.g., they had worked within end-of-life for less than six-months, or were not currently working in this context). In hindsight, I questioned the benefit of such strict criteria, as individuals who did meet the required entry rules and were able to participate in the study, shared experiences from various time points during their career. Additionally, based on the findings from my study, individuals with less experience might be more likely to experience crying.

I considered whether to submit an ethics amendment to allow these two individuals to participate, and discussed this dilemma with my research supervisors. I had different responses however, as one supervisor felt I should submit an amendment, and my other two supervisors said that I should not, due to time restrictions of the project.

Considering this, along with the time-consuming nature of IPA research, I decided against submitting an ethics amendment and did not interview these two individuals. Instead, I thanked them for their interest in the project, and offered to send a summary of the main findings when the project was complete.

### **The Role Change**

Although I had previous experience of conducting research interviews, I noticed some anxiety prior to, and during, the initial two interviews. This manifested as an uncertainty of how far to pry into the participant's experience. As the purpose of these interviews was to access as much subjective and detailed experience as possible, it was important that I discovered why this was occurring. I reflected that the difference between these interviews (in comparison to the previous ones I had conducted) was that I was interviewing psychological therapists. As a trainee psychologist, I was used to being assessed and judged on my performance, and I acknowledged that this process felt similar.

Subsequently, I realised that I was placing considerable pressure on myself to perform the "perfect" interview, which could impact negatively on the interview process. For example, the researcher is expected to put the participant at ease so they feel comfortable sharing their experience (Liamputtong, 2007). Additionally, I wanted the interview to feel reflective and safe for participants, rather than formal and impersonal.

Understanding why I felt anxious was reassuring, and my confidence grew as I completed further interviews. This helped me to become more flexible within the interviews, and although I held the interview schedule in mind, it did not dictate the structure or flow. In

IPA research, the interview schedule should act as a flexible guide which may change as the interview progresses (Smith, Flowers & Larkin, 2009). This approach allows the researcher to explore any unexpected insights that may arise that can be considered relevant to the research question. Despite my initial concerns about my performance, and that this might impact on the level of detail participants felt able to share, they engaged in reflective and detailed interviews.

It has been suggested that the lack of relationship between the researcher and the participant can lead to greater opening-up and sharing of personal information (Reinharz, 1992). Several participants commented that they had shared more personal information than they intended to (no participants appeared distressed by this, or asked for their information to be withdrawn from the study, despite this being stated on the Participant Information Sheet and verbally discussed). For some participants, this included sharing information relating to loss in their own lives, and for others, experiences of personal therapy were discussed. The participant's emotions were evident at times, with one displaying anxiety about crying with a client who was dying, and others becoming tearful when sharing experiences of loss. It occurred to me that the boundaries might be different within a research context, and that the trainee/qualified psychologist divide might have narrowed somewhat.

The nature of the interview differed, with seven participants completing face-to-face interviews, and three individuals choosing to complete telephone interviews (due to location restrictions). Telephone interviews can present some challenges for the researcher, as they are unable to see the response of the participant (e.g., whether they are becoming distressed) (Birks & Mills, 2011). Some individuals may prefer telephone interviews however, finding it easier to discuss difficult or sensitive topics in depth (Mathias & Harcourt, 2014; Novick, 2008). Thus, telephone interviews may not necessarily impact negatively on the quality of the data collected (Holt, 2010). This appears to be relevant to the current study, as the level of

reflection and detail provided did not appear to differ depending on the type of interview (whether face-to-face or telephone).

All participants were provided with a Debrief Sheet following the interview. For participants that I interviewed over the telephone, this had been sent via email, to avoid delay. It was important to still provide this, even though I assumed that most participants would be aware of support services, given their professional role.

### **Doing Emotion Work**

Lee and Lee (2012) stated that when conducting research on sensitive topics, it is important to consider the impact of this on the researcher. Often, the well-being of the researcher is ignored, with the focus instead on the participant (Sherry, 2013). Despite this, the researcher may encounter emotionally distressing content at various points of the process including data collection and analysis (Dickson-Swift, 2017).

Emotion work theory has been suggested as one way of understanding the researcher's emotional experience throughout the research process (Fitzpatrick & Olsen, 2015; Hochschild, 1983; Dickson-Swift, 2017). Strategies of surface and deep acting are thought to be used by the researcher in response to the distressing experiences they may face. One researcher from another paper described suppressing their tears during an interview:

I felt sadness and frustration in response to his stories, but I didn't cry... I was aware of my facial expressions and actively tried to sustain an "open" and "active listening" expression: lips closed, gaze fixed on either Joe or my tea cup (Fitzpatrick & Olsen, 2015, p.51).

Although the researcher above contained their tears during the interview, they later cried in the privacy of their own home. I can relate to this experience, as although I often had times during the interviews where I felt great empathy and sadness towards the participant's account, I used surface acting strategies to maintain a professional and calm appearance.

Although I contained my emotions during the interview, I had one instance where I experienced an emotional response following this. During one particularly sad interview, where a participant tearfully shared an account of their own recent bereavement, they mentioned a song that they had a great connection to. This song resonated with them, as it had helped them to cope with their loss, and they asked that I listen to it following the interview. Later, when I listened to the song at home, I was transported emotionally back to the interview setting. Although I did not cry, I experienced the same sense of sadness I had felt in response to the participant's story.

It has been suggested that beliefs about professionalism may limit the expression of emotion for the researcher, similar to how display rules operate within other settings (Dickson-Swift, James, Kippen & Laimputtong, 2009). Subsequently, researchers perform emotion work to manage their emotions, so they conform with professional and academic expectations. One researcher described: "fieldworkers share a culture dominated by ideologies of professionalism... emotions are suspect. They contaminate research by impeding objectivity... emotion work... moulding their feelings to meet other's expectations" (Kleinman & Copp, 1993, p.2).

### **Methodological Considerations**

Although I had completed IPA previously, I had forgotten how lengthy and time-consuming the analysis process can be. My interviews were very reflective (possibly as they were completed with psychological therapists), and I questioned whether I was doing enough interpretation of the themes that emerged from the data. The sense of responsibility to complete a thorough and accurate analysis felt overwhelming at times, particularly as I was analysing large amounts of data.

Qualitative research has been criticised due to its interpretative nature, and the role of the researcher in deciding what is considered a theme (Taylor & Ussher, 2001). To overcome

my concerns, emergent themes were discussed with the project supervisors. I also attended an IPA study group at a local University, where my concerns about “getting it wrong” were normalised. Having the research question in front of me was also helpful, and enabled me to stay focused, and reduced my feelings of being overwhelmed. The process of analysis can be an iterative one, and my themes changed at various points, even during writing-up my findings (Smith et al., 2009).

Generalising the findings can be difficult within IPA, due to its smaller sample sizes, and case-by-case approach to analysis (Smith & Osborn, 2003). As such, general claims cannot be made based on this study alone. Despite this, it is hoped a detailed insight into the experiences of TCIT within a palliative or end-of-life context has been provided. Further research considering this phenomenon with other samples of therapists working in similar end-of-life contexts may lead to the development of more general claims (Smith & Osborn, 2003).

### **Links to Clinical Practice**

Despite some of the challenges described above, I have opted to work in a context where I regularly experience issues relating to death and dying. I have found this research process valuable in helping me to consider my own responses while working therapeutically within this setting. Having an awareness of the qualitative experiences of other psychological therapists working with end-of-life issues has been normalising and reassuring. I have been able to share my findings within my team at work, which has helped my colleagues to make sense of some of the emotion (and their response to this) that can occur within this context. In my experience, understanding that welling-up in response to a client’s story is normal, can help professionals to adopt a more compassionate approach towards themselves, and feel less isolated.

At times, I do experience welling-up within the therapeutic encounter. Although I am not entirely comfortable with this yet, I do feel that my willingness to be with my tears has increased. I have become more aware of when I am likely to experience a welling in my eyes, through developing an awareness of my own triggers. Similar to the participants in my study, I feel it is always a balancing act between experiencing some acceptable emotion, but not becoming excessively upset.

I am keen to disseminate the findings from the research paper and literature review further. An overview of the study in its early stages was shared via a presentation at Lancaster University in June 2017. This presentation was observed by course staff and other trainee psychologists. This was a helpful process, as it provided an opportunity to reflect on the research at this stage.

Most participants cited wanting to “help out a trainee” as their reason for participating, and recalled their own challenging experience of training. Some commented on their interest in the study, and that they considered therapist crying in therapy an important topic to explore. For several participants, some uncertainty was expressed regarding the findings, and whether their responses would be similar or dissimilar to other psychological therapists that took part. Dickson-Swift, James, Kippen and Liamputtong (2007) described how researchers can feel a sense of privilege when participants choose to share their experiences with them. Subsequently, this can result in feelings of responsibility for the researcher, and that they should do something with the participants story. Thus, I feel a sense of importance in sharing these findings with the participants, but also more widely.

### **Conclusion**

This critical appraisal has aimed to provide a reflective overview of my research journey. I have used it as an opportunity to expand on various methodological considerations, and highlight my decision-making process when I faced challenges. It is important to



consider the impact of your own background and personal experiences when conducting qualitative research, and this felt particularly important within the context of death and dying. Finally, I have highlighted how the research has impacted on my clinical work, and my plans for dissemination.

### References

- Birks, M. & Mills, J. (2011). *Grounded Theory: A Practical Guide*. Los Angeles, CA: Sage Publications Ltd.
- Blume-Marcovici, A. C., Stolberg, R. A., & Khademi, M. (2013). Do therapists cry in therapy? The role of experience and other factors in therapists' tears. *Psychotherapy*, 50 (2), 224-234. doi: 10.1037/a0031384
- Counselman, E. F. (1997). Self-disclosure, tears, and the dying client. *Psychotherapy*, 34, 233-237. doi: 10.1037/h0087715
- Department of Health and Social Care. (2008). *End of life care strategy: Promoting high quality care for all adults at the end of their life*. London: Crown Copyright. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136431/End\\_of\\_life\\_strategy.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf)
- Dickens, C. (2016). *Great Expectations*. Great Britain: The Planet. (Original work published 1890).
- Dickson-Swift, V. (2017). Emotion and sensitive research. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 1-18). Singapore: Springer.
- Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2007). Doing sensitive research: What challenges do qualitative researchers face? *Qualitative Research*, 7 (3), 327-353. doi: 10.1177/1468794107078515
- Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2009). Researching sensitive topics: Qualitative research as emotion work. *Qualitative Research*, 9 (1), 61-79. doi: 10.1177/1468794108098031
- Fitzpatrick, P., & Olsen, R. E. (2015). A rough road map to reflexivity in qualitative research into emotions. *Emotion Review*, 7 (1), 49-54. doi:10.1177/1754073914544710
- Hockey, J. (2007). Closing in on death? Reflections on research and researchers in the field of death and dying. *Health Sociology Review*, 16 (5), 436-446. doi: 10.5172/hesr.2007.16.5.436

- Holt, A. (2010). Using the telephone for narrative interviewing: A research note. *Qualitative Research*, 10 (1), 113–121. doi:10.1177/1468794109348686
- Katz, R. S., & Genevay, B. (2002). Our patients, our families, ourselves: The impact of the professional's emotional responses on end-of-life care. *American Behavioral Scientist*, 46 (3), 327-339. doi: 10.1177/000276402237767
- Kleinman, S., & Copp, M. A. (1993). *Emotions and Fieldwork*. Thousand Oaks: Sage publishing Ltd.
- Krau, S. D. (2016). The difference between palliative care and end of life care: More than semantics. 51 (3), *Nursing Clinics of North America*, 51 (3), 9-10. doi: 10.1016/j.cnur.2016.07.002
- Laimputtong, P. (2007). *Researching the vulnerable: A guide to Sensitive research methods*. London: Sage Publications Ltd.
- Lee, R., & Lee, Y. (2012). Methodological research on “sensitive” topics: A decade review. *Bulletin of Sociological Methodology*, 114, 35-49. doi: 10.1177/0759106312437139
- Mathias, Z. & Harcourt, D. (2014). Dating and intimate relationships of women with below knee amputation: An exploratory study. *Disability and Rehabilitation*, 36 (5), 395-402. doi:10.3109/09638288.2013.797509
- NHS England (2014). NHS England's actions for end of life care: 2014-16. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>
- Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in Nursing & Health*, 31 (4), 391–398. doi:10.1002/nur.20259
- Reinharz, S. (1992). *Feminist Methods in Social Research*. New York: Oxford University Press.
- Rhue, J. W. (2001). Death, bereavement, and the therapist. In S. Kahn, & E. Fromm (Eds.), *Changes in the therapist* (pp. 117-131). Mahwah: Erlbaum Publishers.
- Shaw, R. L. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, 7 (3), 233-243. doi: 10.1080/14780880802699092

- Sherry, E. (2013). The vulnerable researcher: Facing the challenges of sensitive research. *Qualitative Research*, 13 (3), 278-288. doi: 10.1108/QRJ-10-2012-0007
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications Ltd.
- Smith, J., A., & Osborn, M. (2003). *Interpretative phenomenological analysis in qualitative psychology: A practical guide to research methods*. London: Sage Publications Ltd.
- Taylor, G. W., & Ussher, J. M. (2001). Making sense of S&M: A discourse analytic account. *Sexualities*, 4 (3), 293–314. doi:10.1177/136346001004003002
- Valizadeh, S., Dadkhah, B., Mohammed, E., & Hassankhani, H. (2014). The perception of trauma patients from social support in adjustment to lower-limb amputation: A qualitative study. *Indian Journal of Palliative Care*, 20 (3), 229–238. doi:10.4103/0973-1075.138401

**Section Four: Ethics Documentation**

Word Count: 5027

Laura-Jayne Richardson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

## Welcome to the Integrated Research Application System

## IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

**Please enter a short title for this project** (maximum 70 characters)

Crying with patients in palliative care services.

**1. Is your project research?**

Yes  No

**2. Select one category from the list below:**

- Clinical trial of an investigational medicinal product
- Clinical investigation or other study of a medical device
- Combined trial of an investigational medicinal product and an investigational medical device
- Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- Basic science study involving procedures with human participants
- Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- Study involving qualitative methods only
- Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- Study limited to working with data (specific project only)
- Research tissue bank
- Research database

**If your work does not fit any of these categories, select the option below:**

Other study

**2a. Please answer the following question(s):**

- a) Does the study involve the use of any ionising radiation?  Yes  No
- b) Will you be taking new human tissue samples (or other human biological samples)?  Yes  No
- c) Will you be using existing human tissue samples (or other human biological samples)?  Yes  No

**3. In which countries of the UK will the research sites be located?** *(Tick all that apply)*

- England
- Scotland

- Wales  
 Northern Ireland

**3a. In which country of the UK will the lead NHS R&D office be located:**

- England  
 Scotland  
 Wales  
 Northern Ireland  
 This study does not involve the NHS

**4. Which applications do you require?**

*IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.*

- IRAS Form  
 Confidentiality Advisory Group (CAG)  
 National Offender Management Service (NOMS) (Prisons & Probation)

*For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.*

*For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.*

**Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?**

- Yes  No

**4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:**

- Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
- Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
- Research limited to use of previously collected, non-identifiable information
- Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
- Research limited to use of acellular material
- Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
- Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

**5. Will any research sites in this study be NHS organisations?**

- Yes  No

**6. Do you plan to include any participants who are children?**

Yes  No

**7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?**

Yes  No

*Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.*

**8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?**

Yes  No

**9. Is the study or any part of it being undertaken as an educational project?**

Yes  No

Please describe briefly the involvement of the student(s):  
Chief Investigator

**9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?**

Yes  No

**10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?**

Yes  No

**11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?**

Yes  No



**Integrated Research Application System**  
**Application Form for Research involving qualitative methods only**

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

**Short title and version number:** (maximum 70 characters - this will be inserted as header on all forms)  
 Crying with patients in palliative care services.

**PART A: Core study information**
**1. ADMINISTRATIVE DETAILS**
**A1. Full title of the research:**

Crying with patients in palliative care services: The experiences of psychological therapists.

**A2-1. Educational projects**

Name and contact details of student(s):

**Student 1**

	Title	Forename/Initials	Surname
	Miss	Laura-Jayne	Richardson
Address	8 Cote Green Road		
	Marple Bridge		
	Stockport		
Post Code	SK6 5EH		
E-mail	l.richardson6@lancaster.ac.uk		
Telephone	07742107222		
Fax			

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:

Doctorate in Clinical Psychology

Name of educational establishment:

Lancaster University

Name and contact details of academic supervisor(s):

**Academic supervisor 1**

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Address	Doctorate in Clinical Psychology		

	Faculty of Health and Medicine
	Furness College, Lancaster University
Post Code	LA1 4YG
E-mail	i.j.fletcher@lancaster.ac.uk
Telephone	01524593301
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):

*Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.*

Student(s)	Academic supervisor(s)
------------	------------------------

<b>Student 1</b> Miss Laura-Jayne Richardson	<input checked="" type="checkbox"/> Dr Ian Fletcher
--	---

*A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.*

#### A2-2. Who will act as Chief Investigator for this study?

- Student  
 Academic supervisor  
 Other

#### A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Miss Laura-Jayne Richardson
Post	Trainee Clinical Psychologist
	MSc in Psychology - Merit
	BSc in Psychology - 2:1
Qualifications	A Level Psychology A
	A Level Art B
	A Level Philosophy C
	9 GCSE's grades A* - B (English literature and language, Dual award science, Art, Mathematics, French, Geography, Religious Studies).
ORCID ID	
Employer	Lancashire Care NHS Foundation Trust
Work Address	Doctorate in Clinical Psychology
	Faculty of Health and Medicine
	Furness College, Lancaster University
Post Code	LA1 4YG
Work E-mail	l.richardson6@lancaster.ac.uk
* Personal E-mail	laura_jayne25@hotmail.com
Work Telephone	01614499902
* Personal Telephone/Mobile	07742107222
Fax	

*\* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*

*A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.*

**A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?**

*This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.*

	Title Forename/Initials Surname
	Dr Diane Hopkins
Address	Research Integrity and Governance Officer Research Services, Room B14 Furness College, Lancaster University
Post Code	LA1 4YG
E-mail	ethics@lancaster.ac.uk
Telephone	01524592838
Fax	

**A5-1. Research reference numbers. Please give any relevant references for your study:**

Applicant's/organisation's own reference number, e.g. R & D (if available):	N/A
Sponsor's/protocol number:	N/A
Protocol Version:	N/A
Protocol Date:	
Funder's reference number:	N/A
Project website:	N/A

**Additional reference number(s):**

Ref.Number	Description	Reference Number
N/A		N/A

*Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.*

**A5-2. Is this application linked to a previous study or another current application?**

Yes  No

*Please give brief details and reference numbers.*

N/A

**2. OVERVIEW OF THE RESEARCH**

*To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.*

**A6-1. Summary of the study.** *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This qualitative study aims to explore the experiences, or views, of psychological therapists who cry when working with a patient within a palliative care context. It intends to answer the research question: 'How do therapists working in

palliative care view or experience crying in the therapeutic encounter?" The term 'therapist' is used to refer to any clinical staff that provide a one to one psychological intervention or talking therapy within their role, for which they receive clinical supervision.

To date, there has been limited research exploring the qualitative experiences of psychological therapists who cry when with a patient. This is despite one mixed-method study suggesting that almost three quarters of therapists reported experiences of crying (Blume-Marcovici, Stolberg & Khademi, 2013). This could suggest there are gaps within our knowledge of the factors that contribute to the therapists' tears, and the impact this could have on the therapeutic encounter. In a palliative care context, it may be even more likely for therapists to experience tears, due to the focus of the therapeutic work being on end of life care and not recovery. Therefore, this would make the current research relevant, and potentially frequently occurring within therapeutic practice in palliative care.

It is anticipated that between two and 12 individuals will take part in the research. This is in line with recommendations for the proposed method of analysis, which is Interpretative Phenomenological Analysis (IPA), given the time-consuming and detailed nature of this method (Smith, Flowers & Larkin, 2009). Participants will be encouraged to discuss their experiences, or views, and reflect on these during a semi-structured interview with the Chief Investigator. This interview will last approximately one hour. After the interviews are completed, they will be analysed using IPA to see whether any themes emerge from the data.

**A6-2. Summary of main issues.** *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

*Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.*

#### Gaining informed consent

All participants will be required to read and sign a consent form before taking part in the research. This process differs slightly depending on where the interview takes place. For face to face interviews, the Chief Investigator will complete this form with participants prior to starting the interview. For individuals who wish to be interviewed over the telephone or Skype, they will be asked to read, sign, and return the consent form through the post, prior to the interview being completed. They will be encouraged to keep a copy of this form for their own records. All participants will be given the opportunity to ask questions about the research before consenting to take part.

#### Confidentiality

The initial communication (email and blog) will be sent on behalf of the Chief Investigator to potential participants via the organisations that have agreed to assist with recruitment. Therefore, the identity of potential participants will remain confidential, unless they choose to contact the Chief Investigator directly to participate in the research. Only the Chief Investigator will have access to participants personal data, and the recruiting organisations will not know which individuals decided to take part in the research.

All participants will receive a copy of the participant information sheet and consent form which includes information regarding confidentiality. This will also be verbally explained to participants in advance of completing the semi-structured interviews.

Consent forms, and other participant information in paper form, will be stored in a locked cabinet at the Chief Investigator's home address that only they have access to. Consent forms will be stored separately to other anonymised data. Audio data, will be securely transferred to the Chief Investigators safe file space via the Lancaster University Virtual Private Network (VPN), and deleted from the Dictaphone. Transcripts and analysis will be stored and completed securely on this file space, and accessed through the VPN. Transcripts will be anonymised, and participants will be given a pseudonym. Any identifiable information (E.g., participants name, demographic information, location, turns of phrase) will be removed from the transcripts and any quotes used in the write-up of the research paper. All electronic information/materials will be password protected and encrypted, and destroyed after a period of 10 years. All paper data will be destroyed as soon as the project is complete. Consent forms will be saved in an electronic format and securely transferred to the DCLinPsy admin team, where they are stored for a period of 10 years.

#### Consideration of risk / Limits to confidentiality

Risk will be considered throughout the project in regards to both the participant and Chief Investigator. The limits of confidentiality are explained to all participants prior to the interviews, and is clearly stated on the participant information sheet and consent form. Participants who wish to undertake their interview at work will be informed that the Chief Investigator cannot control for interruptions, noise, soundproofing Etc., and that for this reason, full confidentiality

cannot be guaranteed. Additionally, participants will be informed that if they express any intent to harm themselves or others, then confidentiality will be broken in order to keep them safe. Where possible, this would be discussed with the participant first. If this were to happen, the Chief Investigator would contact the research team to ask for guidance and determine an appropriate course of action. For all participants, details of support networks have been included on the participant information sheet and debrief sheet, and participants are encouraged to contact their GP or Trust staff support services in the first instance.

As participants will be offered the opportunity to be interviewed within their own home, the Lancaster University DClinPsy Lone Worker Policy for Trainee Psychologists will be followed. This involves providing a member of the research team with an envelope containing details of the interview. This would only be opened if the Chief Investigator did not make contact by an agreed time. In this instance, the police would be called.

#### Right to withdraw

Participants will be informed that they can withdraw from the project for a period of two weeks following their interview being completed. After this, it may be difficult to remove their data, as it will have merged with that of other participants and used to generate the findings, although every effort will be made where possible. Participants will be made aware that there will be no negative implications for choosing to withdraw their data from the research.

### 3. PURPOSE AND DESIGN OF THE RESEARCH

#### A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- Case series/ case note review
- Case control
- Cohort observation
- Controlled trial without randomisation
- Cross-sectional study
- Database analysis
- Epidemiology
- Feasibility/ pilot study
- Laboratory study
- Metanalysis
- Qualitative research
- Questionnaire, interview or observation study
- Randomised controlled trial
- Other (please specify)

#### A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

This study aims to answer the following research question: 'How do therapists working within palliative care view, or experience, crying within the therapeutic encounter?'

#### A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Not applicable.

#### A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Although a relatively neglected area within the literature, recent research has suggested that the majority of psychological therapists have cried when with a client during a therapy session. In a mixed-method survey of 684 U.S. psychologists, postdoctoral psychology fellows, and psychology graduate students, Blume-Marcovici, Stolberg and Khademi (2013) reported that 72% of therapists had cried in therapy in their role as a therapist. They found that although the majority of therapists reported crying in therapy, there were certain factors, such as, gender, personality and empathy, that did not appear to influence whether tears were shed when with a client. Instead, contextual factors

appeared to have more impact, such as the clinical experience of the therapist, their theoretical orientation, and affective tone, or feelings, present during the session. Furthermore, the majority of therapists did not find that their tears had a negative impact overall, but that this demonstration of emotion could actually be useful, and assist the therapeutic relationship. In a paper published this year, Matise (2016) developed a quantitative questionnaire to 'measure' therapists crying in session, with the aim of this being used in larger research studies. This suggests that despite the limited research to date, the concept of therapists' crying in therapy is an area of current relevance in the psychology / therapeutic literature, and is anticipated to grow.

To date, the majority of the qualitative literature on therapists' crying in therapy, is taken from the patient's perspective. This literature indicates that the therapist's tears can be perceived by the client as either detrimental or beneficial to therapy outcome (Pendleton, 2015; Tritt, Kelly & Waller, 2015). This is similar to the literature on self-disclosure in therapy, where it has been suggested that the client can consider the psychotherapy as more effective when therapists appropriately self-disclose (Barrett & Berman, 2001). Furthermore, it suggests that crying in session, if done within the same spirit that appropriate self-disclosure is, could be considered to make the therapy more effective from the client's perspective.

There is even less literature considering the qualitative experiences of the therapists who cry during therapy with a client (British Psychological Society, 2013). To date, there are three published case studies detailing the therapists own accounts of crying in therapy with clients (Counselman, 1997; Owens, 2005; Rhue, 2001). Overall, these papers suggest that crying can at times be therapeutically appropriate and beneficial to treatment. One of these case studies considered the therapist's own experiences of providing therapy to a couple when one partner was diagnosed with a terminal illness (Counselman, 1997). In this particular case, the therapist decided to change their approach during therapy by self-disclosing more frequently 'in service of greater connection with the clients' (p. 233). This literature is important, as it suggests that this particular therapist altered their usual way of working, once a client was diagnosed with a terminal illness. Furthermore, they felt willing to share more of themselves within the therapeutic relationship, and re-considered previously established professional boundaries.

As the case study by Counselman (1997) only considers the experience of one individual within this context, further research into terminal diagnosis would help to provide a greater insight into this phenomenon. Although there has been a recent published qualitative study exploring therapist's experiences of crying in therapy, this research was conducted with a sample of 11 therapists working in a university counselling setting (Matise, 2015). Matise reported that certain factors help to determine whether tears were viewed as useful to the therapeutic encounter: the degree and timing of the tears, how culturally acceptable the tears were, and gender of the therapist. It also depended upon whether the tears were viewed as genuine and relevant to the client and the therapy session, as opposed to unresolved difficulties that the therapist was experiencing, which could potentially be interpreted as an inappropriate disclosure. Despite this, they reported that a lack of clarity existed in relation to crying and how therapists' experience intense emotions within the therapeutic relationship. Furthermore, as this sample considered the experiences of counsellors within a university context, it could be argued that psychological therapists working within palliative care are likely to have a different experience. Literature considering medical doctors suggests that the setting in which emotions are experienced is significant, as supported by Zambrano and Barton (2011), who reported that doctors experience death differently depending upon the context in which they work. This supports the rationale for looking into the same phenomenon within a different context in the current research, as the findings are likely to provide a unique insight into a relevant field.

#### The current research

To date, there has been very little qualitative research exploring the concept of therapists crying with clients in therapy. This implies that gaps may exist in our knowledge of the conditions and factors that are likely to contribute to the therapists' tears, and the impact this may have on the therapeutic encounter. In particular, it is possible that this phenomenon may be more likely within a palliative care context, due to the focus of the therapeutic work being on the end of life, instead of recovery. Therefore, this would make the target phenomenon relevant, and potentially more frequently occurring, within therapeutic practice in palliative care.

**A13. Please summarise your design and methodology.** *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

As this project wishes to explore the subjective experience and views of psychological therapists who cry when with a patient whilst working within palliative care, a qualitative design is appropriate to the research question. Participants will be asked to undertake semi-structured interviews, and this data will be analysed using Interpretative Phenomenological Analysis (IPA). This is an appropriate type of analysis for the current research, as it is concerned with exploring an individual's experience of something (Smith, Flowers & Larkin, 2009). Additionally, asking participants to complete semi-structured interviews is considered an effective way of accessing detailed accounts, personal stories, thoughts and feelings about a chosen topic (Reid, Flowers & Larkin, 2005).

It is anticipated that between two and 12 individuals will take part in the research. This is in line with recommendations for IPA research at doctoral level, due to the detailed and thorough analysis process (Smith, Flowers & Larkin, 2009). Interviews will take place face to face, over the telephone, or through Skype. Participants will be given a choice as to how and where they would like to be interviewed, where possible. Participants that wish to be interviewed over Skype will be informed of the limitations of this method, as it is not wholly secure. Each participant will be asked to complete one interview, that will last approximately 60 minutes, depending on how much they wish to say. Participants will be recruited on a first come first served basis, which is clearly stated on the participant information sheet. Individuals that want to take part but cannot due to reaching full capacity, will be thanked for their interest in the study, and informed that they can request a summary of the findings.

Participants will be psychological therapists that work within a palliative care service, and have experiences or views that they wish to share on crying when working with a patient. The term 'psychological therapist' can refer to any clinical staff providing one to one psychological interventions or counselling/talking therapies, for which they receive clinical supervision.

Recruitment will take place through several health-related organisations: [REDACTED]

[REDACTED] Communication sent by the above organisations is on behalf of the Chief Investigator, and differs for each service. [REDACTED] have agreed to forward a communication email to service members who meet the inclusion/exclusion criteria. This email contains contact details for the Chief Investigator, and has a link to a Lancaster university website where individuals can access a copy of the participant information sheet and consent form. [REDACTED] have agreed to send the same email, but have also asked that the Chief Investigator attends one of their meetings to informally present the research. [REDACTED] have asked that the Chief Investigator write a blog that can be included in their e-newsletter. This blog will contain information about the study including contact details for the Chief Investigator, and a link to the Lancaster University website. [REDACTED] have an online 'Discussion List' and it has been agreed with a contact at [REDACTED] that the Chief Investigator's field supervisor can post an email on the list to advertise the research.

Additionally, snowball sampling will be used to assist recruitment, whereby individuals that hear about the research are able to let other potential participants know about the project (Willig, 2008). This is clearly stated on all communication sent to potential participants.

**A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?**

- Design of the research
- Management of the research
- Undertaking the research
- Analysis of results
- Dissemination of findings
- None of the above

*Give details of involvement, or if none please justify the absence of involvement.*

There are two field supervisors involved with the project who are clinical psychologists currently working within palliative care services in the NHS.

The field supervisors will provide input regarding the design, management, and dissemination of the project. They will provide some input to analysis, and have agreed to check / advise on the overall themes once the analysis is complete, and individuals are anonymous within the research. This is due to the possibility that they may know potential participants due to working within the current field and wishing to protect confidentiality. Regarding dissemination, they will assist with the write-up of the research and provide draft reads at various stages, and consider appropriate dissemination (E.g., any presentations for Lancaster University, poster, and possible publication in a relevant journal).

To date, they have assisted with the design of the research, providing feedback on the initial thesis proposal, assisting with means of recruitment, and the interview schedule. They have also provided a draft read of the ethics application before submission.

#### 4. RISKS AND ETHICAL ISSUES

## RESEARCH PARTICIPANTS

**A15. What is the sample group or cohort to be studied in this research?**

Select all that apply:

- Blood
- Cancer
- Cardiovascular
- Congenital Disorders
- Dementias and Neurodegenerative Diseases
- Diabetes
- Ear
- Eye
- Generic Health Relevance
- Infection
- Inflammatory and Immune System
- Injuries and Accidents
- Mental Health
- Metabolic and Endocrine
- Musculoskeletal
- Neurological
- Oral and Gastrointestinal
- Paediatrics
- Renal and Urogenital
- Reproductive Health and Childbirth
- Respiratory
- Skin
- Stroke

Gender: Male and female participants

Lower age limit: 18 Years

Upper age limit: No upper age limit

**A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).**

- Participants must be psychological therapists who currently work within a palliative care context.
- Participants will have worked within a palliative care service for a minimum of six months at the time of interview.
- Participants may be male or female. Individuals will not be excluded based on gender.
- Participants will be over 18 years old.

**A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).**

- Participants will not be excluded from the research based on their job title (E.g., psychologist, psychotherapist, counsellor, Etc.), but may be excluded based on their role. For example, participants must be able to discuss their experiences, or views, of crying when working therapeutically on a one to one basis with a patient (E.g., providing psychological interventions or counselling), and must receive clinical supervision to support this role.



-Participants must be English speaking and able to communicate well enough to participate in an interview lasting approximately one hour. This is due to financial restrictions of the research and being unable to afford a translator.

### RESEARCH PROCEDURES, RISKS AND BENEFITS

**A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.**

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Potential participants will receive an email via the organisations that have agreed to assist with recruitment.	Two	N/A	Approx. 5 minutes.	Information about the study will be sent on behalf of the Chief Investigator by the organisations that have agreed to assist with recruitment. This process may be repeated in two weeks time if there is not enough interest generated in the research by then.
Eligibility check (check that potential participants meet the inclusion and exclusion criteria).	One	N/A	Approx. 10 minutes.	The Chief Investigator to discuss eligibility criteria over the telephone with potential participants.
Seeking informed consent.	One	N/A	Approx. 10 minutes.	The Chief Investigator to gain informed consent. For face to face interviews this will take place at the time and place of the interview (workplace or home). For telephone or Skype interviews, this will take place in advance of the interview and be returned to the Chief Investigator via post or email.
Semi-structured interviews.	One	N/A	Approx. one hour.	The Chief Investigator will complete all interviews for the study. Interviews will take place at a location to suit the participant, which may be at their home address, workplace, telephone or Skype.
Provide participants with the debrief sheet and an opportunity to ask questions.	One	N/A	Approx. 10-20 mins.	The Chief Investigator will complete this following the interview. They will hand participants a copy of the debrief sheet when the interviews were face to face, and post or email a copy to those that completed the interview over the telephone or Skype. The information will be discussed with participants immediately following the interview.

**A21. How long do you expect each participant to be in the study in total?**

After gaining informed consent, participants will be expected to participate in a semi-structured interview with the Chief Investigator lasting approximately one hour (60 minutes), depending on how much they wish to say. Following completion of the interview, participants will be given the debrief sheet and asked whether they have any questions. This is anticipated to take between 10 and 20 minutes. Therefore, the total amount of time that participants will be in the study is between 60 and 100 minutes.

**A22. What are the potential risks and burdens for research participants and how will you minimise them?**

*For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.*

Although it is not anticipated that taking part in this research will cause any distress, it is important to consider the Chief Investigators response in such a case. If this were to happen, the Chief Investigator would pause the interview

to ask the participant how they were, and whether they would like to continue. This may be more challenging with interviews that take place over the telephone, as the Chief Investigator may not be able to tell as easily that the individual is becoming distressed. To overcome this, the Chief Investigator will remain attentive to the wellbeing of the participant throughout the interview, and check in with them if they have any concerns.

Details of support networks have been included on both the participant information sheet and the debrief sheet, and participants are encouraged to contact their GP or Trust support services in the first instance, if they require this.

**A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?**

Yes  No

**A24. What is the potential for benefit to research participants?**

It is hoped that this research will help to increase our understanding of the experiences and views of psychological therapists who cry when with a patient whilst working within palliative care services. Although participants may find it interesting to participate, there are no direct benefits to taking part, although some people may find it helpful to talk about their experiences. Participants will not be offered money or any other incentives for taking part in this study.

**A26. What are the potential risks for the researchers themselves? (if any)**

Although it is not anticipated that completing the research will cause any distress, the Chief Investigator would be able to contact their own GP or research team, for support if needed.

Additionally, as participants will be offered the opportunity to be interviewed in their own home or at their place of work, the Lancaster University DClinPsy Lone Worker Policy for trainees will be followed to keep the Chief Investigator safe. This process involves the Chief Investigator informing a 'contact person,' who will be a field supervisor, that they will be conducting an interview in someone's home or place of work. Prior to the interview, the contact person will be provided with a sealed envelope which contains the Chief Investigator's information, car details (registration, make and model) and details of the visit (the participants name, address, date of interview, start time and estimated finish time). If the Chief Investigator does not message or telephone the contact person by an agreed time, then they will try to reach them to check they are okay. If there is no response, then the contact person is required to call the police and open the sealed envelope to pass the information on.

## RECRUITMENT AND INFORMED CONSENT

*In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.*

**A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?** For example, identification may involve a disease register, computerised search of social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).

Participants will be recruited via several healthcare related organisations. These are: [REDACTED]  
[REDACTED] Communication sent by the above organisations is on the behalf of the Chief Investigator, and will contain her contact name, telephone number, and email address. Potential participants will be encouraged to contact her directly if they wish to learn more about the project, or they would like to take part.

The means of recruitment will differ depending upon the organisation:

[REDACTED] have agreed to forward a communication from the Chief Investigator via email to relevant group members. These members will be defined based on the inclusion and exclusion criteria mentioned previously. The email will contain some basic information about the study, and contain a link to a Lancaster University webpage where individuals can access the participant information sheet (PIS) and consent form. This communication email will contain the main researcher's name, university mobile telephone number and email address. An email from the founder of [REDACTED] has been included in the Appendices section of the ethics Protocol, confirming that they are willing to assist with recruitment.



Yes     No

*If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.*

*If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.*

If participants decide to take part, they will be asked to sign the consent form before the interview, and demographic information will also be collected at this time (only demographic information that is required will be collected: age, gender, professional role, therapeutic orientation, and amount of time working within palliative care).

For face to face interviews, the Chief Investigator will check that participants have considered the participant information sheet for a period of at least one day (24 hours) before agreeing to take part. Following this, the main researcher will go through the consent form with participants before the interview begins, and ask them to sign the form at this time. Participants will be offered the opportunity to ask any questions about the research during this time.

For individuals who are interviewed over Skype or the telephone, they will be asked to read, sign, and return the consent form through the post, or via email if they are able to scan and send a signed copy, prior to the interview being completed. They will be encouraged to keep a copy of this for their own records.

Participants will be reminded of the information provided on the consent form prior to commencing their interview, in particular, that they are able to withdraw from the study for a period of two weeks following the interview being completed. After this period, it may be difficult to exclude a participants data, as it may have been merged with other individuals data during the analysis process. Every effort will be made where possible however to extract this data.

*If you are not obtaining consent, please explain why not.*

Not applicable.

*Please enclose a copy of the information sheet(s) and consent form(s).*

**A30-2. Will you record informed consent (or advice from consultees) in writing?**

Yes     No

**A31. How long will you allow potential participants to decide whether or not to take part?**

All participants will be given at least one day (24 hours) to read over the participant information sheet before deciding whether they wish to take part.

**A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?(e.g. translation, use of interpreters)**

As participants are expected to participate in semi-structured interviews lasting approximately one hour, it is important that they are able to cope with the demands of the interview, and can provide sufficient detail and reflections about the target phenomenon (Willig, 2008). Therefore, participants must be English speaking and able to communicate well enough to participate. This is due to financial restrictions placed on the research, and being unable to afford a translator.

**A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.**

- The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

- The participant would continue to be included in the study.
- Not applicable – informed consent will not be sought from any participants in this research.
- Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

*Further details:*

Participants must be able to provide informed consent to take part in this research. Participants are only required to complete one interview with the Chief Investigator lasting approximately one hour. As this would represent the participants full involvement within the research, there would be no need to exclude data that was collected when the participants had the capacity to consent.

**CONFIDENTIALITY**

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

**Storage and use of personal data during the study**

**A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? (Tick as appropriate)**

- Access to medical records by those outside the direct healthcare team
- Access to social care records by those outside the direct social care team
- Electronic transfer by magnetic or optical media, email or computer networks
- Sharing of personal data with other organisations
- Export of personal data outside the EEA
- Use of personal addresses, postcodes, faxes, emails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals
- Use of audio/visual recording devices
- Storage of personal data on any of the following:
- Manual files (includes paper or film)
  - NHS computers
  - Social Care Service computers
  - Home or other personal computers
  - University computers
  - Private company computers
  - Laptop computers

*Further details:*

Audio data will be transferred from the Chief Investigator's Dictaphone to a safe personal file space via the Lancaster University Virtual Private Network (VPN). This transfer will take place at the earliest possible time as the recording device is not encryptable. In the meantime, the recording device will be stored in a locked at the Chief Investigators home, that only they have access to. Participant interview data will be deleted from the recording device once transferred to the server, and deleted from the server once the project is complete. Transcription and analysis of the interview data will be completed by the Chief Investigator and stored on the same file space, so interview data can be kept and accessed securely through the Lancaster VPN.

Any personal information, such as demographic information or contact details for participants in paper form, will be

stored in a locked cabinet that only the Chief Investigator has access to at their home address. This information will be kept separately from other anonymous participant information. Only the Chief Investigator will have access to the participant's personal data. All personal/demographic data will be destroyed once the project is complete.

Transcripts will be anonymised and identifiable information will be removed, such as, the participants name, any demographic information, and location details. The Chief Investigator will use pseudonyms in these transcripts and in the write-up of the research paper/use of direct quotations. Either the first audio recording of an interview, or a typed-up and anonymised transcript, will be shared with the Chief Investigator's academic supervisor. The purpose of this is to ensure that the interviews are completed to a good standard, and to ask for feedback on the Chief Investigator's style and questions during the interview. The Chief Investigator will share anonymised, coded, transcripts with their supervisors at a later stage, in order to access support with the analysis.

All electronic data on the computer, laptop, or USB, will be encrypted and password protected. Once the project is complete, all remaining paper and electronic data will be destroyed, excluding the participant consent forms. These will be scanned and saved in an electronic format and paper copies will be destroyed. The electronic consent forms will be securely transferred to the DClinPsy admin team, under protection and encryption. This data will be stored at Lancaster University for a period of ten years, and destroyed following this.

**A37. Please describe the physical security arrangements for storage of personal data during the study?**

Consent forms, and other participant information in paper form, will be stored in a locked cabinet that only the Chief Investigator has access to at their home address. The consent forms will be stored separately to any other anonymised data. Only the Chief Investigator will have access to the participant's personal data. Emails/letter correspondence from participants will be destroyed once the project is complete, or sooner, if a participant wishes to withdraw from the study for any reason.

Audio data will be transferred to the Chief Investigator's personal file space via the Lancaster VPN and password protected as soon as possible following the interview, so it can be stored securely. Participant interview data will be deleted from the recording device once transferred to the server, and deleted from the server once the project is complete.

Transcription and analysis of interview data will be conducted by the Chief Investigator and stored on their secure file space. Analysis will take place using Word or Excel, either at University or the Chief Investigator's home address, as the transcripts can be accessed securely through the Lancaster VPN.

All electronic data on the computer, laptop, or USB, will be encrypted and password protected. Once the project is complete, all paper data will be destroyed. The participant consent forms will be scanned and saved in an electronic format and the paper copies will be destroyed. Following this, they will be securely transferred to the DClinPsy admin team, under protection and encryption. This data will be stored at Lancaster University for a period of 10 years, and destroyed following this. Electronic data will also be retained for a period of 10 years in case of future analysis for publication purposes by the Chief Investigator.

**A38. How will you ensure the confidentiality of personal data? Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.**

Any consent forms, and other participant information in paper form, will be stored in a locked cabinet that only the main researcher has access to at their home address. Only the Chief Investigator will have access to the participant's personal data. Organisations that assisted with recruitment will not be made aware of which individuals decided to take part in the research.

Transcripts will be anonymised and any identifiable information will be removed, such as, the participants name, any demographic information, and location details. The Chief Investigator will use pseudonyms in these transcripts and in the write-up of the research paper, and again, any potentially identifiable information will be removed. Participants will be made aware that direct quotes from the interviews will be used in the final write-up, but that these will be anonymised and any identifiable information will be removed.

All electronic data on the computer, laptop, or USB, will be encrypted and password protected. Once the project is complete, all paper data will be destroyed. Consent forms will be scanned and saved in an electronic format and the paper copies destroyed. Following this, they will be securely transferred to the DClinPsy admin team, under protection and encryption. This data will be stored at Lancaster University for a period of 10 years, and destroyed following this. As mentioned above, electronic data will also be retained for a period of 10 years in case of future analysis.

**A40. Who will have access to participants' personal data during the study? Where access is by individuals outside the**

*direct care team, please justify and say whether consent will be sought.*

The Chief Investigator will be the only individual who has access to participants personal information. Personal information will not be shared within the research team (field and research supervisors) unless a participant expresses that they, or others, are at risk of harm. In this instance, it may be that the Chief Investigator may need to break confidentiality in order to keep the participant safe.

#### Storage and use of data after the end of the study

##### **A41. Where will the data generated by the study be analysed and by whom?**

The interview data will be analysed by the Chief Investigator. The Chief Investigator will share anonymised, coded, transcripts with their research team at a later stage, in order to access support with the analysis.

Audio data will be transferred from the Chief Investigator's recording device to a secure file space via the Lancaster VPN. Transcription and analysis of interview data will be conducted by the Chief Investigator from this secure file, and stored on this space. Analysis will take place using Word or Excel, either at University or the Chief Investigator's home address, as the transcripts can be accessed securely through the Lancaster VPN.

##### **A42. Who will have control of and act as the custodian for the data generated by the study?**

	Title	Forename/Initials	Surname
	Dr	Bill	Sellwood
Post	Programme Director		
Qualifications	PhD		
Work Address	Doctorate in Clinical Psychology		
	Furness College, Lancaster University		
	Lancaster		
Post Code	LA1 4YG		
Work Email	b.sellwood@lancaster.ac.uk		
Work Telephone	01524593998		
Fax			

##### **A43. How long will personal data be stored or accessed after the study has ended?**

- Less than 3 months
- 3 – 6 months
- 6 – 12 months
- 12 months – 3 years
- Over 3 years

##### **A44. For how long will you store research data generated by the study?**

Years: 10  
Months: 0

##### **A45. Please give details of the long term arrangements for storage of research data after the study has ended. Say**

*where data will be stored, who will have access and the arrangements to ensure security.*

Once the project is complete, all paper data will be destroyed. Consent forms will be scanned and saved in an electronic format and the paper copies will be destroyed. Following this, they will be securely transferred to the DClinPsy admin team, under protection and encryption. This data will be stored at Lancaster University for a period of 10 years, and destroyed following this. Other electronic data will also be retained for a period of 10 years, in case of future analysis.

The data generated from the study will not be made available to researchers that are not the Chief Investigator. This is to ensure confidentiality, anonymity and specificity of data.

#### INCENTIVES AND PAYMENTS

**A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?**

Yes  No

**A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?**

Yes  No

**A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?**

Yes  No

#### NOTIFICATION OF OTHER PROFESSIONALS

**A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?**

Yes  No

*If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.*

#### PUBLICATION AND DISSEMINATION

**A50-1. Will the research be registered on a public database?**

Yes  No

*Please give details, or justify if not registering the research.*  
No suitable database exists.

*Registration of research studies is encouraged wherever possible.*  
*You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.*



**A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:**

- Peer reviewed scientific journals
- Internal report
- Conference presentation
- Publication on website
- Other publication
- Submission to regulatory authorities
- Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- No plans to report or disseminate the results
- Other (please specify)

A summary of the findings will be offered to participants that took part, individuals that wanted to take part but were unable, and organisations that assisted with recruitment. The thesis will also be available after the project is submitted, which is a public document.

**A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?**

All participants will be provided with a pseudonym and any identifiable information will be removed to ensure participants remain anonymous. Although direct quotations will be used in the write-up, any information within these quotes that could reveal a participants identity will be removed (for example, turns of phrase commonly used by the participant, location, or demographic information). No information will be included that would reveal the organisations that assisted with recruitment, or the particular services within which participants work.

**A53. Will you inform participants of the results?**

- Yes     No

*Please give details of how you will inform participants or justify if not doing so.*

Participants that took part in the research will be asked if they would like a summary of the findings once the research has been submitted to Lancaster University. This information will also be shared with the organisations that assisted with recruitment, although the identity of the individuals that took part will remain confidential.

**5. Scientific and Statistical Review****A54-1. How has the scientific quality of the research been assessed? Tick as appropriate:**

- Independent external review
- Review within a company
- Review within a multi-centre research group
- Review within the Chief Investigator's institution or host organisation
- Review within the research team
- Review by educational supervisor
- Other

*Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:*

A research proposal suggested by the Chief Investigator was considered by the research team (research and field supervisors). Recommendations and amendments were made to the proposal following this process. The research proposal was then reviewed by the DClinPsy Lancaster University research team, and it was confirmed that the project could be submitted for ethical review.

*For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.*

*For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.*

**A59. What is the sample size for the research?** *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 12  
 Total international sample size (including UK): 12  
 Total in European Economic Area: 12

*Further details:*

It is anticipated that between two and 12 participants will take part in the research.

**A60. How was the sample size decided upon?** *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

This sample size is in line with recommendations for doctoral research using IPA, due to the time consuming and detailed nature of the analysis process (Smith, Flowers & Larkin, 2009). Additionally, as the current research explores a topic that has not been considered previously within a palliative care context, this sample size should offer an opportunity to achieve a comprehensive coverage of the diversity and range of experiences contained within the sample.

**A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.**

The data will be analysed using Interpretative Phenomenological Analysis (IPA). The steps outlined in Smith, Flowers and Larkin (2009) will be followed as a guideline for analysing the data. Although an element of interpretation of the data is required in qualitative research, procedures (E.g., an audit trail of the analysis) and engaging reflexively can be employed to minimise researcher bias (Willig, 2008). To ensure the Chief Investigator follows this, a reflective diary will be kept throughout the research process. Additionally, support will be provided by the research team through supervision, which can help to encourage reflectivity within the research.

It is suggested for IPA research that an interview schedule is decided in advance, and the research team has assisted the Chief Investigator in the development of this. Although it is useful to have a schedule prepared, this should be flexible and questions may change when the interview process begins (Smith, Flowers & Larkin, 2009). The types of questions that will be asked are open-ended and do not make judgements about a particular participants experience. For example, 'Can you tell me how you feel about crying in therapy (with a client)?' or 'Do you think crying can effect the therapeutic encounter?' A copy of the interview schedule can be found within the ethics protocol, attached to this document.

The Chief Investigator will complete all transcription following the interviews taking place. This stage is considered a part of the analysis process, as the Chief Investigator begins to become knowledgeable and immersed in the data. Following this, detailed reading and analysis of individual transcripts will take place, after which themes may be generated across the data sets.

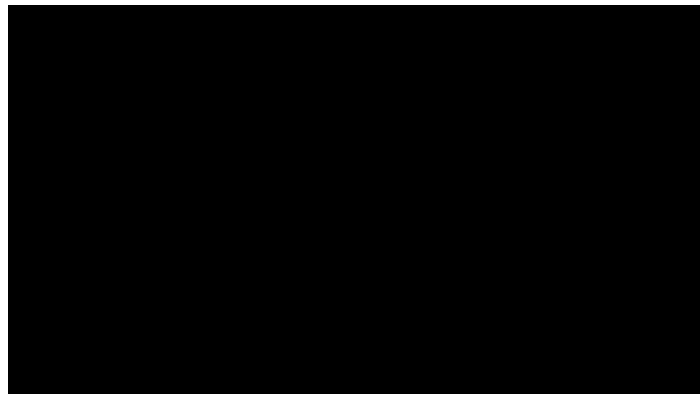
## 6. MANAGEMENT OF THE RESEARCH

**A63. Other key investigators/collaborators.** *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title Forename/Initials Surname
	Dr Ian Fletcher
Post	Academic Supervisor / Senior Lecturer in Research Methods
Qualifications	PhD

Employer Lancaster University  
 Work Address Doctorate in Clinical Psychology  
 Faculty of Health and Medicine  
 Furness College, Lancaster University  
 Post Code LA1 4YG  
 Telephone 01524593301  
 Fax  
 Mobile  
 Work Email i.j.fletcher@lancaster.ac.uk

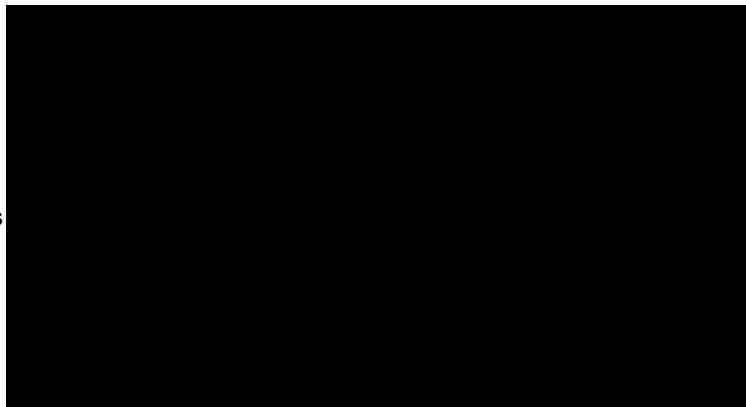
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 Qualifications  
 Employer  
 Work Address



Post Code  
 Telephone  
 Fax  
 Mobile  
 Work Email



Post  
 Qualifications  
 Employer  
 Work Address



Post Code  
 Telephone  
 Fax  
 Mobile  
 Work Email



**A64. Details of research sponsor(s)**

**A64-1. Sponsor**

**Lead Sponsor**

- Status:  NHS or HSC care organisation  
 Academic  
 Pharmaceutical industry  
 Medical device industry

Commercial status:

- Local Authority
- Other social care provider (including voluntary sector or private organisation)
- Other

*If Other, please specify:*

**Contact person**

Name of organisation Lancaster University  
Given name Diane  
Family name Hopkins  
Address Research Services, Room B14, Furness College  
Town/city Lancaster  
Post code LA1 4YT  
Country UNITED KINGDOM  
Telephone 01524592838  
Fax  
E-mail d.hopkins@lancaster.ac.uk

**Is the sponsor based outside the UK?**

- Yes  No

*Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.*

**A65. Has external funding for the research been secured?**

- Funding secured from one or more funders
- External funding application to one or more funders in progress
- No application for external funding will be made

What type of research project is this?

- Standalone project
- Project that is part of a programme grant
- Project that is part of a Centre grant
- Project that is part of a fellowship/ personal award/ research training award
- Other

Other – please state:

**A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? Please give details of subcontractors if applicable.**

- Yes  No

**A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?**

Yes  No

*Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.*

**A69-1. How long do you expect the study to last in the UK?**

Planned start date: 01/04/2017

Planned end date: 30/09/2017

Total duration:

Years: 0 Months: 5 Days: 30

**A71-1. Is this study?**

Single centre  
 Multicentre

**A71-2. Where will the research take place? (Tick as appropriate)**

- England  
 Scotland  
 Wales  
 Northern Ireland  
 Other countries in European Economic Area

Total UK sites in study 4

**Does this trial involve countries outside the EU?**

Yes  No

**A72. Which organisations in the UK will host the research? Please indicate the type of organisation by ticking the box and give approximate numbers if known:**

- NHS organisations in England  
 NHS organisations in Wales  
 NHS organisations in Scotland  
 HSC organisations in Northern Ireland  
 GP practices in England  
 GP practices in Wales  
 GP practices in Scotland  
 GP practices in Northern Ireland  
 Joint health and social care agencies (eg community mental health teams)  
 Local authorities  
 Phase 1 trial units

<input type="checkbox"/> Prison establishments	
<input type="checkbox"/> Probation areas	
<input checked="" type="checkbox"/> Independent (private or voluntary sector) organisations	4
<input type="checkbox"/> Educational establishments	
<input type="checkbox"/> Independent research units	
<input type="checkbox"/> Other (give details)	
Total UK sites in study:	4

**A73-1. Will potential participants be identified through any organisations other than the research sites listed above?**

Yes     No

**A74. What arrangements are in place for monitoring and auditing the conduct of the research?**

Either the first audio recording of an interview, or a typed-up and anonymised transcript, will be shared with the Chief Investigator's academic supervisor. The purpose of this is to ensure that the interviews are completed to a good standard, and to ask for feedback on the Chief Investigator's style and questions during the interview. The Chief Investigator will later share anonymised, coded, transcripts with the research team (research and field supervisors) at a later stage, in order to access support with the analysis process.

Additionally, telephone and face to face supervisions are offered by the research and field supervisors. These take place every six weeks, and informal supervision can be requested as needed. Draft reads will be completed by the research team at various stages of the write-up of the research paper.

**A76. Insurance/ indemnity to meet potential legal liabilities**

*Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

**A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.**

*Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.*

- NHS indemnity scheme will apply (NHS sponsors only)
- Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

*Please enclose a copy of relevant documents.*

**A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.**

*Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.*

- NHS indemnity scheme will apply (protocol authors with NHS contracts only)

Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

**A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?**

*Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.*

- NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

**A78. Could the research lead to the development of a new product/process or the generation of intellectual property?**

Yes  No  Not sure

**PART C: Overview of research sites**

**Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites.** For further information please refer to guidance.

Investigator identifier	Research site	Investigator Name
IN1	<input type="radio"/> NHS site <input checked="" type="radio"/> Non-NHS site	Forename Laura Middle name Family name Richardson Email l.richardson6@lancaster.ac.uk Qualification (MD...) Trainee Clinical Psychologist MSc (Psychology) BSc Hons (Psychology) Country UNITED KINGDOM
	Institution name [REDACTED] Department name [REDACTED] Street address [REDACTED] Town/city Post Code Country [REDACTED]	
IN2	<input type="radio"/> NHS site <input checked="" type="radio"/> Non-NHS site	Forename Laura Middle name

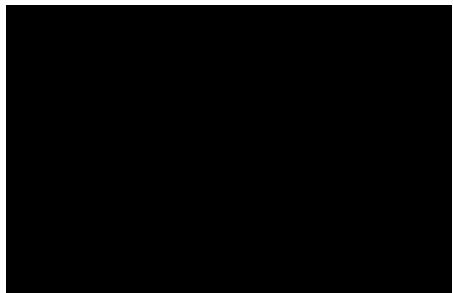
IN3

Institution name [REDACTED]  
Department name [REDACTED]  
Street address [REDACTED]  
Town/city [REDACTED]  
Post Code [REDACTED]  
Country [REDACTED]

- NHS site
- Non-NHS site

Country: England

Organisation name  
Address  
Post Code



Family name Richardson  
Email I.richardson6@lancaster.ac.uk  
Qualification (MD...) Trainee Clinical Psychologist  
MSc (Psychology)  
BSc Hons (Psychology)  
Country UNITED KINGDOM

Forename Laura  
Middle name  
Family name Richardson  
Email I.richardson6@lancaster.ac.uk  
Qualification (MD...) Trainee Clinical Psychologist  
MSc (Psychology)  
BSc Hons (Psychology)  
Country UNITED KINGDOM

IN4

Institution name [REDACTED]  
Department name [REDACTED]  
Street address [REDACTED]  
Town/city [REDACTED]  
Post Code [REDACTED]  
Country [REDACTED]

- NHS site
- Non-NHS site

Forename Laura  
Middle name  
Family name Richardson  
Email I.richardson6@lancaster.ac.uk  
Qualification (MD...) Trainee Clinical Psychologist  
MSc (Psychology)  
BSc Hons (Psychology)  
Country UNITED KINGDOM



## **Thesis Protocol**

### **Crying with patients at end-of-life: The experiences of psychological therapists**

#### **Research team**

Main Researcher – Laura-Jayne Richardson – Trainee Clinical Psychologist, Lancaster University/Lancashire Care NHS Foundation Trust

Research Supervisor – Dr Ian Fletcher – Senior Lecturer in Research Methods, Lancaster University

Field Supervisor – [REDACTED]

Field Supervisor – [REDACTED]

#### **Introduction**

Although a relatively neglected area within the literature, recent research has suggested that the majority of psychological therapists have cried when with a client during a therapy session. In a mixed-method survey of 684 U.S. psychologists, postdoctoral psychology fellows, and psychology graduate students, Blume-Marcovici, Stolberg and Khademi (2013) reported that 72% of therapists had cried in therapy in their role as a therapist. They found that although the majority of therapists reported crying in therapy, there were certain factors, such as, gender, personality and empathy, that did not appear to influence whether tears were shed when with a client. Instead, contextual factors appeared to have more impact, such as the clinical experience of the therapist, their theoretical orientation, and affective tone, or feelings, present during the session. Furthermore, the

majority of therapists did not find that their tears had a negative impact overall, but that this demonstration of emotion could actually be useful, and assist the therapeutic relationship. In a paper published this year, Matise (2016) developed a quantitative questionnaire to 'measure' therapists crying in session, with the aim of this being used in larger research studies. This suggests that despite the limited research to date, the concept of therapists' crying in therapy is an area of current relevance in the psychology / therapeutic literature, and is anticipated to grow.

To date, the majority of the qualitative literature on therapists' crying in therapy, is taken from the patient's perspective. This literature indicates that the therapist's tears can be perceived by the client as either detrimental or beneficial to therapy outcome (Pendleton, 2015; Tritt, Kelly & Waller, 2015). This is similar to the literature on self-disclosure in therapy, where it has been suggested that the client can consider the psychotherapy as more effective when therapists appropriately self-disclose (Barrett & Berman, 2001). Furthermore, it suggests that crying in session, if done within the same spirit that appropriate self-disclosure is, could be considered to make the therapy more effective from the client's perspective.

There is even less literature considering the qualitative experiences of the therapists who cry during therapy with a client (British Psychological Society, 2013). To date, there are three published case studies detailing the therapists own accounts of crying in therapy with clients (Counselman, 1997; Owens, 2005; Rhue, 2001). Overall, these papers suggest that crying can at times be therapeutically appropriate and beneficial to treatment. One of these case studies considered the therapist's own experiences of providing therapy to a couple when one partner was diagnosed with a terminal illness (Counselman, 1997). In this particular case, the therapist decided to change their approach during therapy by self-disclosing more frequently 'in service of greater connection with the clients' (p. 233). This

literature is important, as it suggests that this particular therapist altered their usual way of working, once a client was diagnosed with a terminal illness. Furthermore, they felt willing to share more of themselves within the therapeutic relationship, and re-considered previously established professional boundaries.

As this case study only considers the experience of one individual within this context, further research into terminal diagnosis would help to provide a greater insight into this phenomenon. Although there has been a recent published qualitative study exploring therapist's experiences of crying in therapy, this research was conducted with a sample of 11 therapists working in a university counselling setting (Matise, 2015). Matise reported that certain factors help to determine whether tears were viewed as useful to the therapeutic encounter: the degree and timing of the tears, how culturally acceptable the tears were, and gender of the therapist. It also depended upon whether the tears were viewed as genuine and relevant to the client and the therapy session, as opposed to unresolved difficulties that the therapist was experiencing, which could potentially be interpreted as an inappropriate disclosure. Despite this, they reported that a lack of clarity existed in relation to crying and how therapists' experience intense emotions within the therapeutic relationship. Furthermore, as this sample considered the experiences of counsellors within a university context, it could be argued that psychological therapists working with individuals who have a palliative diagnosis or are approaching the end of their lives are likely to have a different experience.

Literature considering medical doctors suggests that the setting in which emotions are experienced is significant, as supported by Zambrano and Barton (2011), who reported that doctors experience death differently depending upon the context in which they work. This supports the rationale for looking into the same phenomenon within a different context in the current research, as the findings are likely to provide a unique insight into a relevant field.

### **The current research**

To date, there has been only mixed-method research and case studies into the concept of therapists crying with clients in therapy, but there has been very little qualitative research exploring this. This suggests there may be gaps in our knowledge of the conditions and factors that are likely to contribute to the therapists' tears, and the impact this may have on the therapeutic encounter. In particular, it is possible that this phenomenon may be more likely within a palliative care context, due to the focus of the therapeutic work being on the end of life, instead of recovery. Therefore, this would make the target phenomenon relevant, and potentially more frequently occurring, within therapeutic practice in palliative care.

This research aims to expand on the literature relating to therapists crying in therapy, through completing semi-structured interviews with psychological therapists working with individuals with a palliative diagnosis or are approaching the end of their lives. Therefore, the research question that this study aims to address is: 'How do psychological therapists working with individuals who have been given a palliative diagnosis or are approaching the end of their lives view or experience crying in the therapeutic encounter?'

## **Methodology**

### **Design**

As this project wishes to explore participant's subjective experience, a qualitative design is appropriate to the research question. Participants will be asked to undertake semi-structured interviews based on the research question and aims of the project. Participants will be made aware in advance of what to expect for participating in the interviews, for example, the time commitment involved and also that sensitive topics may be addressed, as suggested by Willig (2008), who argues that it is important to make sure that individuals can cope with the demands of qualitative interviews.

The interview data will be analysed using Interpretative Phenomenological Analysis (IPA). This is an appropriate type of analysis for the research question and aims, as it is concerned with exploring an individual's experience of something (Smith, Flowers & Larkin, 2009). Langridge (2007) suggested that the 'focus of IPA studies is on how people perceive an experience, or rather what any particular experience means for them: A focus of the life world' (p. 107).

IPA is best suited to research in which participants are encouraged to offer a rich, detailed, first-person account of their experiences (Smith, Flowers & Larkin, 2009). Therefore, asking individuals to participate in in-depth, semi-structured interviews is an effective way of accessing such accounts as they allow participants the opportunity to tell their stories, reveal their thoughts and feelings about the target phenomenon, and speak freely and reflectively about their ideas and concerns (Reid, Flowers & Larkin, 2005).

### **Participants**

Participants will be psychological therapists who currently work with individuals who have been given a palliative diagnosis or are approaching the end of their lives. The term 'psychological therapist,' is used to refer to any clinical staff providing one to one psychological therapy. For example, this may be a Clinical Psychologist, Counselling Psychologist, Psychotherapist, Counsellor, Trainee Clinical Psychologist, Assistant Psychologist, or Clinical Nurse Specialist. Therefore, participation in the project is not dependent upon job title, but on the role which the individual occupies. It is essential that they deliver one to one psychological interventions or counselling within this role, for which they receive clinical supervision.

This project aims to recruit between two and 12 participants. As the current research explores a topic that has not been considered previously within a palliative or end-of-life context, this sample size should offer an opportunity to achieve a comprehensive coverage of

the diversity and experiences contained within the sample. Furthermore, this sample size is in line with recommendations for the proposed method of data analysis, which is IPA (Smith, Flowers & Larkin, 2009). As IPA focuses on the detailed account of an individual's experience, it is suggested that this type of analysis benefits from a concentrated focus on a small number of cases (Smith, Flowers & Larkin, 2009).

It has been suggested for IPA research that a sample must be purposive and homogenous, meaning that individuals share some underlying experience but do not differ much in demographics (Langridge, 2007). In the current research, the sample will consist of psychological therapists working with individuals who have been given a palliative diagnosis or are approaching the end of their lives, and who have experienced, or hold views, on crying when with a patient.

### **Inclusion and exclusion criteria**

#### *Inclusion criteria:*

-Participants must be psychological therapists who currently work with individuals who have been given a palliative diagnosis or are approaching the end of their lives. Individuals are asked to currently work within this setting, as it is hoped that they will be more likely to accurately recall the target phenomenon.

-It is anticipated that participants will have a range of clinical experience and will have worked with individuals who have a palliative diagnosis or are approaching the end of their lives for different lengths of time. As participants are required to have sufficient experience of the target phenomenon or hold a view that they are able to discuss in detail during an interview, it is suggested that they have a minimum of six months experience working clinically with these individuals.







information about the project and contact details for the main researcher (see Appendix.6). An email from the main researcher's field supervisor, confirming that they are happy to post the email, can also be seen (Appendix. 7).

Snowball sampling will be used to help recruit individuals to the study. This means that individuals that hear about the research will be able to let other potential participants know about the project (Willig, 2008). It is made clear on the communication provided (PIS, email, and advert) that individuals may forward the information on to other potential participants.

If the above methods of recruitment do not encourage enough participants to volunteer for the study, then this process will be repeated after a period of two weeks. Providing the inclusion and exclusion criteria are met, participants will be recruited on a first come first served basis. Individuals' who would like to take part but are unable, will be thanked for their interest in the project, and informed that they can ask for a summary of the findings when the project is complete.

## **Procedure**

Communication sent by the above organisations on behalf of the main researcher will contain a contact name, telephone number, and email address. Potential participants will be encouraged to contact the main researcher directly if they wish to learn more about the project or would like to take part.

If individuals make contact, the main researcher will speak to them directly over the telephone to discuss the project in more detail. This will include talking through the study, PIS (Appendix. 8) and consent form (Appendix. 9), checking that participants fully understand the purpose of the research, and answering any questions.

All participants should have already accessed the PIS and consent form, however if they have not, the main researcher will post a copy to them, or direct them to the online versions on the Lancaster University website. This is to ensure that individuals have at least one full day (24 hours) between reading the PIS and consenting to take part. Also at this time, the main researcher will check that participants meet the inclusion and exclusion criteria for taking part in the research. Participants that do not meet the criteria, will be informed why, and unable to take part.

Following this, arrangements for the interviews will be made. Where possible, interviews will take place at a location that is preferred by the participant, which may be their own home or place of work. As individuals will be recruited nationally, it may be that some participants live too far away to be interviewed face to face, and in this instance, individuals will be offered the opportunity to be interviewed over Skype or the telephone instead. Where possible, it is considered preferable by the main researcher, to complete face to face interviews. If any participants wish to be interviewed over Skype, then the main researcher will set up a professional Skype account specifically for use in this research project only. This account will not be used for other purposes. For participants who wish to be interviewed via Skype, the main researcher will have informed them previously this is not wholly secure, and they will be reminded of this at the time of the interview also.

If participants decide to take part, they will be asked to sign the consent form before the interview, and demographic information will also be collected at this time including: their age, gender, professional role, therapeutic orientation, and the amount of time they have worked in a palliative or end-of-life context (Appendix 10).

For face to face interviews, the main researcher will check that participants have previously seen the consent form and considered this for a period of at least one day before agreeing to take part. Following this, the main researcher will go through the consent form

with participants before the interview begins, and ask them to sign the form at this time.

Participants will be encouraged to keep a copy of this for their own records.

For individuals who are interviewed over Skype or the telephone, they will be asked to read, sign, and return the consent form through the post or email, prior to the interview being completed. They will be encouraged to keep a copy of this for their own records. Participants will be reminded of the information provided on the consent form prior to commencing their interview.

Semi-structured interviews will be conducted using a set interview schedule. Interviews will last up to 60 minutes, depending on the individual and how much they wish to say. They will be recorded on the main researcher's Dictaphone. The interview schedule will consist of various topics, including the participants' experiences or views of crying when with a patient, and their reflections of how this may or may not have impacted on the therapeutic encounter (Appendix 11). This interview schedule has been decided in advance, with the assistance of the research team. Although it is helpful to have a schedule in mind when interviewing participants, this should be flexible and may change when the interview begins (Smith, Flowers and Larkin, 2009). This is because the participant may reveal interesting insights during the interview that are unexpected, and in IPA research it is suggested that the interviewer may wish to explore these experiences further, as long as they are relevant to the research question.

In line with IPA research, the types of questions that will be asked of participants will not make assumptions about the individual's experience or lead them towards particular answers. The questions asked will be open, and allow for participants to talk at length about their experiences. A 'funnel' approach is recommended, whereby the interview will start with more general questions that allow participants to become comfortable with the process, before inviting them to discuss more direct experiences of the target phenomenon (Smith,

Flowers & Larkin, 2009; Willig, 2008). Participants will be informed before the interview begins that they do not have to answer questions that they are not comfortable with, and may ask to skip these. Participants will also be reminded that they are able to take a break at any point, or can stop the interview completely if they wish to, without needing to provide a reason.

Once the interview is complete, participants will be thanked for their involvement and asked if they have any questions. They will be reminded that their data remains anonymous and that they can withdraw from the project for a period of two weeks. After this it may be difficult to remove their data, as it will have been merged with that of other participants and used to generate the findings, although every effort will be made where possible. They will also be reminded that they can request a summary of the findings once the project has been written-up. Finally, participants will be provided with a debrief sheet (Appendix 12). This contains information about sources of support, should participants feel that they would benefit from this.

Participants who complete face to face interviews will be handed a copy of the debrief form. Those interviewed over the telephone / Skype will be sent a copy through the post or email. The information contained on debrief form is also included on the PIS, so individuals who declined to participate are also able to access support.

As mentioned previously, the semi-structured interviews will be analysed using IPA. The steps outlined in Smith, Flowers and Larkin (2009) will be followed as a guideline. An element of interpretation of the data is required in qualitative research but procedures (e.g., an audit trail of the analysis) and engaging reflexivity can be employed to minimise researcher bias (Willig, 2008). To ensure this, the main researcher will keep a reflexive diary throughout the project.

**Additional materials**

In addition to the materials mentioned above, a Dictaphone will be used to record the interviews, and a laptop to transcribe the interviews. A mobile telephone will be acquired through Lancaster University, so participants are able to contact the main researcher directly.

**Confidentiality of data**

Participants will be reassured that their information will be anonymised by the main researcher. Any consent forms, and other participant information in paper form, will be stored in a locked cabinet at the main researcher's home that only they have access to. The consent forms will be stored separately to anonymised data, such as the interview transcripts. Only the main researcher will have access to the participant's personal data.

Audio data will be transferred to the main researcher's personal file space (H: drive) via the Lancaster VPN and password protected as soon as possible following the interview, so it can be stored securely. Participant interview data will be deleted from the recording device once transferred to the server, and deleted from the server once the project is complete. Therefore, transcripts will be typed up using secure copies on the server rather than those on the recording device.

Transcripts will be anonymised and any identifiable information will be removed, such as, the participants name, any demographic information, and location details. Transcription and analysis of interview data will be conducted by the main researcher and stored on their secure space on the H: drive. Analysis will take place using Word and Excel, either at university or the main researchers home address, as the transcripts can be accessed securely through the Lancaster VPN. The main researcher will use pseudonyms in these transcripts and in the write-up of the research paper, and again, any potentially identifiable information will be removed. Participants will be made aware that direct quotes from the

interviews will be used in the final write-up, but that these will be anonymised and any identifiable information will be removed.

Either the first audio recording of an interview, or a typed-up and anonymised transcript, will be shared with the academic supervisor. The purpose of this is to ensure that the interviews are completed to a good standard, and to ask for feedback on the main researcher's style and questions during the interview. The main researcher will share anonymised, coded, transcripts with their supervisors at a later stage, in order to access support with the analysis.

All electronic data on the computer, laptop, or USB, will be encrypted and password protected. Any electronic files will be destroyed as soon as the project is complete. Participants can request a summary of the report once it has been written.

Once the project is complete, all paper data will be destroyed, excluding the participant consent forms. These will be scanned and saved in an electronic format and the paper copies will be destroyed. Following this, they will be securely transferred to the DCLinPsy admin team, under protection and encryption. This data will be stored at Lancaster University for a period of ten years, and destroyed following this. The main researcher will also keep this anonymised electronic data for ten years, in case they wish to publish from this in the future.

### **Confidentiality and risk**

As the recruitment documents are sent via the organisations mentioned previously, the main researcher is not aware of who this information has been sent to on her behalf. Therefore, the main researcher will only become aware of potential participant's identity once they contact her on the telephone number or email provided within this documentation.

Risk will be considered throughout the project, in relation to both the participant and the main researcher. The limits of confidentiality will be explained to all participants prior to commencing their interview. Confidentiality will be considered when deciding where to undertake the interview, and participants that choose to complete this at their work will be informed that confidentiality cannot be guaranteed.

Although confidentiality will be maintained where possible, the participant will be informed that if they express any intent to harm themselves or others, then confidentiality will be broken. Participants will be reminded that this is to ensure their own safety, and that this would be discussed with them first, where possible. This has been documented on the PIS. If a participant were to express an intent to harm themselves or others, the main researcher would consult with their research or field supervisors to ask for guidance and to determine the appropriate course of action.

It may be that participants do not express an intention to harm themselves or others, but become emotionally distressed during the interview. Although this is not anticipated, it is important to consider the main researcher's response in such a case. If this were to happen, the main researcher would pause the interview to ask the participant how they were, and whether they would like to continue with the interview. This may be more challenging with interviews that take place over the telephone, as the main researcher may not be able to tell as easily that the individual is becoming distressed. To overcome this, the main researcher will remain attentive to considering the wellbeing of the participant throughout the interview, and check in with them if they have any concerns. Details of support networks have been included on both the PIS and the debrief sheet, and participants are encouraged to contact their GP or appropriate Trust staff support services in the first instance if they require this. The main researcher can contact their own GP, or academic and field supervisors, if they experience any distress themselves through completing this research.

Additionally, as participants will be offered the opportunity to be interviewed in their own home or at their place of work, the Lancaster University DClinPsy Lone Worker Policy for trainees will be followed. This process involves the researcher informing a 'contact person,' who may be a supervisor or a fellow trainee that they will be conducting an interview in someone's home. Prior to the interview, the contact person will be provided with a sealed envelope which contains the researcher's information, car details (registration, make and model) and details of the visit (the participants name, address, date of interview, start time and estimated finish time). If the researcher does not message or telephone the contact person by an agreed time, then they will try to reach the researcher to check they are okay. If there is no response, then the contact person is required to call the police and open the sealed envelope to pass the information on.

### **Practical Issues**

Any costs associated with the project are to be covered by Lancaster University's Doctorate of Clinical Psychology Course. There will be no payment offered to participants for taking part in the study, which has been made clear on the PIS.

As participants will be interviewed either at home or over the telephone / Skype, it is not expected that there will be any travel costs incurred for participants. Travel expenses may be incurred for the main researcher however if participants wish to be interviewed at home or work, and live a considerable distance away.

There will be stationary costs associated with printing out the relevant paperwork and purchasing envelopes and stamps. A university mobile telephone will be required so that participants are able to contact the main researcher directly, which will be provided by Lancaster University.

### **Complaints**



Details have been provided on the PIS and consent forms if individuals wish to make a complaint or raise any concerns about the research. They can contact Dr. Bill Sellwood (DClinPsy Programme Director) on 01524 593998, or b.sellwood@lancaster.ac.uk.

Alternatively, if participants would like to talk to someone not involved with the DClinPsy course, they can contact Professor Roger Pickup (Chair of the FHMREC) on 01524 593746, or r.pickup@lancaster.ac.uk.

### **Dissemination**

It is intended for the current research to be published in an appropriate peer-reviewed journal following submission as part of the main researcher's doctoral thesis. The research will also be presented at Lancaster University as part of this qualification, to other trainee clinical psychologists, programme staff, and researchers. Participants will be informed that the research may be published, and that they will be able to ask for a summary of the project once it has been completed.

### **Timeline**

April/May 2017 – Submit ethics application to University ethics

May/June – April 2017 – Re-submit ethics with amendments / Write introduction and method / Sections for research paper alongside

June/July 2017 – Begin recruitment and fieldwork when ethics is returned / Type-up interview transcripts and start analysis as soon as possible

August 2017 – Aim to complete interviews and analysis / Start to write-up results section

September 2017 – Submit results and discussion sections and a full draft once complete

November 2017 – Submit thesis

## References

- Barrett, M. S. & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Counselling and Clinical Psychology*, 69 (4), 597 – 603. doi: 10.1037//0022-006X.69.4.597
- Blume-Marcovici, A.C., Stolberg, R.A., & Khademi, M. (2013). Do Therapists Cry in Therapy? The Role of Experience and Other Factors in Therapists' Tears. *Psychotherapy*, 50, 224- 234. doi: 10.1037/a0031384
- Blume-Marcovici, A. C., Stolberg, R. A., Khademi, M. & Giromini, L. (2015). When therapists cry: Implications for supervision and training. *The Clinical Supervisor*, 34 (2), 164 – 183. doi: 10.1080/07325223.2015.1048556
- British Psychological Society. (2013). The tears of a therapist. BPS Digest. Retrieved online from: <http://digest.bps.org.uk/2013/older-more-experienced-therapists-cry.html>.
- Counselman, E. F. (1997). Self-disclosure, tears, and the dying client. *Psychotherapy*, 34, 233- 237. doi: 10.1037/h0087715
- Langridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Pearson Education Limited: Essex.
- Maise, M. (2015). An exploration of the personal experiences and effects of counselors' crying in session. *The Professional Counselor*, 5 (1), 28 – 38. doi: 10.15241/mm.5.1.28
- Maise, M. (2016). Measuring counselors' attitudes towards crying in session: A pilot study. *The Practitioner Scholar: The Journal of Counseling and Professional Psychology*, 5, 73 -87.
- Owens, C. (2005). Moved to tears: Technical considerations and dilemmas encountered when working with a 13 year-old boy with acquired quadriplegia. *Journal of Child, Psychotherapy*, 31, 284-302. doi: 10.1080/00754170500370753

- Rhue, J., W. (2001). *Death, bereavement, and the therapist*. In S. Kahn & E. Fromm (Eds.). *Changes in the therapist* (pp. 117-131). Mahwah, NJ: Erlbaum Publishers.
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage Publications Ltd: London.
- Tritt, A., Kelly, J. & Waller, G. (2015). Patients' experiences of clinicians' crying during psychotherapy for eating disorders. *Psychotherapy*, 52 (3), 373-380. doi: 10.1037/a0038711
- Vingerhoets, A. J. J. M., Cornelius, R. R., Van Heck, G. L. & Becht, M. C. (2000). Adult crying: A model and review of the literature. *Review of General Psychology*, 4 (4), 354 – 377. doi:10.1037//1089-2680.4.4.354
- Willig, C. (2008). *Introducing Qualitative Research in Psychology*. Open University Press: Berkshire.
- Zambrano, S. C. & Barton, C. A. (2011). On the journey with the dying: How general practitioners experience the death of their patients. *Death Studies*. 35 (9), 824 – 851. doi:10.1080/07481187.2011.553315.

## Appendix 4-A

*Email communication (1) for one of the healthcare organisations*

**Email Communication****Re: Crying with patients at end-of-life: The experiences of psychological therapists**

**Are you a psychological therapist currently working with individuals with a palliative diagnosis or who are approaching the end of their lives?**

My name is Laura Richardson, and I am a trainee clinical psychologist studying at Lancaster University.

I would like to invite you to take part in a research project considering your experiences, or views of, crying with a patient who has a palliative diagnosis or is approaching the end of their life. It may be that you have experienced this personally, or not experienced this yourself, but have strong views that you wish to share in an interview. I am interested in your reflections on this topic, including any positive or negative experiences or opinions that you may have.

**Who can take part?**

I am asking for individuals to apply that have delivered one to one psychological interventions or counselling to patients for which you received clinical supervision. You will need to be over 18 years-old, and speak fluent English. If you decide to take part, you will be asked to complete an interview lasting approximately one hour, depending on how much you wish to say.

**How can I take part?**

Please click the link below to read a patient information sheet and consent form for the study.

Please read this information carefully if you would like to take part.

**(Link for PIS and consent form to go here)**

If you are interested in participating in the research, or you have any further questions, then please contact me on the telephone number or email address below. Alternatively, you can write to me if you prefer.

### **Contact details**

Laura Richardson (Main researcher)

Lancaster University Doctorate in Clinical Psychology

Furness College

Lancaster University

LA1 4YG

Tel: (number)

Email: l.richardson6@lancaster.ac.uk

**Please feel able to circulate this information to any colleagues that may be interested in taking part.**

**Thank you for taking the time to read this email.**

## Appendix 4-B

*Blog for one of the organisations assisting with recruitment*



Laura Richardson is a Trainee Clinical Psychologist at Lancaster University conducting a piece of research on the experiences of psychological therapists working with individuals with a palliative diagnosis or who are approaching the end of their lives. Here she explains the reasons why this research is important and how you can help.

**Researching the experiences of psychological therapists crying with patients who have a palliative diagnosis or are approaching the end of their lives?**

**Why is this research important?**

Recent research suggests that up to 72% of psychological therapists have cried with a client during a therapy session (Blume-Marcovici, Stolberg & Khademi, 2013). Certain factors, such as gender, personality, and empathy, did not appear to influence whether tears were shed. Instead, factors such as the amount of clinical experience the therapist had, their theoretical orientation, and the feelings, present during a session seemed to have more of an impact. Interestingly, most therapists reported that their tears did not have a negative impact on treatment, but that this could help the therapeutic relationship.

The British Psychological Society (2013) reported there was a lack of literature considering the experiences of therapists who cry during therapy with a client, and that the majority of qualitative literature is taken from the client's perspective (Pendleton, 2015; Tritt, Kelly & Waller, 2015). To date, there are three published case studies detailing the therapist's accounts of crying with clients (Counselman, 1997; Owens, 2005; Rhue, 2001). Overall,

these papers suggest that crying can at times be therapeutically appropriate and beneficial to treatment. One of these case studies considered the therapist's experiences of providing therapy to a couple when one partner was diagnosed with a terminal illness (Counselman, 1997). In this particular example, the therapist altered their usual way of working, once a client was diagnosed with a terminal illness, and felt willing to share more of herself within the therapeutic relationship. As this case study only considers the experience of one individual, further research into therapists working in palliative care would help to provide a greater insight into this concept.

More recently, a study explored therapist's experiences of crying in therapy in a university counselling setting (Matise, 2015). Matise reported that certain factors help to determine whether tears were viewed as useful during therapy: the degree and timing of the tears, how culturally acceptable the tears were viewed, and the gender of the therapist. It also depended whether the tears were viewed as genuine and relevant to the client and the therapy session. Despite this, they reported that further research was needed, as a lack of clarity existed in relation to crying, and how therapists' experience intense emotions within the therapeutic relationship generally.

To date, there has been limited qualitative research exploring therapists crying with clients in therapy. This suggests there may be gaps in our knowledge of the factors that are likely to contribute to the therapists' tears, and the potential impact of this on the therapeutic encounter. In particular, it is possible that this may be different within a palliative or end-of-life context, due to the focus of the therapeutic work being on the end of life.

**Do you currently work with individuals who have a palliative diagnosis or are approaching the end of their lives?**

I am currently recruiting participants for this research, which will include semi-structured interviews lasting approximately one hour with individuals that have delivered one to one psychological interventions or counselling to patients, for which they received clinical supervision. Participants must be willing to discuss their experiences, or views of, crying with a patient who has a palliative diagnosis or is approaching the end of their life. It may be that participants have not experienced this personally, but have strong views that they wish to share in an interview. Participants need to be over 18 years old, and speak fluent English.

**You can click the link below to access more information about the project:**

**(Link to go here to Lancaster University website)**

**Would you like to take part in this research?**

If you are interested in participating in the research, or you have any questions, then please contact the main researcher, **Laura Richardson**, Trainee Clinical Psychologist, on **(telephone number)**, or email **l.richardson6@lancaster.ac.uk**. Alternatively, you can write to me at:

Laura Richardson (Trainee Clinical Psychologist)

Lancaster University Doctorate in Clinical Psychology

Furness College

Lancaster University

LA1 4YG

**Please feel free to circulate this information to any colleagues that may be interested in taking part.**



## Appendix 4-C

*Email Communication (2) for two of the organisations*

**Re: Crying with patients in palliative**



**care services: The experiences of psychological therapists**

My name is Laura Richardson, and I am a Trainee Clinical Psychologist studying at Lancaster University. I would like to invite you to take part in a research project considering your experiences, or views of, crying with patients who have a palliative diagnosis or are approaching the end of their lives.

You are invited to take part in this study if you have delivered one to one psychological interventions or counselling to patients, for which you have received clinical supervision.

This study will involve completing an interview lasting approximately one hour.

Please contact me using the details below for further information about the project including a participant information sheet and consent form.

Laura Richardson (Main researcher)

Lancaster University Doctorate in Clinical Psychology Furness College

Lancaster University

LA1 4YG

**Tel:** (number)

**Email:** [lrichardson6@lancaster.ac.uk](mailto:lrichardson6@lancaster.ac.uk)

**Please feel free to circulate this information to any colleagues that may be interested in taking part.**

**Thank you for taking the time to read this email.**

## Appendix 4-D

*Participant Information Sheet***Participant Information Sheet****Crying with patients in palliative care services: The experiences of psychological therapists**

My name is Laura Richardson and I am a trainee clinical psychologist studying at Lancaster University. I would like to invite you to take part in a research project considering your experiences, or views of, crying with a patient when working with individuals with a palliative diagnosis or are approaching the end of their lives. It may be that you have experienced this personally, or not experienced this yourself, but have strong views that you wish to share in an interview. I am interested in your reflections on the topic including any positive or negative experiences or opinions you may have.

I am asking for individuals to apply that have worked therapeutically on a one to one basis with patients, providing psychological interventions or counselling, for which they received clinical supervision. You may be a clinical psychologist, counselling psychologist, trainee psychologist, counsellor, psychotherapist, or clinical nurse specialist. Individuals may apply regardless of job title, as long as they have experience of offering psychological therapeutic work within a palliative care service for at least six-months, and feel able to reflect on this during an interview. You need to be aged over 18 years to take part.

**What will I be asked to do if I take part?**

You will be asked to complete an interview lasting approximately an hour, depending on how much you wish to say. This interview can take place face to face or at your home, or at your place of work, if you prefer. Alternatively, we can complete the interview over the telephone or Skype, if that is easier. The interview will be audio-recorded and following our interview, I will analyse what you have said to see if it is similar to how others feel. Please note, that although we can complete an interview via Skype, this method of interviewing is not wholly secure.

Before our interview, I will ask you to sign a consent form to confirm that you are happy to take part.

**Do I have to take part?**

No, you don't need to take part, and it is your choice if you decide to. There are no negative implications through not taking part.

**Are there any benefits to attending?**

It is hoped that this research will help us to learn more about the experiences and views of psychological therapists working with individuals with a palliative diagnosis or who are approaching the end of their lives. Although you may find it interesting to participate, there are no direct benefits to taking part, although some people do find it helpful to talk about their experiences.

Unfortunately, I cannot offer money or any other incentives for taking part in this study.

**Are there any risks?**

There are no risks anticipated with taking part. However, if you experience any distress, you are encouraged to contact one of the contact persons provided at the bottom of this sheet.

**How many people will take part?**

It is hoped that up to 10 individuals will participate. If more than 10 people wish to take part, then the first 10 to express an interest will be able to participate.

**Who has reviewed the project?**

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

**Will my data be identifiable?**

All efforts will be made to ensure that your information remains confidential. Audio data from the interview will be transferred to a safe space on the Lancaster University Viral Private Network once the interviews are complete, and deleted from the audio recording device. This data will be deleted from the server once the project is complete. Your consent forms and personal information will be stored in a locked cabinet at all times and anonymised. Anything that identifies you, such as, your name, demographic information, or location, will be removed.

Your interview will be typed-up and anonymised. These interview transcripts will not be shown to anyone outside of the research team. Any electronic copies of the interview will be encrypted and stored on a password-protected computer. Direct quotes from the interview will be used in the written report, however any identifying information will be removed, and you will be given a pseudonym. When the project is complete, electronic data will be stored securely at Lancaster University and also with the main researcher for a period of 10 years, before being destroyed.

There may be occasions when information cannot be kept confidential. This may happen if you tell me any information that suggests you or another person are at risk of harm. In this situation, I would have a duty to inform you my research supervisors in order to keep you and others safe. Where possible, this would be discussed with you first.

**What if I want to withdraw from the study?**

You are able to withdraw from the study at any point in the two weeks following your interview. After this time period, it may not be possible to do so, as your data may have been merged with that of other participants and used to generate the findings.

Please note, that if you decide to withdraw from the study, you do not have to give a reason for why this is.

**What will happen to the results?**

The results of the study will be written up in a report and submitted to Lancaster University as part of my Doctorate in Clinical Psychology. The report may be published in a journal in the future. I will also tell the organisations that helped with recruitment about my findings but they will not know who has taken part. You will be given a summary of the overall findings and you are welcome to request a copy of the report.

**How can I take part?**

If you are interested in sharing your experiences of offering peer-support, or you have any further questions, then please feel free to contact me on the number at the bottom of this information sheet. Alternatively, you are welcome to email me on the email address below.

**Where can I obtain further information about the study if I need it?**

If you have further questions about this study, then please contact me to discuss this:

Laura-Jayne Richardson

Lancaster University Doctorate in Clinical Psychology

Furness College

Lancaster University

LA1 4YG

Tel: (number)

Email: l.richardson6@lancaster.ac.uk

**Complaints**

If you have any problems or concerns about any aspect of this study and you do not wish to speak to me directly, then you can contact:

Dr Bill Sellwood (Programme Director)

Doctorate in Clinical Psychology

Furness College

Lancaster University

LA1 4YG

Tel: 01524 593998

Email: b.sellwood@lancaster.ac.uk

Alternatively, you may wish to speak to someone who is not involved with the doctorate course. In this case, you should contact:

Professor Roger Pickup (Chair of FHM Research Ethics Committee)

Faculty of Health and Medicine

Division of Biomedical and Life Sciences

Lancaster University

LAI 4YG

Tel: 01524 593746

Email: r.pickup@lancaster.ac.uk

**Resources in the event of distress**

I have included the details for one organisation below that you can contact for additional support, if you feel this will be helpful. Please note, that in the first instance you might speak with your own GP or Trust support systems, if you feel that this information has caused you any distress.

**Saneline:**

Website: [www.sane.org.uk/what\\_we\\_do/support/helpline](http://www.sane.org.uk/what_we_do/support/helpline)

Tel: 0300 3047000

**Please feel able to circulate this information to any colleagues that may be interested in taking part.**

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

Laura-Jayne Richardson

Trainee Clinical Psychologist

Lancaster University



## Appendix 4-E

*Consent Form***Crying with patients at end-of-life:  
The experiences of psychological therapists**Health &  
MedicineLancaster  
University

Please read the statements below carefully and tick the boxes on the right if you are happy to give your consent.

Thank you for your interest in this study.

*Please tick*

1. I confirm that I have read the information sheet and fully understand what my involvement will be.
  
2. I confirm that I have been given the opportunity to ask questions about the research.
  
3. I understand that my participation in this study is voluntary and that I can withdraw from the study up until two weeks after my interview, without giving a reason. I am aware that doing so will have no negative consequences.
  
4. I understand that if I choose to be interviewed at my workplace or within my work hours, that it may not be possible to ensure that my participation in the research remains confidential.

5. I understand that the interview will be audio-recorded and typed into an anonymised written transcript. I am aware that these audio-recordings will be kept securely until the project is complete, and will then be destroyed.
6. I understand that direct anonymous quotations may be used in The write-up of this study and I agree to this.
7. I understand that other members of the research team may look at my anonymised transcript, and I consent to this.
8. I understand that if I disclose any information that puts myself or others at risk of harm, then confidentiality will be broken in order to keep us safe. Where possible, this will be discussed with me first.
9. I am aware that the results of this study may be submitted for publication in the future. In addition, I understand that the results will be shared with the organisations that assisted with recruitment, and that the findings will be presented at Lancaster University.
10. I am aware that Lancaster University will keep electronic copies of the interviews for a period of ten years, and I consent to this. I am aware that the main researcher will keep anonymised electronic data for a period of ten years, and I consent to this.

11. I consent to take part in this research study.

Name of participant (please print): .....

Signed: .....

Date: .....

Name of researcher: .....

Signed: .....

Date: .....

## Appendix 4-F

*Demographic Information Sheet*

**Crying with patients at end-of-life:  
The experiences of psychological therapists**

Health &  
Medicine

Lancaster  
University



Please complete the following information sheet. The information on this form will remain confidential and will not be used in the final report.

If you have any questions about why we are asking for this information, then please do not hesitate to ask the researcher.

Your age: .....

Your gender: .....

Your professional title: .....

Your therapeutic orientation: .....

The amount of time you have worked in a palliative or end-of-life context: .....

**Thank you for completing this form.**

## Appendix 4-G

*Interview Schedule*

**Crying with patients at end-of-life:  
The experiences of psychological therapists**

Health &  
Medicine

**Pre-interview process:**

-Introduce self to the participant and read through the PIS to check whether they have any questions or concerns. I will answer any questions at this time, and make sure they fully understand and feel comfortable with the information.

-All participants will be reminded of the items on the consent form prior to starting their interview. For face to face interviews, participants will be asking to sign the consent form before commencing the interview.

-For participants who are interviewed over Skype or the telephone, the consent form will have been sent out in advance, signed by the participant, and returned to the researcher via the post. For these individuals, the consent form will still be read aloud prior to starting the interview to remind the participant of the process.

-Participants will be reminded that the recording can be stopped at any point if they change their mind and wish to withdraw from the study.

*Pre-amble:* The below information will be given to all participants although the actual wording will be paraphrased to enable rapport to be built.

Thank you for participating in this study. I would like to have a discussion with you about your experiences, or views, of crying when with a patient when working within a palliative or end-of-life context. I am going to start by asking you some general questions about your role to help you get used to the interview, and then I will ask you some questions about your work within palliative or end-of-life contexts, and any experiences or views that you hold about crying when working with patients.

Please keep in mind there are no right or wrong answers, and that I am just as interested in hearing any negative points as I am in positive ones. It is okay if you do not feel comfortable answering certain questions, please just let me know, and we can move on to a different question. Also, remember that if at any time you want to stop the interview for whatever reason, then that is fine, and it will not affect you in any negative way. I expect this interview to last about an hour, depending on how much you want to say, but please let me know if you want to take a break at any point. I am going to record our conversation today on my Dictaphone to help me to remember it properly. I will make sure that this recording stays safe until after our interview, and that all of your responses remain confidential. Just to remind you, that the only time that I would break this confidentiality, is if you were to say something that I felt placed you or someone else at risk of harm. I would then need to break confidentiality in order to keep you safe, although I would try to speak with you about this first, where possible. Does that sound okay? Do you have any questions about what I just said?

If participant has no questions, then check they are ready to begin and start the interview.

### **Interview questions**

**1. Can you tell me why you volunteered to take part?**

*Possible prompts: Can you tell me more about that?*

*Why was that?*

**2. Can you tell me how you feel about crying in therapy (with a client)?**

*Possible prompts: Can you give me any examples of when you have cried in therapy?*

*How did the crying come about?*

*What was it about for you, do you think? (sadness, joy, happiness... Etc)*

*Was there any impact on you?*

*How did the crying affect the client?*

*What happened after this?*

*How do you feel about that?*

*Is crying in therapy talked about (at work, supervision... Etc)*

**3. You might not have, but have you changed the way you view crying in therapy over time?**

*Possible prompts: Why?*

*How do you feel about that?*

**4. Do you think crying can affect the therapeutic encounter?**

*Possible prompts: In what way?*

*How about your relationship with clients?*

**5. How do you see your relationship with crying in therapy in the future?**

*Possible prompts: Why is that?*

*How do you feel about that?*

**6. We're coming towards the end of the interview now, but can I ask whether there's anything we haven't already talked about that you think is important to share?**

Possible prompts: Can you tell me more about that?

What do you mean by...?

**7. And finally, can you tell me how you have found the interview?**

*Possible prompts: Can you tell me more about that?*

*What do you mean by...?*

**Closing the interview:**

Thank you for sharing your experiences with me today.

*Inform the participant that the recorder will now be turned off.*

**Post-interview process:**

-The participant will be asking how they found the interview and how they are feeling afterwards.

-Participants will be given a copy of the debrief form. They will be informed that my contact details are on the bottom of the form, should they wish to ask me any questions at a later date, or have any concerns. They will be advised that they can contact their own GP or Trust if they need any additional support following the interview.



## Appendix 4-H

*Debrief Sheet*

**Crying with patients at end-of-life:  
The experiences of psychological therapists**

Health &  
Medicine



**Thank you for taking part in this study.**

I hope that you have found it to be a positive experience. Your contribution will help us to learn more about the experience and views of psychological therapists working within a palliative care context. In particular, how they find the emotional aspects of this role, and their experiences and views of crying when working with a client. It is hoped that these findings may be useful for other psychological therapists working within similar contexts.

**What happens next?**

Following the interviews, I will write up the results and produce a research paper as part of my thesis. This paper will be submitted to Lancaster University as a part of my Doctorate in Clinical Psychology and may be submitted for publication in a journal in the future. I will also be sharing these with the organisations that helped me to recruit participants to this study. As you have taken part, you can request a summary of the overall findings if you would like one, once the project has been completed.

**What if I have any questions about the research?**

If following this process, you have any questions about the research, please contact me on (telephone number) or email me at [l.richardson6@lancaster.ac.uk](mailto:l.richardson6@lancaster.ac.uk).

**What if I wish to make a complaint or have any concerns?**

Alternatively, if you wish to speak with someone to make a complaint or raise any concern about the research, then please contact Dr Bill Sellwood (Lancaster University Clinical Psychology Programme Director) on 01524 593998 or [b.sellwood@lancaster.ac.uk](mailto:b.sellwood@lancaster.ac.uk).

Alternatively, if you wish to contact someone who is not involved directly with the course, please contact Professor Roger Pickup (Chair of FHM Research Ethics Committee) on 01524 593746, or [r.pickup@lancaster.ac.uk](mailto:r.pickup@lancaster.ac.uk).

### **Additional support**

I have included details for an organisation below that you can contact for additional support, if you feel this will be helpful. Please note, that in the first instance you might speak with your own GP or Trust support systems, if you feel that this information has caused you any distress.

### **Saneline:**

Website: [www.sane.org.uk/what\\_we\\_do/support/helpline](http://www.sane.org.uk/what_we_do/support/helpline)

Tel: 0300 3047000

### **Thank you again for taking part in this study.**

Laura-Jayne Richardson (Trainee Clinical Psychologist)

Lancaster University Doctorate in Clinical Psychology

Furness College

Lancaster University

LA1 4YG

Tel: (mobile number)

Email: [l.richardson6@lancaster.ac.uk](mailto:l.richardson6@lancaster.ac.uk)

## Appendix 4-I

*FHMREC approval  
letter (1)*

Applicant: Laura Richardson  
Supervisor: Ian Fletcher  
Department: Health Research  
FHMREC Reference: FHMREC16044

11 April 2017



Dear Laura,

**Re: Crying with patients in palliative care services**

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838

Email:- [fhmresearchsupport@lancaster.ac.uk](mailto:fhmresearchsupport@lancaster.ac.uk)

Yours sincerely,

A handwritten signature in black ink that reads 'Diane Hopkins'.

Dr Diane Hopkins  
Research Integrity and Governance Officer, Secretary to FHMREC.

Appendix 4-J  
Application form for ethics amendment

Health &  
Medicine

Lancaster  
University



Faculty of Health and Medicine Research Ethics Committee (FHMREC) Lancaster University  
Application for Amendment to Previously Approved Research

1. Name of applicant: Laura Richardson
2. E-mail address and phone number of applicant: l.richardson6@lancaster.ac.uk
3. Title of project: Crying with patients in palliative care services: The experiences of psychological therapists
4. FHMREC project reference number: FHMREC16044
5. Date of original project approval as indicated on the official approval letter (month/year): 11th April 2017
6. Please outline the requested amendment(s)  
**Note that where the amendment relates to a change of researcher, and the new researcher is a student, a full application must be made to FHMREC:** In my previous application, I specified that participants had to work within a palliative care service. I wish to change and broaden my inclusion criteria to include psychotherapists who work with individuals with a palliative or terminal diagnosis and are approaching the end of their lives. To reflect this change in sample, the title of the project will change to: Crying with patients at end-of-life: The experiences of psychological therapists.
7. Please explain your reason(s) for requesting the above amendment(s): I wish to make this amendment as several psychological therapists have asked to take part that regularly work with individuals with a palliative diagnosis and are approaching the end of their lives, but do not work within a formal palliative care service. These potential participants have valuable experiences of the target phenomenon to share which could enhance the overall quality and detail of the data collected. Additionally, to focus on the experiences of these individuals of working with people with a palliative diagnosis, instead of their work within a particular service, suits the chosen method of analysis of Interpretative phenomenological analysis (IPA).

Guidance:

- a) Resubmit your research ethics documents (**the entire version which received final approval, including all participant materials, your application form and research protocol**), with all additions highlighted in yellow, and any deletions simply 'struck through', so that it is possible to see what was there previously.
- b) This should be submitted as a **single PDF** to [Diane Hopkins](#). There is no need to resubmit the Governance Checklist

Applicant electronic signature:

Date: 15th August 2017

Student applicants: please tick to confirm that you have discussed this amendment application with your supervisor, and that they are happy for the application to proceed to ethical review: Yes - discussed with project supervisor.

**Project Supervisor name** (if applicable): Dr Ian Fletcher

Date application discussed: 14th July 2017

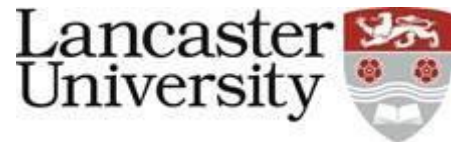
***You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application***

Applicant: Laura Richardson  
Supervisor: Ian Fletcher  
Department: Health Research  
FHMREC Reference: FHMREC16148

Appendix 4-K *FHMREC*

*approval letter*  
(2)

21 August 2017



Dear Laura

**Re: Crying with patients at end-of-life: The experiences of psychological therapists**

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838

Email:- [fhmresearchsupport@lancaster.ac.uk](mailto:fhmresearchsupport@lancaster.ac.uk)

Yours sincerely,

A handwritten signature in black ink that reads "Diane Hopkins".

Dr Diane Hopkins  
Research Integrity and Governance Officer, Secretary to FHMREC.