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Talking Through the Silence: How do Clinical Psychologists who Have Experienced Suicide Bereavement 'Make Sense' of Suicide?

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Farah Dauhoo[1], Jacqui Gratton[2], Jeanette Fuller[3], and Lizette Nolte[4]

Abstract

There is a lack of research concerning therapists' emotional responses to the suicide of clients and/or friends and family and yet, professionally, therapists commonly manage suicide risk of their clients and need to abide by relevant policies. Using a purposive sampling technique, twelve female clinical psychologists working in the UK were recruited via social media platforms. A qualitative method was adopted to offer an in-depth understanding into the lived experiences of losing a loved one and/or client to suicide. The semi-structured interviews took place via video-call or via telephone for up to one hour. Three themes were identified as follows: how talk is experienced as a way of making sense of suicide the messiness of being human,and an experience that helps psychologists face suicide. This study brings to light the dilemmas experienced by clinical psychologists who are both clinicians and survivors of suicide. The findings highlight the lack of conversation relating to bereavement by suicide within mental health services. This study offers insight into how clinical psychologists experience suicide bereavement, and discusses the clinical and UK policy implications.

[1]University of Hertfordshire, Hatfield, UK
[2]University of Hertfordshire School of Life and Medical Sciences, Hatfield, UK
[3]Luton and Bedfordshire Older People's Mental Health Service, UK, East London NHS Foundation Trust, Bedfordshire, UK
[4]School of Life and Medical Sciences, Doctorate in Clinical Psychology, University of Hertfordshire, Hatfield, UK

Corresponding Author:
Farah Dauhoo, University of Hertfordshire, Hatfield AL10 9AB, UK.
Email: farahnaazsalarun@gmail.com

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There is a lack of research concerning therapists' emotional responses to the suicide of clients and/or friends and family and yet, professionally, therapists commonly manage suicide risk of their clients and need to abide by relevant policies. Using a purposive sampling technique, twelve female clinical psychologists working in the UK were recruited via social media platforms. A qualitative method was adopted to offer an in-depth understanding into the lived experiences of losing a loved one and/or client to suicide. The semi-structured interviews took place via video-call or via telephone for up to one hour. Three themes were identified as follows: how talk is experienced as a way of making sense of suicidethe messiness of being human,and an experience that helps psychologists face suicide. This study brings to light the dilemmas experienced by clinical psychologists who are both clinicians and survivors of suicide. The findings highlight the lack of conversation relating to bereavement by suicide within mental health services. This study offers insight into how clinical psychologists experience suicide bereavement, and discusses the clinical and UK policy implications.

Introduction

The World Health Organisation reports that globally one person dies by suicide every 40 s (WHO, 2019), with 6,859 people reported to have taken their own life across the UK and the Republic of Ireland in 2018 alone (Simms et al., 2019). For every person who dies by suicide, a further 6 to 135 people are affected (Pompili et al., 2008; Cerel et al., 2017), including friends and family who are referred to as 'survivors of suicide'. Suicide bereavement also affects a multitude of systems, including schools, workplaces, faith communities, sports organisations, and healthcare. Figures suggest that one third of people who die by suicide in the UK are under the care of specialist mental health services (BPS, 2017), therefore mental health professionals are highly likely to be affected by suicide bereavement.

When working with people who are feeling suicidal, existing research indicates that healthcare professionals report feelings of empathy (i.e. the ability to understand and share the feelings of another), distancing, guilt (i.e. a natural emotional response of worry that you have done something wrong), anxiety and fear (Høifødt & Talseth, 2006). There have been a number of studies exploring the impact of client suicide on mental health professionals, however there are few studies on UK clinical psychologists despite the fact that this professional group regularly work with people who present with risk.

Research undertaken in the USA indicates that one in five clinical psychologists are likely to experience a client loss through suicide (Kleespies et al., 2011), and yet

USA-based psychology training programmes are noted to offer limited input into this topic (Knox et al., 2006). It is important to consider how clinical psychologists make sense of suicide as assessing and monitoring suicide risk is an important part of the role and it is often an essential skill listed within the job description. Furthermore, the way clinical psychologists understand suicide may influence the formulation and intervention they decide upon. Clinical psychologists and mental health professionals alike may benefit from examining their own attitudes and beliefs towards suicide, and consider the extent to which this helps or impedes their ability to effectively engage with clients who report feeling suicidal. Existing research does not account for how clinical psychologists make sense of suicide nor does it consider what is helpful when managing the complexities of suicide bereavement.

From the perspective of an insider researcher of the first author, this study explored how clinical psychologists think about suicide, talk about suicide, and manage the ethical dilemmas which surface in the aftermath of a suicide. Conducting research from an insider researcher perspective has been noted to enhance the depth of understanding (Kanuha, 2000) and increase the degree of tuning into the experiences of participants (Maykut & Morehouse, 1994), which can facilitate disclosure of potentially embarrassing or shaming information.

Within this article, I explore and report on the impact of suicide bereavement amongst clinical psychologists who have experienced a suicide loss of a client and/or a loved one. This is significant because the existing literature on the mental health needs of clinical psychologists and mental health clinicians alike who hold the dual role of being a survivor of suicide as well as a clinician, is fairly limited. Yet these professional groups are often managing suicide risk or face managing highly complex risk presentations. This study focuses on the experiences of clinical psychologists as they form a large group of professionals working within NHS services in the UK, who are regularly involved with assessing risk and suicide risk across all levels of direct clinical care.

This research is also significant as it contributes to an emerging research base, and considers a psychological perspective of the experience of suicide bereavement from a unique angle of a survivor of suicide who is also a mental health professional. The research offers insight into how the experience of suicide bereavement may influence or be influenced by risk-management procedures such as risk-assessments and safety planning, and brings to light the ethical dilemmas and mental health difficulties experienced by clinical psychologists who are bereaved by suicide. The research question was: how might the experience of suicide bereavement impact the relationship to suicide, and how may this influence the management and impact of working with people who are suicidal?

Methods

A qualitative methodology was adopted to offer an in-depth understanding into the lived experiences of losing a loved one or client to suicide.

Participants

A purposive sampling technique was employed and 12 participants were recruited via social media platforms. In order to participate in the research, each participant had to be working in the UK as clinical psychologists either within the Government provided National Health Service (NHS), the private sector or third sector organisations. Participants were required to have had two or more years post qualification experience (to ensure they were working fairly autonomously) and had to have been closely affected by issues of suicide either within personal and/or professional contexts. Each participant confirmed that the suicide loss had taken place over two years ago. From an ethical perspective, two years between the time of the suicide and the interview allowed for some psychological distance between the significant life event and the research interview (Darden & Rutter, 2011). Participants were over the age of 21, and came from diverse backgrounds in terms of religion, marital status and ethnicity.

Within the sample of twelve participants, all were female. Participants were aged between 32 and 49 years old. The number of years of post qualification experience ranged from 3.5 years to 20 years. Four participants reported losing a client, six participants lost a loved one (i.e. family member, friend, colleague), and two reported losing both a client and a loved one to suicide. Participants lived in various locations across England.

A systematic literature review was undertaken to offer a synthesis and critique of the relevant research relating specifically to how clinical psychologists make sense of suicide when they themselves have a personal experience of losing a client, colleague or loved one to suicide. A rigorous literature search strategy was adopted to search six journal databases. In order to capture international research articles, the search was not limited by country but limited to the English language. The search identified 2180 articles, 21 duplicates were removed and 2159 articles remained. These articles where subsequently screened by title, and against the inclusion and exclusion criteria. The literature search yeilded in seven articles identified as relevant. Themes were identified through a scientific process of firstly reading each full-text article thoroughly, and extracting the information that was considered relevant (Siddaway et al., 2019). From this process, four themes were recognised to cover the key points across the seven articles, these were; The *"Occupational Hazard",* The Professional Impact, Emotional Reactions to Client Suicide, Supervision. These themes informed the focus of the current study and subsequent development of the interview schedule.

Procedure

Full ethical approval was granted by the University of Hertfordshire's Health and Human Sciences Ethics Committee and the study was conducted in accordance with the approval. The interviews took place via video-call or via telephone for up to one hour.

Data Analysis

The interviews were transcribed verbatim and analysed by the first author, using the six-phase thematic analysis method (Braun & Clarke, 2006) using an inductive approach. Coding was done by hand and no computer software was used. As per the six-phase approach to thematic analysis, line-by-line codes were recorded for each interview transcript which were later reviewed to identify patterns and themes. Once the themes were finalised along with the thematic map, the primary themes, and the subthemes within them were named and further defined. To assess for quality, the coding was reviewed by the second and third authors. To ensure inter-rater reliability, an external reviewer was invited to review two transcripts, and their coding was reviewed for similarities and differences. This process revealed a high-degree of agreement between the coding of transcripts. The quality of this study was assessed against Tracy's (2010) article titled "Eight Big-Tent Criteria for Excellent Qualitative Research". It was concluded that this study satisfied these criteria.

Results

Three primary themes and subsequent subthemes were identified from the analysis. Each theme, subtheme and supporting quotes will be presented, quotations have been allocated pseudonyms to protect the identities of the participants.

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

- Subtheme 1: Talk as inhibited
- Subtheme 2: Talk as valued
- Subtheme 3: Talk as triggering

The subtheme, *talk as inhibited*, indicated how talking about one's personal view of suicide and talking about one's experience of suicide bereavement is limited due to a sense of anticipated discomfort, a fear of invading privacy, and a fear of being judged or misunderstood. Suicide prevention initiatives put in place by Government policies were also contributing to the inhibited conversations. An example of one such Government policy is the 'zero-suicide' initiative, which was created in Detroit, USA as part of a strategy to reduce the suicide rate in healthcare services. In 2015, the initiative was brought to the UK, and emulated in the NHS.

The second subtheme, *talk as valued*, reflected that when conversations about suicide bereavement did occur, they were mostly experienced as meaningful conversations which enabled participants to reflect on their own beliefs and stance in relation to suicide. Some participants reported that the experience of suicide bereavement enabled them to talk to their own family, their clients and their supervisor in an open and honest way, with less fear and anxiety, as indicated in the following quote:

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

The final subtheme, *talk as triggering*, reflected how participants noticed themselves feeling anxious in response to hearing conversations about suicide. Some participants also noticed feeling dissociated and disembodied when the methods of suicide being discussed were similar to the method used by the person known to the participant, as expressed in the following quote:

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

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

- Subtheme 1: Walking in the families' shoes
- Subtheme 2: Self-doubt
- Subtheme 3: Suicide as 'the solution'
- Subtheme 4: The right to live, the right to die
- Subtheme 5: When views are not aligned

The second theme brings to light the dilemmas that arise in relation to suicide bereavement. The first subtheme, *walking in the families shoes*, reflected how participants who lost a relative to suicide felt more able to empathise and connect with the grief of families of clients who complete suicide. Participants expressed the dilemma of occupying both the role of psychologist and 'survivor of suicide', as they are unsure whether to share their own experience as a way of connecting to the grief of others.

The second subtheme, *self-doubt,* captures how participants questioned their own clinical skills following the experience of suicide bereavement. Most participants reported wondering what they could have said or done differently, as illustrated in the quote below:

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

This sense of self-doubt was reported across the participants who experienced a suicide bereavement in their personal as well as professional life, regardless of years of experience and seniority.

The third subtheme, *suicide as the solution*, reflected how suicide was conceptualised as a response to distress, and an escape. Suicide was also understood as occurring

when people are living with unsurmountable amounts of emotional pain, as illustrated in the following quote:

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

The fourth subtheme, *the right to live, the right to die*, reflected how most participants felt strongly that people had the right to decide to end their life. There was a sense of discomfort at not acknowledging this in the workplace. This led to participants questioning their own position in relation to keeping people alive who verbalise that they wish to end their own life. Questions were also raised relating to whether people with mental health problems, or people who are emotionally distressed, have the capacity to decide to end their own life. This was pertinent to whether they were able to make an informed decision, weigh up their options and whether they are aware that life could change. Some participants felt a mental capacity assessment, which assesses whether an individual has the capacity to make a decision when they need to, could be completed to explore whether they understand the implications of making a decision to end their life.

The fifth subtheme, *when views are not aligned*, reflects the incongruity between the participants' values and Government policies such as the 'zero-suicide' policies. This dilemma is illustrated in the quote below:

> *"I can sit with distress or the uncertainty of whether somebody may or may not commit suicide in the moment… however I am also employed by the NHS and my duty is to ensure that people stay alive…so there is something I have to do that might go slightly against my personal values…" - Belinda*

Participants emphasised that they would always do their utmost best to keep people safe in line with Government policies and risk management procedures. However, most participants also reported that they continue to hold on to the view that clients do have a choice, which generates a dilemma. To navigate this dilemma, a both-and approach was adopted (i.e. the duty of care and proection of clients remained a priority alongside recogniseing that clients have a choice). Some participants reflected on how the NHS Trust may respond to serious incidents and suicides by introducing suicide prevention initiatives. Participants acknowledged how these initiatives are a way of managing the anxieties and complexities that are present in relation to suicide, but expressed that it can feel reductionist in its approach and can appear to shift the agency and responsibility onto the clinician.

Theme 3: An experience that helps psychologists face suicide

- Subtheme 1: Resilience in the face of risk
- Subtheme 2: The experience of loss shaped career
- Subtheme 3: The light within the dark clouds

The first subtheme, *resilience in the face of risk*, reflected how losing someone to suicide resulted in having an increased awareness and antenna for risk both within their personal and professional contexts. Participants reported having more curiosity when talking to people about suicide or suicidal ideation which led to more thinking about the meaning behind the method used by people who have attempted or completed suicide. There was a reported sense of feeling liberated at having experienced a suicide either within a personal or professional context as participants expressed the feeling that they had survived their worst feared scenario, as illustrated in the quote below:

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

A greater tolerance for sitting with risk was also reported, and participants reported feeling more attuned to people experiencing hopelessness or suicidal ideation.

The second subtheme, *the experience of loss shaped career*, captured how the experience of suicide bereavement led to participants opting for a career in clinical psychology. Some participants believed that most people enter helping professions as a way to rescue someone they know.

The final subtheme, *the light within the clouds*, captures what clinical psychologists find helpful in coping with the dilemmas following a suicide bereavement. Gilbert's (2009) model of Compassion Focused Therapy (CFT) was the model of choice as participants felt it acknowledged the complexity of the human experience and suffering, and facilitated self-compassion and compassion towards others. Compassion Focused Therapy (CFT) involves being sensitive to our own or other people's distress, and learning how to skilfully alleviate this.The value of belonging to a religious faith and holding onto hope was also acknowledged.

Discussion

This study brings to light the dilemmas experienced by clinical psychologists who are both clinicians and survivors of suicide. This study focuses on the experiences of clinical psychologists as they form a large group of professionals who are regularly involved with assessing risk and suicide risk across all levels of direct clinical care. However, the findings can be transferable across wider mental health professionals.

The finding that conversations about suicide bereavement were limited due to an apparent fear of being judged for holding certain views supports the findings by Tillman (2006), who found that participants feared being judged by colleagues for doing something wrong following a client suicide. This finding extends upon what was found in the literature, and adds new detail to the findings by Tillman (2006). Findings from the current study highlight how participants were worried about being judged for the alternative views they held which adds a moral dimension about how society thinks about suicide, and what is deemed acceptable.

Some conversations about suicide bereavement within team meetings and between colleagues were experienced as devoid of context or blasé. This finding adds to the report by Davidsen (2011) who asserted that because suicide is difficult to talk about, staff may use euphemisms such as *"topped himself"*, *"this sort of incidence"* and *"died suddenly like that"* (Foggin et al., 2016, p. 740) as a way of professionally distancing themselves from the event (Neimeyer & Pfeiffer, 1994). A potential consequence of this is that if there is no platform for staff to voice what is difficult, staff may be more likely to experience compassion fatigue (Figley, 2002), which is a term that describes the psychological, emotional and physical impact of helping others. Amonsgst staff, this may come across as disconnected and lacking in empathy.

The experience of losing a loved one and/or client to suicide for some participants led to conversations about risk being approached with openness and less fear. In some cases, when clinical psychologists were able to talk to supervisors about their experience of suicide bereavement, it enabled better communication. This finding supports Finlayson and Simmonds (2018) who summarised that supervision can be a useful coping mechanism for processing the loss. This finding appears to add a new dimension to the existing literature as it suggests that talking about suicide can contribute to a shift towards a greater ability to cope with challenges following a traumatic event (Janoff-Bulman, 2004).

The experience of suicide bereavement led to feelings of anxiety being activated, specifically upon hearing clients or colleagues talk about suicide which bore similarities with their own loss. This finding supports Tillman (2006), who also concluded that following a client suicide, participants reported trauma symptoms such as dissociation and intrusive thoughts. This is a significant finding because clinical psychologists and mental health professionals are not always considered as 'survivors of suicide', yet this finding demonstrates the need for this dual role to be acknowledged. It indicates that appropriate support or referral for a psychological intervention needs to be provided to staff.

The intricacies of navigating the dual position of a 'survivor of suicide' and a psychologist was a novel finding. This duality led to increased empathy towards family members of people who end their life, which is a finding that builds on the findings by Anderson (1999). Other dilemmas include the experience of self-doubt which contributes to feelings of guilt and failure. This finding supports Clark et al. (2009) who also noted that psychotherapists experienced a crisis of confidence within their professional role following a client suicide. Interestingly, self-doubt was also experienced amongst those whose loss was a suicide in their personal life, which is a finding that adds to existing literature. Perhaps this was seen as a 'missed opportunity' to support someone in their personal life.

There was a notable incongruity between personal views on suicide and the policies on suicide management i.e. the zero-suicide policy (HM Government, 2019). All participants acknowledged their duty of care as clinical psychologists, however findings saw that participants thought there was a need to acknowledge the agency that people have to end their life, a notion which supports the libertarian perspective that people

should have the autonomy to decide to commit suicide (Szasz, 2002). To manage this dilemma, a 'both-and' position (Sexton et al., 2004) was employed which enabled participants to hold on to their values of respecting choice and also do everything they should to prevent the suicide in line with formal requirements, despite this meaning putting their personal views aside. A further way of managing this was to not share these views, as demonstrated by inhibiting conversations. However, this can be difficult to maintain over time and may have unintended consequences, such as burnout, compassionate fatigue, or a reluctance to speak to staff about risk related concerns.

It was suggested that people with mental health problems may benefit from a capacity assessment to explore that the implications of making this decision is understood. This finding appears to support assertions by Hewitt (2013) who advocates that psychological pain should be regarded with the same significance as physical pain, thus even people with serious mental health problems can make a rational decision to end their own life.

Despite the experience of suicide bereavement initially relating to feelings of self-doubt, over time some participants reported feeling more resilient and confident when supporting people who are feeling suicidal. This finding is consistent with the idea of gaining "*strength through suffering*", in that there is a new found strength to cope with the unexpected following a traumatic event (Janoff-Bulman, 2004). Participants reported having more curiosity around the meaning of the method used to attempt or complete suicide, and noticed subtle non-verbal cues, they also had more confidence to raise this with clients. This may be understood within a context of post traumatic growth (Tedeschi & Calhoun, 2004), which suggests that positive psychological change can occur in the wake of struggling with a highly challenging, stressful, and traumatic events. The experience of suicide bereavement was found to have been instrumental in generating new possibilities for exploring risk with clients. This enriches our understanding of the impact of suicide bereavement amongst clinical psychologists, and may be transferable across mental health professionals.

Some participants entered the field of psychology to develop their understanding of suicide loss, and some reported entering the field to try and 'rescue' family members. This finding supports Sussman's (2007) reflections that a powerful motivator to enter the profession is to resolve inner conflict coupled with an innate desire to 'work things out'. This mirrors the concept of the "*wounded healer*" (Zerubavel & Wright, 2012, p.482), which describes how psychotherapists search for their own self-growth through entering the profession. Therefore, one might suggest that the experience of losing a loved one to suicide may have motivated participants to enter the profession of clinical psychology to develop their understanding of suicide and emotional distress. There is a need for recognition of "*wounded healers*" (Zerubavel & Wright, 2012, p.482), as the relative absence of conversations in the field of Psychology and mental health services may promote a sense of shame and secrecy. This may prohibit the timely access to support and guidance when needed, as well as the profession learning from the insights of their workforce.

It is important to note certain contradictions in the findings. For example, some participants reported that talking about suicide felt inhibited in the work context, but valued talking about suicide when opportunities arose. Elsewhere, some participants reported

feeling hyper-vigilant, and feelings of anxiety were activated, but participants also reported feeling more confident to approach the topic as time progressed. This demonstrates the fluid nature of navigating between these positions. Other factors which appear to influence how clinical psychologists navigate between these positions may be the time since the loss occurred, and a more supportive supervisory relationship

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

Implications

Some conversations about suicide and suicide risk in multi-disciplinary teams (MDTs) were described as blasé and not attending to the context and content of the event. Furthermore, the finding that some participants thought others in their team feared talking about suicide with clients as it may make things worse, while we know from previous research enquiring about suicide with clients may in fact reduce suicidal ideation (Dazzi et al., 2014), points towards a possible area for development within team working, e.g., psycho-education about the value of opening up conversations about suidice and/or skills development for staff in how to initiate such potentially difficult conversations. To address this, conversations could be facilitated across the various mental health professions in various forums i.e. away days, Continuing Professional Development (CPD) slots, workshops, and seminars, in order to promote an openness and awareness. Schwartz rounds may also offer an alternative approach for conversations about the impact of suicide bereavement, as they provide a structured forum for clinical and non-clinical staff to come together to discuss the emotional aspects of working in healthcare and reflect on their roles (Farr & Baker, 2017).

The absence of open conversations about suicide was related to not feeling safe enough and a fear of judgement. It would be important to consider how to enable

clinical psychologists and other mental health professionals to feel ‘safe enough’ to speak about this topic. Staff may benefit from having an open non-judgemental space to reflect on their experience and how suicide impacts on their practice. This may involve reflective practice sessions, and increased liaison with third sector organisations that specialise in suicide bereavement to gain insight into how to generate a sense of safety and promote discussions within groups. This may also be a useful space to navigate the feelings of self-doubt, blame and responsibility, and would enable professionals with shared experiences to connect and not feel alone in their experience (Tedeschi et al., 2007).

It would be useful to set up a special interest group to ensure that the mental health profession is actively engaging with research within the field. Supervisors may also be supported with training on how to support staff who have experienced suicide bereavement of a client or a loved one. This may heighten their awareness of the role of self-doubt and self-blame, and enable supervisors to engage in exploratory conversations about how the staff member is experiencing the loss.

The training programmes for psychology and other mental health professions would benefit from dedicating more lecture time and group discussion on the topic of suicide and suicide bereavement. It would be useful for training programmes to consider that many people have existing experience of suicide bereavement, and others may experience this at some point in their career. Thus, inviting a space for these experiences to be shared is important. It would also be helpful to discuss the practicalities relating to the aftermath of a client suicide which could support both trainees and qualified staff to navigate this otherwise unknown territory.

It may be useful to consider how a compassion focused frame could be adopted by services at an organizational level to promote connecting with difficult feelings and challenges in the workplace. Gilbert (2009) describes compassion as the insight and sensitivity to the suffering of others, along with the courage and commitment to prevent such suffering. It may be worthwhile to consider this lens to address the structural matters which undoubtedly influence such conversations, before such a space could come to exist. If the conversations in the team can be met with a compassionate stance, and modelled by the service and managers, it may support the team to embody such principles in their work with clients and with themselves, potentially generating a circular process. As CFT works with issues of shame and self-criticism which can contribute to feeling unsafe (Gilbert, 2014), it would seem appropriate to use this model to cultivate a compassionate organisation which allows for different positions, and which promotes people talking openly, within a non-judgmental setting. Organisations that nurture self-compassion amongst healthcare workers have been shown to improve their ability to remain compassionate towards others (Wiklund Gustin & Wagner, 2013).

It is clear that the suicide prevention initiatives bring up ethical dilemmas for clinical psychologists, and might well be problematic for other mental health professionals. An ethical way around this is to ensure that services are offered the resources needed to support people in a crisis to reduce the despair people are in, which would improve the effectiveness of such initiatives. Despite £25 million being pledged to improve

suicide prevention within the UK National Health Service (HM Government, 2019), there remains a sense that this is not sufficient to deliver such a task (Matthews-King, 2018). It may also be worthwhile to engage clinical psychologists and other mental health professionals with experience of suicide bereavement in policy making with the aim of reducing the sense of clinician blame where appropriate.

Strengths & Limitations

A strength of this study is that it received an overwhelmingly positive response to participant recruitment, which was completed in under two weeks of the research being advertised. This indicated how this research topic was one that appealed to many clinical psychologists and shows the need within the profession to open up conversation on this topic. Although this study focused on interviewing clinical psychologists, the findings are applicable across therapeutic professions and across mental health professionals generally. Participants were recruited with varying degrees of post-qualification experience, ranging from three and a half years to twenty years' experience and worked in a variety of clinical settings, which offered a broad overview across different services.

As an insider researcher, the first author noticed being drawn to certain themes more strongly than others. Researching from this position allowed for more understanding of the phenomena relating to suicide (Saidin, 2016), and this dual role appeared to enable participants to speak openly. A common challenge that insider researchers face, is navigating between being both the researched and the researcher (Chavez, 2008). To mitigate this, regular research team meetings took place, the first author also recorded thoughts and reflections via a "*stream of conscious writing*" (Van Heugten, 2004) in a journal. Collectively, these actions helped the first author to create some distance and remain impartial.

A limitation of this study is the lack of diversity in the participant sample. Whilst efforts were made to recruit clinical psychologists from diverse ethnic backgrounds, it transpired that there was a lack of response. This may reflect the current lack of diversity represented in the field as all but one identified as white British, which is likely to mirror the current UK clinical psychology workforce (BPS, 2015). In relation to faith and spirituality, ten of the twelve participants reported that they did not identify with a religion or identified as an atheist which supports the findings that psychologists in the UK are less likely to identify as religious (Smiley, 2001).

It is also a possibility that the intersectionality between religion, ethnicity, culture, spirituality and being a 'survivor of suicide' acted as a barrier to participating in this study. By naming this gap and bringing in the voice of the first author as an insider researcher of a BAME background, it is intended that this will begin to promote an openness to having these conversations. One implication to address this may be to have people from different BAME backgrounds visibly speaking about the topic of suicide bereavement on training programmes, conferences, seminars and workshops.

Participants who lost a loved one, a friend, a colleague or a client to suicide pre-training or post-qualification were interviewed. By not differentiating between the nature of the relationship (personal or professional) or between the timing of the

loss (pre-training or post-qualification), the study may have not captured the potential differences in these experiences. This is an area to consider for further research. However, as is the case for the first author, it should not be assumed that mental health professionals only experience one type of suicide bereavement.

Conclusion

This study explored how clinical psychologists made sense of suicide following their own experience of losing a loved one and/or a client. Given that this research area is relatively neglected, this study aims to bridge this research gap. Findings indicate that suicide was understood as a response to unsurmountable and unresolved deep emotional pain, an escape from a life people no longer wish to be in, a choice, and at times an understandable response. Making sense of suicide was shaped by the experience of self-doubt, and occupying the dual role of both 'survivor of suicide' and clinical psychologist. The findings highlight the emotional turmoil experienced by clinical psychologists upon hearing colleagues or clients speak about suicide and suicide methods which resonated with their own experience, and the lack of conversation relating to suicide within mental health services. These experieces were likely associated with the discomfort of talking, emotions such as shame or guilt and a fear of being judged, alongside the tensions clinical psychologists described between their own understandings about suicide and the policies they are required to (and committed to) follow as employees in the NHS in relation to suicide prevention. Compassion Focused Therapy (CFT) was suggested as a useful frame to support clinical psychologists and wider organisations to cope with the dilemmas that arise in the aftermath of a suicide. This study highlights the need for broader conversations around suicide bereavement within the fields of mental health and clinical psychology. Useful and meaningful policy implications are suggested to offer some ideas to begin to address some of these challenges.

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ORCID iD

Farah Dauhoo https://orcid.org/0000-0001-6664-2346

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Author Biographies

Farah Dauhoo is a clinical psychologist working within the East London Foundation Trust NHS mental health trust services across Bedfordshire, with a specialist interest in working with children and adolescents (looked after children) and older adults.

Jacqui Gratton, Principal Clinical Psychologist, is clinical lead in the NHS for staff support across West Essex, UK, and runs a private practice providing coaching, supervision and consultation to individuals and organisations. Her clinical and research expertise is in trauma exposed staff groups and vicarious trauma as well as more general personal and professional development.

Jeanette Fuller is a Clinical Psychologist working in Older People's Service in the South East of England. She has been involved in a variety of research, including work on shame and guilt in forensic patients, evaluations of psychological interventions and staff experiences in working in mental health settings, including the current research. She is currently completing her knowledge component of clinical neuropsychology training and is developing research experience in cultural neuropsychological assessment and general neuropsychological practice.

Lizette Nolte, DSystPsy is research lead on the Doctorate in Clinical Psychology programme at University of Hertfordshire, United Kingdom and a clinical psychologist and systemic and family therapist in clinical practice. Her research focuses on family wellbeing and meaning-making, including within the contexts of family safeguarding, parental mental health and perinatal healthcare and family bereavement.