THE EXPERIENCE OF PSYCHOLOGISTS AFTER THE SUICIDE OF THEIR PATIENT

by

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DECLARATION

Student number: 42871018

I declare that the experience of psychologists after the suicide of their patient is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

________________________  _______________________
SIGNATURE                DATE

(Mr. W.M. Teichert)
Dedication

This study is dedicated with love to my wife and best friend, Rejuan. Thank you for encouraging me to follow my passion. You are the song in my heart.
Acknowledgements

I would like to acknowledge the following individuals for their contribution to this study:

My supervisors, Professor Vasi van Deventer and Dr Retha Visagie. Thank you for your passion and encouragement. Your insistence on conceptual clarity, attention to detail and your genuine interest in my ideas helped me create a study that has exceeded my expectations.

The participants: Thank you for allowing me into your pain. Your voices will bring healing to many more.

My parents: It is a privilege to be called your son. Thank you for showing me the meaning of grace and compassion.

Dr Naseema Vawda: This study was born from our conversations. Thank you for introducing me to the field of suicidology.

Dr Johan Ferreira: Thank you for your practical wisdom as therapist, mentor and friend. Our journey continues.
ABSTRACT

Considering the high incidence of suicide in the South African context, the fact that suicide is considered an occupational hazard for psychologists, with more than half experiencing the suicide of a patient in their career and the dearth of post-suicide qualitative research among psychologists, the purpose of this study is to explore and describe the experience of psychologists after the suicide of their patient, and to develop guidelines as a framework of reference to assist psychologists in dealing with the suicide of their patient.

In keeping with a social constructionist ontological and ecosystemic epistemological theoretical framework, data was collected by means of meaning-making conversations with six purposively selected psychologists, with a minimum of five years’ experience and at least one year having passed after the suicide of their patient.

The data was analysed independently by the researcher and an independent coder using Tesch’s open and descriptive method. The present study found that, following the suicide of their patient, the participants were propelled into a myriad of acutely distressing emotions. They often described a suffocating sense of responsibility for the suicide and the lingering presence of their patient. The participants experienced feelings of guilt and self-doubt, often questioning their own professional competence.

The post-suicide process was described as being both a personally and professionally isolating event, due to the sense of having to carry the burden of the suicide alone for ethical reasons and fear of social stigmatisation.

The participants appeared to grapple with the paradoxical dance between their personal emotional realities and what they perceived to be “clinically” or “professionally” acceptable.

Having gone through the traumatic experience of losing a patient to suicide, most of the participants eventually found new wisdom, which helped them become wounded healers.
Based on these findings, post-vention guidelines with practical actions were developed to assist psychologists in dealing with the suicide of their patient. Recommendations are made with regard to suicidology research, suicide education and psychologists’ practice.

**Key terms:** Suicide; Experience of psychologists; Qualitative research; Social constructionist; Ecosystemic epistemology; Suicidology; Meaning-making conversation
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CHAPTER 1: INTRODUCTION

“I don’t think I’ll ever forget standing at her bed ... seeing her in that state and knowing that this is going to be her last session ...” (Grace, one of the participants)

1.1 INTRODUCTION

This study explores the experience of psychologists following the suicide of their patient. This introductory chapter aims to provide a rationale for the research and then orient the reader to the study by providing an overview of the research process that was followed.

1.2 THE CHOICE OF TOPIC

The background to the choice of topic is provided by introducing “the researcher” or “I” and the context of the study.

1.2.1 Empathic Curiosity

On my second day as an intern clinical psychologist at a state hospital, I, the researcher, saw a patient in psychotherapy who the night before drank a lethal dose of poison and then attempted to hang herself. The experience of trying to emotionally contain an individual that used multiple methods in an attempt to end their life a couple of hours earlier, had a profound impact on me. Based on my assessment of suicide risk, I recommended that the patient be admitted to the psychiatric ward of the hospital for further treatment. A multidisciplinary team of mental health professionals had to decide about the further treatment of the patient. I noticed that the team of experienced mental health professionals expressed uncertainty, fear of various hypothetical scenarios in dealing with a suicidal patient, and a sense of helplessness about having to treat a patient who communicated a clear wish to die.

1 See notes on the use of language in section 1.5.3.
During the decision-making process, some of them shared their stories about having experienced the suicide of their patient. The emotional nature of these experiences evoked empathy, but also research curiosity, in me. I was curious about whether similar experiences of psychologists having experienced the suicide of their patient had been academically documented and if so, if they were consistent with what I observed. The empathic curiosity that emerged from the conversations left me with the lingering question:

*What is the experience of psychologists following the suicide of their patient?*

### 1.2.2 Neglected Stories

This empathic curiosity went from a lingering question to an informal research process, where I enquired from psychologists in my immediate sphere about whether they experienced the suicide of a patient. I spoke to seven different psychologists, all of whom either had one of their patients commit suicide or knew of a colleague who experienced the suicide of their patient. Seemingly raw, untold stories of shock, horror, grief, acute stress symptoms, personal and professional shame and guilt emerged. The one psychologist recounted:

> “When a patient commits suicide the psychologist either gets blamed by the family or at best avoided. There’s a perception that you’re not allowed to mourn. I felt guilty about being sad.”

### 1.2.3 An Opportunity for Further Research

During an initial survey of the literature I discovered that in the South African context, the vast amount of suicidology literature is based on quantitative research (Schlebusch, 2005; 2008; 2012; Schlebusch, Vawda & Bosch, 2003), while qualitative suicidological research presents numerous opportunities for further exploration due to the lack of literature (L. Schlebusch, personal communication, 22 January, 2013; N. Vawda, personal communication, 10 January, 2013). With regard
to the present topic, only one local study (Engelbrecht, 2004) was found on the experience of “therapists” after the suicide of their patient; certain opportunities were presented for further exploration. Darden and Rutter (2011) note that internationally, investigations that consider the psychologist’s experience of a patient committing suicide are negligible. The available literature is discussed in chapter 2 of the present study.

1.3 THE NEED FOR THE STUDY

The incidence of suicidal behaviour in the South African context is high in comparison to international figures (Schlebusch, 2005; 2012). Based on research conducted by Schlebusch (personal communication, 2013), he reports that approximately one to two completed suicides and 20 or more attempts occur every hour in South Africa. These figures can be seen as a conservative estimate, due to the lack of research in rural communities or the non-reporting of a suicide due to social shame (Schlebusch, 2005; 2012; 2013).

Considering Weiner’s (2005) suggestion that half of those individuals who committed suicide were being treated by one or more mental health professionals, it portrays a daunting picture of the burden that mental health professionals have to bear in the South African context. Darden and Rutter (2011) note that “... compared to other mental health disciplines, client assessment, which includes suicide assessment, is central to the role of the psychologist.” Suicide can be viewed as an occupational hazard for psychologists (Gutin, McGann & Jordan, 2011). Statistically, half of psychologists experience the suicide of a patients and many of them experience it more than once (Skodlar & Welz, 2013; Foley & Kelly, 2007). Based on the above figures and thoughts, one could conclude that as a psychologist, the probability of experiencing the suicide of one of your patients is high.

The management of suicidal patients is therefore a skill that is intrinsic to what it means to be a psychologist. It comes with the territory. But what if a patient decides to commit suicide despite the psychologist’s by-the-book efforts to perform a risk assessment, have them sign an anti-suicide contract, mobilise the support of family
members around them or even have them admitted to hospital? International research shows that psychologists experience utter shock, horror, disbelief, betrayal and depression for days, months or years after the suicide, with some leaving the profession (James 2005; Spiegelman & Werth 2005; Kleespies, 2009; Skodlar & Welz, 2013). As noted earlier, my motivation for this study was that the experience of psychologists after the suicide of their patient had not been explored or reported adequately.

1.4 THE PURPOSE OF THE STUDY

The research sought to explore and describe the experience of psychologists after the suicide of their patient and to formulate guidelines to assist therapists in dealing with such an experience.

The two objectives of the study were to

- explore and describe the experience of psychologists after the suicide of their patient, and
- develop guidelines as a framework of reference to assist psychologists in dealing with the suicide of their patient.

1.5 THEORETICAL FRAMEWORK

The major function of the clarification of the theoretical framework is to position the researcher ontologically and epistemologically in relation to the research (Holliday, 2010). While ontology is the study of being, epistemology is the theory about understanding and knowledge (Terre Blanche & Durrheim 2007). The presence of a basic system of ontological and epistemological assumptions with which researchers approach their research is widely accepted (Babbie & Mouton, 2010; Guba & Lincoln, 2013; Creswell, 2007).
1.5.1 Social Constructionist Ontology

Aspects of qualitative, constructivist and co-created research principles are jointly relevant and interwoven into social constructionist ontology (Carruthers, 2007). The word ontology is derived from the two Greek words *ontos*, meaning “being; that which is in existence” and *logos*, meaning “word; speech; thought” (Reber, Allen & Reber, 2009). Ontology specifies the nature of reality that is to be studied, and what can be known about it (Guba & Lincoln, 2011; Terre Blanche, Durrheim & Painter, 2007). Ontological clarification includes questions about the researcher’s assumptions about the nature of the world, the nature of reality and what we can know about it. The ontological framework for this study is *social constructionist*.

According to Burr (2003:2-4), a social constructionist ontological approach has the following characteristics:

- *a critical stance toward taken-for-granted knowledge*: The researcher must remain critical about how he or she perceive reality and not accept the popular (or his or her personal) meanings ascribed to constructs;
- *historical and cultural specificity*: The language used in the discourse of describing and understanding the world is relative to the historical and cultural understanding in a given time frame and cultural context;
- *knowledge is sustained by social processes*: The meanings people ascribe to their understanding of the world are constructed by means of daily interactions with other people. Language therefore plays a crucial role in conceptualising the reality of each individual as it is co-constructed in social interactions; and
- *knowledge and social action go together*: The social understanding (as generated by the social processes in society) of knowledge about a given topic informs the socially acceptable actions that follow these actions. In the present study, an example might be that a psychologist might perceive the suicide of a patient as something that was inevitable due to the patient’s illness and severity of symptoms caused by a complex relationship between biological, psychological and social factors, while in the middle ages suicide
was often perceived as precipitated by demonic possession or sin (Schlebusch, 2005).

Two of the main tenets of social constructionist ontology are further expanded below.

1.5.1.1 Multiple realities

These research principles are based on a relativistic theory of knowledge that introduces the notion that multiple accounts of reality exist and that it is impossible to find an absolute, objective truth (Gergen & Gergen, 2004; Keeney, 1983). In this ontological framework, understanding is not gained in isolation, but in a social process of shared meaning and involvement, where the context informs the research process and the research process enables the researcher to draw new distinctions and punctuations (Searle, 2010). The implication here is that meanings are neither static, nor unchangeable, but are the product of social interaction over time. In the present study, meaning was co-constructed from the reality of the researcher, the participants and the literature.

A social constructionist ontology values the adoption of a “not-knowing” position in order to create new meanings from conversations rather than impose one’s own understanding of reality on someone else (Mandim, 2001). With regard to the research process in the present study, the “not-knowing” position (or non-expert) did not suggest that the researcher lacks the experience or qualification to conduct the research, but rather that there was no privileged position (Gergen, 2009; Gergen & Gergen, 2004; Combs & Freedman, 1996).

1.5.1.2 Language, context and reflexivity

A social constructionist ontological framework emphasises the importance of language as mediating social knowledge (Mandim, 2001). To be reflexive in the research process requires an acknowledgement that constructing reality is a social process rooted in language (Mandim, 2001). During the present study, the research
content evolved according to the various conversations that took place between the researcher and the various co-creators of meaning, namely the participants, the independent coder and the group of co-creators found in the literature. By reflecting on these conversations and allowing new meanings to emerge from the text, the researcher and the co-creators develop new language and realities through what Gergen et al. (1986) and Hoffman (1990) call “emancipatory dialogue”.

In conclusion, a social constructionist ontological framework was preferred because an ontological framework of multiple realities creates a context for the researcher in which to partake with the research participants in discovering the language they use to describe their version of reality by honouring it as their authentic truth (Gergen, 2009; Searle, 2010; Combs, 1996; Berger & Luckman, 1967). I come from a background where I worked in contexts where I was regularly confronted with individuals proclaiming their “absolute truth” at the cost of divergent perspectives. I experienced the marginalisation of individuals based on gender, sexual orientation, ethnicity and religion and developed a personal ethos of engaging with other individuals from a “not-knowing” position. From the “not-knowing” position I choose to view the individuals whom I interact with as the expert in their own reality and experiential world. As a researcher, this position allows me to engage with the participants in a context of respect and openness, which is conducive to a rich, multi-layered and descriptive meaning-making process.

This study presents the experience of six psychologists’ after the suicide of their patient. The need for and the objectives of the study guided the decision to use a social constructionist ontological framework to create new meanings by means of interactions with numerous co-creators of meaning.

1.5.2 Ecosystemic epistemology

“Epistemology specifies the nature of the relationship between the researcher (knower) and what can be known” (Terre Blanche et al., 2007:6). One could therefore conclude that the researcher’s epistemological stance is an orientation toward the research process and the frame of enquiry.
The current research was done from an ecosystemic epistemological position, which is characterised by a move away from the traditional Cartesian (linear) conceptualisation of the research process to a circular, interactional epistemology that includes the complex network of systems of which the research participants form part. It acknowledges context, relationship, ecology, interaction, complexity, wholeness and “fit” (Keeney, 1979).

There are certain key implications of an ecosystemic epistemological approach to research, which will now be discussed.

### 1.5.2.1 Hierarchy

The research process is a shared journey of discovery where the researcher and the participant both have the freedom to express their construction of reality, thereby creating a new reality that is co-constructed (Gergen, 2009; Searle, 2010). The traditional relationship between researcher and the object of study in traditional schools of research is therefore challenged (Becvar & Becvar, 2009; Carruthers, 2007). One of the key differences between a linear epistemology and an ecosystemic epistemology is that the privileged position of the researcher observing the object of study does not exist. The relationship between the researcher and the participants is guided by an awareness of a circular interaction and co-creation of meaning through language, which ultimately leads to the creation of a new shared reality (Keeney, 1983).

### 1.5.2.2 Causality

Interactions between individuals are viewed as having circular causality as opposed to linear causality. To describe this in terms of research, linear causality will emphasise the researcher as “doing” research on participants, while a circular causal perspective focuses on the reciprocal influence that the researcher, the literature and the participants have on one another, as indicated in figure 1.1. There is therefore a dialectic and not dualistic way of thinking and understanding the research process.
1.5.2.3 Meta-perspective of human interactions

Becvar and Becvar (2009:11) describe the meta-perspective of human interactions when they note the following:

“Systems theory/cybernetics therefore may be said to be a theory of theories, or a meta-theory. It is descriptive only and suggests that we suspend judgements about what is good and bad, right and wrong. We are urged to consider goodness and badness relative to context. The important issue is utility, or appropriateness, neither of which can be decided out of context.”

In this framework, the focus is on finding the meaning of the interviews and meaning-making conversations in their context, as opposed to treating it as isolated pieces of information. This meta-perspective of human interactions emphasises the important role that reflection plays during the interaction with the participants and rejects the notion that an individual could be researched in isolation.

1.5.2.4 Both/and approach

Gergen (2009), Keeney (1983), Keeney and Morris (1985) and Auerswald (1985) argue that a binary position (either/or dichotomy) is not only unnecessary, but also limiting to the research process. During the present study, apparent paradoxical realities were viewed as two sides of the same coin. These paradoxical realities
allowed for a rich description of the themes and categories that emerged from the meaning-making process.

1.5.2.5 Punctuating parts of the whole

A holistic understanding of the research context allows the researcher to consciously choose specific parts of the whole to investigate. This choice of a specific part in the whole is the researchers’ *punctuation*. *Punctuation* of specific aspects of the research context reduces the whole into manageable and practical pieces (Mandim, 2001). In the greater “context” of psychologist-patient interaction, the present study punctuates the experience of *psychologists* (*specific perspective*), *after the suicide* (*specific time frame*) of their patient. The rationale for choice of punctuation has been discussed earlier in this chapter.

1.5.2.6 The focus is on the patterns that develop over time between individuals

The interactional *patterns* between individuals in its given context are emphasised in an ecosystemic framework (Becvar & Becvar, 2009). These patterns are maintained by means of self-corrective *feedback* loops (Becvar & Becvar, 2009). Capra (1996:56) describes the feedback loop as “a circular arrangement of causally connected elements, in which an initial cause propagates around the links of the loop, so that each element has an effect on the next, until the last feeds back the effect into the first element of the cycle.” Similar to that of a living organism, the concept of *homeostasis* in the context of a relational network describes the ability of social systems to maintain themselves in a state of dynamic balance by means of these self-regulatory feedback loops (Becvar & Becvar, 2009). During the research process, the focus is on observing and reflecting on these patterns that develop during the interviews by asking the question about “what” is happening “when” and “where” in the session rather than “why” it is happening (Becvar & Becvar, 2009).

In conclusion, Babbie and Mouton (2010), Guba & Lincoln (cited in De Vos et al., 2009) and Creswell (2007) all emphasise the importance of “fit” between the
epistemological frame and the topic of research. An ecosystemic epistemological framework was preferred for the following three main reasons:

- the researcher was trained in an ecosystemic paradigm during his master’s degree in clinical psychology at the University of South Africa, which has given him the ecosystemic epistemological language to express himself clearly throughout this research;
- both internationally and in South Africa, no ecosystemic exploration of the topic has been found. An ecosystemic exploration will therefore contribute to the body of knowledge available; and
- as evidenced by the discussion of the various implications of an ecosystemic epistemological framework, there is a “fit” between the topic of study and the epistemological frame.

1.5.3 The Use of Language

_I, the researcher_

The language used during this research will be _both_ from a third person perspective (“the researcher”) _and_ the first person perspective (“I”) for two reasons.

Firstly, in a social constructionist ontological and ecosystemic epistemological framework, the observer replaces the observed as the focus of attention. Subjectivity is seen as inevitable, as the one who is observing perceives, acts on and participates in creating his or her own reality (Becvar & Becvar, 2009). The interdependence of both the observer and the individual being observed forms an integral part of the holistic view of the context of human interactions in the systemic framework (Becvar & Becvar, 2009). Reality is therefore not limited to one perspective (or person) that might create an “either/or” tension as previously explained. Therefore, in the course of this research _both_ the terms “researcher” _and_ “I”, “myself” or “me” are used to refer to me as a researcher/observer that strives for trustworthiness, but is aware of my own subjectivity.
The terms used to describe the participants are “participants”, “co-creators” and “psychologists”. As previously discussed, this multi-verse use of language is in keeping with an ecosystemic framework (which rejects the “either/or” dichotomous thinking) that the participants need to be called a singular name throughout the research for the sake of continuity. These terms are used interchangeably, depending on the context in which they are used.

1.6 RESEARCH DESIGN

Fouché (cited in De Vos et al., 2009) describes the research design as the system that aims to find answers to the research questions. Babbie and Mouton (2010) define research design as guidelines and instructions followed in addressing the research problem.

The study aimed to explore the experience of psychologists after the suicide of a patient. The research design used in this study can be described as a qualitative (Denzin & Lincoln, 2011; Creswell, 2009), exploratory (Babbie & Mouton, 2010), descriptive (Babbie, 2012) and contextual (Creswell, 2009; Guba & Lincoln, cited in De Vos et al., 2009) design. The research design will be discussed in-depth in chapter 3.

1.7 RESEARCH METHOD

The study was conducted in two mutually inclusive phases. These “phases” are described separately to provide conceptual clarity in the circular meaning-making process, rather than to create an either/or dichotomy. The first phase consisted of an exploration and description of the experience of psychologists after the suicide of their patient, as described in chapter 4. Based on the findings of the first phase, the second phase focused on the development of guidelines as a framework of reference to assist psychologists in dealing with the suicide of their patient, as
described in chapter 5. An overview of these phases, with specific reference to the research methods that were employed, follows below.

1.7.1 POPULATION AND PARTICIPANT SELECTION

Greeff (cited in De Vos et al., 2009) refers to population and sample as elements such as people, behaviour, aspects and issues of the population that are included in the research. The target population is the set of participants who meet the sampling criteria and from whom the sample is selected (Babbie & Mouton, 2010; Mouton, 2009).

In the present study, purposive sampling was used (Babbie & Mouton, 2010). The population and selection of the participants (six psychologists), guided by specific selection criteria, are described in more depth in section 3.4 of chapter 3.

1.7.2 DATA COLLECTION

In line with a social constructionist framework, data was collected by means of “meaning-making” conversations with the co-creators of this study, namely the literature, participants and an independent coder. The voices of the relevant authors in the literature initially introduced the topic by providing areas where further exploration was required. The first conversation with the six participants, who experienced the suicide of their patient, consisted of an in-depth, semi-structured interview during which field notes were kept. An independent coder co-created the data analysis findings of the initial interviews through a “meaning-making” conversation. In the next round of open-ended meaning-making conversations, new layers of meaning were created by confirming the findings with the participants and re-contextualising the findings in the literature, further deepening the meaning-making process.

The data collection process is further described in section 3.4.2 of chapter 3.
1.7.3 DATA ANALYSIS

According to Greeff (cited in De Vos et al., 2009) data analysis is a process of bringing order, structure and meaning to the mass of gathered data. In the present study, the reflexive and circular nature of a social constructionist framework allowed for data collection and data analysis to occur simultaneously in the meaning-making process (Babbie, 2012; Creswell, 2012). Tesch’s method of open and descriptive coding (Creswell, 2009) was used to analyse the transcribed semi-structured, in-depth interviews and field notes that were collected during the initial conversations with the participants. An independent coder participated in the data analysis process to ensure a next layer of meaning-making and to enhance the trustworthiness of the findings. The findings that emerged from the meaning-making conversation with the independent coder were verified with the participants during the second round of meaning-making conversations in order to further enhance trustworthiness. The findings of the data analysis process were recontextualised in existing literature to co-create a further (shared) reality.

The data analysis process is further described in section 3.4.3 of chapter 3.

1.8 ETHICAL CONSIDERATIONS

The fundamental ethical principle of social research is that it must bring no harm to the participants (Babbie, 2012). The researcher therefore has an ethical obligation to ensure that participants are protected in all reasonable limits from any form of emotional or physical discomfort as a result of the research (Creswell, 2012). The ethical considerations that guided this study are discussed in section 3.5 of chapter 3.

1.9 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba (1985) note that trustworthiness refers to the extent to which the researcher can persuade the readers and audience that the findings of the study are trustworthy. The researcher endeavoured to uphold the principles of qualitative
research rigour by being open, having clarity with regard to his theoretical framework, being thorough in the collecting of data and by considering all data in the process of analysis (Burns, Grove, Gray, Behan & Duval, 2012). The researcher used the trustworthiness model of Lincoln and Guba (1985) (cited in De Vos et al., 2009), which focuses on the credibility, transferability, dependability and confirmability of the research. Section 3.6 of chapter 3 provides a more in-depth discussion of the measure to ensure trustworthiness that was implemented during this research.

1.10 OUTLINE OF CHAPTERS

Chapter 2 presents an overview of the literature relevant to this study. Firstly, the suicidal process and epidemiology of suicide is explored. Next, the existing literature on the experience of psychologists after the suicide of their patient is explored, followed by a discussion about the personal and professional impact of the suicide, post-suicide growth, international and South African research on the topic. This overview of current knowledge leads to a discussion of guidelines for psychologists in dealing with the suicide.

Chapter 3 describes the research design and method that were followed during the course of the research process. The ethical guidelines and trustworthiness measures that were followed are discussed.

In chapter 4, the different co-creators of this research express their experience. The research findings are described and discussed by referring to the themes, categories and subcategories that emerged from the data analysis process, as described in chapter 3. Evidence of these findings is provided in the form of quotes from the different meaning-making conversations and the relevant literature.

Chapter 5 comprises the framework of reference that was developed to assist psychologists in dealing with the suicide of their patient. The challenges and limitations of the study, as well as recommendations for further research, are provided.
CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

The purpose of the study was to explore and describe the experience of psychologists after the suicide of their patient and to then develop post-vention guidelines as a framework of reference to assist psychologists in dealing with the suicide.

A comprehensive exploration of the topic entails an understanding of the phenomena of suicide. The suicidal process and epidemiology of suicide will be discussed in the first section of the literature review. The next section will comprise a review of the existing literature on the experience of psychologists after the suicide of their patient. The personal and professional impact of the suicide, post-suicide growth, international and South African research into the topic will be discussed by surveying the literature and alluding to gaps in knowledge and current debates. This overview of current knowledge leads to a discussion of guidelines for psychologists in dealing with the suicide.

2.2 UNDERSTANDING SUICIDE

Most contemporary definitions of suicide rely on two elements, namely a precise outcome (death) and a prerequisite (the intention or wish to die) (Wasserman & Wasserman, 2009). Mann (2002:303) defines suicidal behaviour as “... the most ‘clear-cut’ and unambiguous act of completed suicide but also includes a heterogeneous spectrum of suicide attempts that range from highly lethal attempts (in which survival is the result of good fortune) to low-lethality attempts that occur in the context of a social crisis and contain a strong element of an appeal for help”. The World Health Organisation (WHO) (2012) states that “For the act of killing oneself to be classed as suicide, it must be deliberately initiated and performed by the person concerned in the full knowledge, or expectation, of its fatal outcome.” The WHO (2012) classifies non-fatal suicidal thoughts and behaviours into three categories, namely suicide ideation, suicide plan and suicide attempt. These three categories
are regarded as integral parts of the suicidal process (Wasserman & Wasserman, 2009; Dyregrov, Plyhn & Dieserud, 2012).

2.2.1 The Suicidal Process

Elements of the suicidal process, namely suicide ideation, suicide attempt and suicide intent are described below, as well as psychological autopsies.

2.2.1.1 Suicide ideation and plan

Suicidal ideation forms part of the evolution of suicidal behaviour, that is thinking about engaging in it, writing or talking about it, or planning it (Wasserman & Wasserman, 2009). Suicidal ideation can be broadly described as any thoughts, images, beliefs, voices or other cognitions reported by the individual about intentionally ending his or her own life (Silverman, 2011). Aldridge and Barrero (2012) further differentiate between different ways in which suicidal ideation and the subsequent planning of a suicide attempt could manifest.

- **Suicidal ideation without a specific method**: the presence of suicidal ideation without thinking about which method of suicide will be used.
- **Suicidal ideation with several non-specific methods**: the presence of suicidal ideation with a variety of methods of suicide contemplated, but no decision as to which one will be used has been taken.
- **Suicidal ideation with a specific method in mind but without a plan**: the presence of suicidal ideation and a choice of specific method of suicide, but no decisions have been made about where and when the act will take place.
- **Suicidal ideation with a specific method and a well-conceived suicidal plan**: the presence of suicidal ideation, a chosen method of suicide, a place and time, and precautions has been taken to avoid being discovered following the conclusion of such an attempt.
2.2.1.2. Suicide attempt

The suicide attempt is the culmination of the evolution of the suicidal process (Wenzel, Brown & Beck, 2009). Schlebusch (2005) differentiates between fatal and non-fatal suicidal attempts. Fatal suicidal behaviour refers to self-inflicted, completed suicidal behaviour that is based on the victim’s intent to die and where that individual achieved his or her predetermined goal (Wasserman & Wasserman, 2009; Schlebusch, 2005). Non-fatal suicidal behaviour refers to self-inflicted suicidal behaviour that does not succeed in ending the victim’s life (Dyregrovet et al., 2012). When referring to non-fatal suicidal behaviour, Schlebusch (2005) distinguishes between attempted suicide as a fortuitous survival of the intended suicide, and parasuicide where the individual did not have the intention of dying by means of the non-fatal suicidal behaviour, but that it could rather be seen as a cry for help. It is therefore apparent that when considering a suicide attempt, a key element to consider is the degree of suicidal intent.

2.2.1.3. Suicidal intent

The classification and assessment of suicidal behaviour, according to the intention to die, is perceived as a crucial skill of a mental health care professional (Wasserman & Wasserman, 2009; Schlebusch, 2005). The measurement of suicidal intent is of particular interest to the present study, due to the nature of the interviews with the psychologists as retrospective reflection on the patient’s fatal suicide. Numerous attempts have been made to “objectively” determine the intent of a suicidal act (Berman, Silverman & Bongar, 2000; Wenzel et al., 2009; Wasserman & Wasserman, 2009). However, Dyregrov et al. (2012) argue that determining the intent of specific behaviour is a very difficult process, particularly if the person under investigation is already deceased. One example of classification of a suicide attempt is Aldridge and Barrero’s (2012) suggestion of four grades of suicidal intent. Based on the previously discussed definitions, the first two grades can be termed “parasuicide” attempts, while grades 3 and 4 as attempted suicides.
• **Grade 1 (low intent):** presence of “suicidal gestures” that cause little or no physical harm, for example superficial wounds.

• **Grade 2 (medium intent):** a suicidal act that requires medical care, but does not threaten an individual’s life, for example ingesting a seemingly innocuous substance or engage in superficial acts of self-cutting (Schlebusch, 2005).

• **Grade 3 (medium-high intent):** a suicidal act that causes mild to severe self-harm that can be potentially fatal. The individual experience a sense of ambivalence after the suicidal act and seeks help, for example ingesting deadly poison, but then notifying potential helpers.

• **Grade 4 (high intent):** a suicidal act where there is a clear plan to ensure the lethality of attempt, for example purchasing a gun and taking precautions to avoid discovery of where the suicidal act is set to be performed.

2.2.1.4. A psychological autopsy

A psychological autopsy is a procedure for investigating an individual’s suicide by reconstructing what the person thought, felt and did preceding his or her suicide (Brockman, 2012). Hawton, Appleby, Platt, Foster, Cooper, Malmberg, Sue and Simkin (1998) note that the aim of a psychological autopsy is to gather information from various sources about the circumstances of an individual’s death in an attempt to understand his or her reasons for the suicide. Although Murthy, Lakshman and Gupta (2010) report that there are no well-developed conceptual or theoretical frameworks for deriving conclusions from the various sources of information collected as a part of a psychological autopsy, Vij (2005) notes that most professionals draw on their experience to relate the suicide to symptoms or syndromes that they would encounter in daily practice. Manson (2000) (cited in Murthy et al., 2010) suggests the following brief outline for a psychological autopsy:

- biographical information of victim (name, age, address, marital status, religious orientation and occupation);
- details surrounding the death (causes, methods and other relevant details);
• a brief outline of victim’s history, for example interpersonal relationships, children, marriage etc.;
• history of deaths in victim’s family, for example suicides, attempted suicides, mental illness, medical illness etc.;
• description of the personality and lifestyle of the victim;
• recent stressors or anticipation of conflict with individuals or authorities;
• interpersonal and/or family functioning of the victim;
• evidence of suicidal ideation or intent; and
• changes in the victim’s behaviour prior to his or her death, for example sexual patterns, habits, hobbies, vegetative functioning etc.

This section on psychological autopsy is by no means comprehensive, because it is not in the scope of this study to provide an elaborate and in-depth analysis of the topic. However, as will be described in chapters 4 and 5, the value of a properly conducted psychological autopsy should not be underestimated.

2.2.2 Epidemiology of Suicidal Behaviour

2.2.2.1 Incidence

Suicidal behaviours both globally and in South Africa are complex, wide-ranging, multidimensional events with different behavioural characteristics (Schlebusch, 2005; Rosenfeld, 2004).

a) Global incidence of suicide

According to the World Health Organisation (2012), approximately one million people of all ages die from suicide every year, with an overall yearly rate of 14 to 16 for every 100 000 of the general population (Schlebusch, 2012; Bertolote, Fleischmann, De Leo & Wasserman, 2009). Suicide rates have increased by 60% in the last few decades and it is projected that the annual number of completed suicides will increase by 2020 to approximately 1.53 million people (WHO, 2012; Bertolote et al.,
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Alarmingly, between 10 to 40 times more people engage in non-fatal suicidal behaviours (attempts), which accounts to 10 to 40 million annual attempted suicides (Bertolote & Fleischmann, 2002).

b) South African incidence of suicide

In the South African context, the prevalence of suicidal behaviour is also exceptionally high (Schlebusch, 2005; 2012). The current South African ratio of fatal versus non-fatal suicides is 1:20 or higher (Schlebusch, 2005; 2012). The most recent suicide rates range from 11.5 for every 100,000 to as high as 25 for every 100,000 of the population (Schlebusch 2011; Varnik, 2012). Among young people, it is estimated that 9.5% of non-natural deaths are due to suicide (Schlebusch, 2012). These rates translate into approximately one to two suicides and 20 or more attempts each hour. In a study done by Schlebusch (2012), he reports that these numbers are higher for some occupational groups such as the South African Police Service, where about 11% of all non-natural deaths are suicide-related.

c) Age

Past studies have shown that suicide rates tend to increase in older people; however, suicide rates among young people, especially in the 15 to 24 year age bracket, are on the increase (Quin, 2005; Bertolote et al., 2009; Schlebusch, 2012). The most recent statistics show that globally, more young people die from suicide than older people (Bertolote et al., 2009). When considering the current literature, both globally and in South Africa, it does appear that suicidal behaviour tended to move from the elderly towards younger people in what is sometimes referred to as the “ungreying” phenomenon (Bertolote, 2001; Schlebusch, 2012).

d) Gender

Statistically, more males commit suicide than females, whereas more females tend to attempt suicide than males, with a male to female ratio of 5:1 for fatal suicides and

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The researcher acknowledges Schlebusch (2012) as a key resource.
a female to male ratio of 3:1 for non-fatal suicides (Masango, Rataemane & Motojesi, 2008; Sadock & Sadock, 2007; Schlebusch, 2012). Suicide is currently among the top five causes of death for both males and females in younger age groups and becomes even more significant in light of the overall ageing of the world’s population (Bertolote et al., 2009).

2.2.2.2 Patient suicidal behaviour

Suicide is considered one of the most frequent client crises encountered by psychologists who engage in psychotherapy. It can be seen as an occupational hazard (Grad cited in Wasserman & Wasserman, 2009). Significantly, it is estimated that half of those individuals are being treated by one or more mental health professionals at the time of committing suicide (Weiner, 2005). Studies have shown that one in five psychologists will experience the loss of a patient to suicide during the course of their careers (Valente, 2003; Kleespies, 2009). Another study found that more than half of therapists experience the suicide of their patients; as reported in survey studies, many of them experiencing it more than once (Skodlar & Welz, 2013; Foley & Kelly, 2007).

During a national survey in America, Chemtob, Hamada, Bauer, Torigoe & Kinney (1988) examined 365 psychologists and found that 22% had lost a patient to suicide. In a more recent study, McAdams and Foster (2000) predicted that approximately 24% of counsellors across a variety of clinical settings will lose a client to suicide at some point during their careers. Some go as far as to say that there are two types of therapists - those who have had a client die by suicide and those that will (Kleespies, 2009; Rudd, Joiner & Rajab, 2004).

Grad (2009) observes that the impact of a patient’s suicide will be more disturbing if such a suicide happens during the formative years of a trainee mental health professional. Research done by Kleespies (2009) among 282 mental health professionals found that nearly 97% reported working with patients during their internship that had suicidal ideation or intent. Furthermore, 33% of these mental health professionals experienced the suicide of a patient. From the literature, it is
clear that patient suicide during internships appears to be a common occurrence (Kleespies, 2009; Lafayette & Stern, 2004). Ellis and Dickey (1998) determined that one third of psychiatric residents experience the suicide of a patient. The high rates of patient suicides that occur during internships are due to the high volume of acutely ill patients with whom they are confronted in the hospital environment (Figueroa & Dalack, 2013; Fang, Kemp, Jawandha, Juros, Long, Nanayakkara, Stepansky, Thompson & Anzia, 2007; Kleespies, Penk & Forsyth, 1993; Kleespies, Smith & Becker, 1990; Knox, Burkard, Jackson, Schaack & Hess, 2006).

According to the researcher’s knowledge, very little research has been done in the South African context into the incidence of completed suicide during psychotherapy.

2.2.2.3 Suicide research in South Africa

Schlebusch (2012) reports that in the South African context, there are three prominent research-based projects.

- **Durban Parasuicide Study (DPS):** this is a multi-centre programme targeting non-fatal suicidal behaviours. Under the leadership of Prof. Lourens Schlebusch, the programme has generated extensive data in the Durban area.
- **National Injury Mortality Surveillance System (NIMSS):** the NIMSS focuses on fatal suicidal behaviour. The data is collected from mortuaries and state forensic laboratories and forms part of a collaborative effort between different research groups and government bodies in South Africa.
- **South Africa Stress and Health study (SASH):** the research contribution of SASH is based on a large epidemiological survey of nationally representative data.

Schlebusch (2012) provides a disturbing profile when he reports that the research data from the DPS, the NIMSS and SASH indicates an unusually high incidence of suicidal behaviour among all age groups in South Africa. Vawda (Personal
communication, 2013) warns that an increase in suicidal incidence in South Africa will inevitably lead to an increase in the quantity of attempted or fatal suicides with which mental health professionals will need to deal. The predominant amount of research in the South African context is centred on the victim and his or her predisposing, precipitating and protective factors. Indigenous research into psychologists and their experience of patient suicide is negligible. The researcher therefore recognises this as a gap in existing research and will endeavour to address this by means of the present study.

2.3 EXPERIENCING THE SUICIDE OF A PATIENT

“If a patient who is, or used to be, in any kind of therapy commits suicide, the event makes his/her therapist a suicide survivor” (Grad cited in Wasserman & Wasserman 2009).

2.3.1 The Personal Impact

The suicide of a patient marks the beginning of an often complex and protracted process of recovery (Grad cited in Wasserman & Wasserman 2009; Spiegelman & Werth, 2005). Jacobson, Norberg and Talseth (2000) report that therapists generally progress through the following three phases after the loss of a patient to suicide:

- the first phase might include an experience of disbelief, denial, a sense of loss of control and shock (Skodlar & Welz, 2013; Darden & Rutter, 2011);
- the second phase might include an experience of guilt, anger, anxiety, depression and feelings of professional incompetence (Talseth et al., 2000; Kleebies, 2009; Ting, Sanders, Jacobson & Power, 2006); and
- the third phase is characterised by a sense of growth or meaning (Talseth et al., 2000).

Following the suicide of a patient, it is reported that mental health professionals experience a variety of emotional and physiological reactions (Rothes, Scheerder,
Van Audenhove & Henriques, 2013; James 2005; Spiegelman & Werth 2005). These experiences are often closely intertwined and therefore hard to separate. In this section, these experiences will be discussed separately, but should be viewed in the context of a myriad of emotions and reactions varying in intensity and depth.

2.3.1.1 Shock and disbelief

Literature suggests that the experience of mental health professionals following the suicide of their patient include shock and anxiety, denial, grief and sadness, guilt and fear of blame, anger, self-doubt, and shame, loss of trust, loneliness and despair (Skodlar & Welz, 2013; Darden & Rutter, 2011). In a study by Ting et al. (2006), they examined the emotional impact of patient suicide on 25 mental health social workers. Participants in their research reported feelings of shock, surprise and disbelief with regard to patient suicide (Ting et al., 2006). Hillman (1997) describes the suicide of a patient as “… the most wrenching agony of therapeutic practice … It goes to the heart of therapy”. James (2005) (cited in Skodlar et al., 2013) reports the therapists’ experience of coming to grips with their post patient suicide reality as follows:

“There are moments spent in the collapse of mental space where there is no room for reflection, and only room for a person’s worst suspicions about herself or himself. As the work proceeds, space develops around those psychotic moments, space for thought, ambiguity, complexity, and emotional fullness. Making a space large enough and staying in it long enough for this psychological work to complete itself is the part of the work that allows a person to know the full truth of her or his experience, and hence, allows for the most healing”.

Grad (cited in Wasserman & Wasserman 2009) and Weiner (2005) found that some of the emotions that psychologists expressed were shock, confusion, denial and disbelief. Similarly, Hendin, Lipschitz, Maltsberger, Haas and Wynecoop (2000) report that the initial reactions of psychologists after the suicide of their patient included feelings of shock and disbelief, followed by grief and guilt over the loss. Shock and disbelief were reported in most of the studies with regard to the psychologists’ reactions after the suicide of their patient (Tsai, Moran, Shoemaker &
2.3.1.2 Grief, sadness and helplessness

When a patient commits suicide, psychologists experience emotions similar to that of losing a loved one (James 2005; Spiegelman & Werth 2005; Kleespies, 2009; Skodlar & Welz, 2013; Horn, 1994). The most frequent emotional response among therapists following the initial reaction of shock and disbelief is a sense of grief and sadness (Hendin, Haas, Maltsberger, Szanto & Rabinowicz, 2004). One therapist describes it as follows (cited in Hendin et al., 2004):

“*My primary emotional response was one of profound loss and sadness. (Ms. A’s) death meant that there was a final end to her struggle and that there was no longer a possibility of a positive outcome. My sadness was especially intense as I was so aware of her strengths, which were unfortunately not enough in balance to deal with her despair and illness. The loss and sadness also involved the loss of (Ms. A’s), someone I knew and enjoyed. I did feel really sad that there was nothing that I or any of my supervisors could do to alter the final outcome.”*

Some of the expressions of grief among mental health professionals included uncontrollable crying, depression, devastation, sleep disturbances, intense sadness and an inability to perform professionally (Grad cited in Wasserman & Wasserman 2009; Weiner, 2005; Ting et al., 2006). Maltsberger (1992) found that in some cases client suicide could produce pathologic grief reactions, including “melancholia, atonement, and narcissistic avoidance.” Darden and Rutter’s (2011) qualitative research among psychologists found that all six the participants met the criterion for complicated grief.

Richards (2000) refers to the theme of hopelessness and helplessness in terms of counter-transference when working with a suicidal patient. Some therapists experience a sense of helplessness when working with suicidal patients due to the depth and severity of their emotional turmoil. When such a patient commits suicide, it
leaves the therapist with a sense of unresolved helplessness and hopelessness (Ting et al., 2006; Talseth et al., 2000; Hall & Epp, 2001; Valente, 1994).

2.3.1.3 Anger and betrayal

Anger was a prominent emotional response among mental health professionals who lost a patient to suicide (Moody, 2010; Rothes et al., 2013; Darden & Rutter, 2011; Pilkinton & Etkin, 2003). Most studies report feelings of anger, blame and a sense of betrayal toward the patient for not contacting the mental health professional prior to the suicide (Ting et al., 2006). One psychologist describes his feelings of anger, betrayal, fear and embarrassment as follows (cited in Hendin et al., 2000):

“I felt surprised and betrayed, for I believed that we had been able to establish something of a therapeutic relationship - perhaps the first such connection in this patient’s long experience with psychiatrists. Yet, at her most critical moment, she felt unable to contact me … Other reactions included anger at having to find out about her death in the manner I did (from her parents a week after her death), embarrassment at having “lost” a patient for whom I felt responsible, fear that she died due to some gross oversight on my part which would eventually be discovered.”

Feelings of anger and betrayal after the suicide stemmed primarily from being rejected as a therapist by the patient (Hendin et al., 2000). The combination of anger and feelings of betrayal has been indicated as playing an important role in compassion fatigue and burnout in psychologists (Munson, 2009; Chemtob, Bauer, Hamada, Pelowski & Muraoa, 1989).

2.3.1.4 Feelings of isolation and withdrawal

All the participants in Darden and Rutter’s (2011) study experienced feelings of intense isolation following the suicide were experienced. One clinician stated the following:
“I felt that I was grieving in a vacuum, that even if there had been a place to talk about my client, that I wasn’t allowed to talk about how much she meant to me” (Gutin et al. cited in Gordon & McIntosh, 2011).

Literature suggests that therapists’ sense of being left to carry the burden of their emotional pain alone proved to be one of the biggest obstacles in the healing process after the suicide of their patient (Doka, 2002). The experience of grieving in isolation due to confidentiality issues and/or professional stigma is likely to be compounded by the lack of resources for supporting clinicians after the suicide (Ellis & Patel, 2012).

Supportive resources for family members who experienced a suicide loss are readily accessible through online forums or support groups. However, there is an almost complete lack of supportive resources for clinicians following such a loss; most clinicians are unaware of those resources (Gutin et al. cited in Gordon & McIntosh, 2011). In the South African context, no such resources are currently available (Vawda, 2013, personal communication). The aims of this study will be to address this gap in the research and to formulate guidelines for psychologists who experience the suicide of a patient.

2.3.1.5 Feeling guilty and responsible

The theme of guilt and responsibility after the suicide of a patient has been documented in numerous studies (James, 2005; Spiegelman & Werth, 2005; Kleespies, 2009; Skodlar & Welz, 2013; Grad cited in Wasserman & Wasserman 2009). Wells (1991) reports that a sense of responsibility, guilt and culpability is one of the main features of psychotherapists after the suicide of their patient. More recently, Grad and Michel (2005) found that psychologists often experience overwhelming guilt and a sense of personal responsibility for the suicide of their patient. Feelings of guilt and responsibility were found in most of the literature that was surveyed (Coverdale et al., 2007; Rothes et al., 2013; Tsai et al., 2012; Yousaf et al., 2002; Gill, 2012).
In a study that provides a different perspective on the above-mentioned findings, and incidentally one of the few studies among psychologists who have experienced the suicide of a patient, Darden and Rutter (2011) found that though their participants felt strongly about being vigilant with regard to suicide prevention and intervention after the suicide of their patient, they also expressed their belief that it was ultimately the patient’s choice to take their own life. This is in contrast to the almost deterministic suicide literature that suggests that therapists are most likely to hold a sense of personal responsibility after client suicides.

In terms of gender differences, Jacobson, Ting, Sanders and Harrington (2004) found that male and female therapists differ in how they react to patient suicide. Grad, Zavasnik and Groleger (1997) reported that female therapists felt guilt more regularly about their patient's suicidal behaviour and were also more likely to seek consultation from supervisors or colleagues after the suicide of a patient. Male therapists were more ambivalent about what course of action to take after the suicide and also had a higher incidence of reporting suicidal behaviour (Chemtob et al., 1989).

### 2.3.2 Professional Impact

“The walk up to the second floor was the loneliest of my life, and the sound of my footfalls on the concrete steps reverberating through the brick-encased stairwell echo in my memory” (Spiegelman & Werth 2005).

Psychologists who survive the suicide of a patient often experience a sense of ambivalence about the limits of help from within the professional community (Skodlar et al., 2013). Kolodny, Binder, Bronstein and Friend (1979) write:

“Just as we are convinced that no exercise of imagination or intellect can really prepare one for such an experience or inoculate one against its impact, so we are convinced that no support system or understanding on the part of colleagues or supervisors can entirely alleviate the pain and self-examination one must go through in the wake of a patient’s suicide”.

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It is conspicuous how little research, in comparison to other areas of suicidology, has been done into the *professional* impact that a suicide has on psychologists.

### 2.3.2.1 Professional stigmatisation and shame

Individuals who experience the suicide of a loved one are left with uncertainty about what other people think and how they will react (Dyregrov et al., 2012). Literature suggests that suicide survivors are stigmatised and are believed to be more psychologically disturbed, less likeable, more blameworthy, more ashamed and more in need of professional help than other bereaved individuals (Harwood, Hawton, Hope & Jacoby, 2002; Armour, 2006; Sveen & Walby, 2008). This perceived emotional vulnerability often causes psychologists to project their own fears, shame and guilt onto their colleagues, thereby stigmatising themselves (Gutin et al., 2011).

Rubenstein (2002) suggests that psychologists avoid speaking about the suicide of their patient due to fear of professional stigmatisation and shame. Darden & Rutter (2011) found that psychologists experience a sense of professional failure and therefore avoid speaking about the suicide of a patient to other colleagues. Bratter (2003) published an article in which he describes how the suicide of some of his patients affected him as a psychotherapist. He experienced shame, failure and a deep sense of loss. Psychologists may experience incompetence following the suicide of a patient and doubt their professional skills as a psychotherapist (Darden & Rutter, 2011; Hendin et al., 2004; Tillman, 2003).

### 2.3.2.2 Hyper-vigilance

Rothes et al. (2013) report that in their study, more than half of the psychiatrists who answered the question related to increased vigilance after the suicide of their patient, described that they were more attentive and/or more vigilant to potential suicidal ideation in their patients. Similarly, Darden and Rutter (2011) found that their participants became hyper-vigilant with regard to patients at risk of suicide.
In a seminal study, Chemtob et al. (1989) also found hyper-vigilance and an increased focus on suicidal themes, assessments and potential suicide risk among therapists who experienced the suicide of their patient.

### 2.3.2.3 Anxiety

Literature suggests that the suicide of a patient causes mental health professionals to experience tremendous anxiety (Ting et al., 2006; Gutin et al., 2011; Talseth et al., 2000). There are numerous reported sources of anxiety such as a fear of litigation, disciplinary action and social stigmatisation (Grad cited in Wasserman & Wasserman 2009; Rossouw, 2009; Spiegelman & Werth, 2005). Anxiety over losing another patient to suicide has led some mental health professionals to avoid working with suicidal patients or to project emotions such as anger toward patients who report suicidal ideation or intent (Weiner, 2005). Walsh and Walsh (2001) question whether this anxiety is due to having to deal with the suicide and the fear of litigation or due to a pre-existing psychological condition on the part of the therapist.

### 2.3.2.4 Experiencing the suicide of a patient while in training

As previously noted, the researcher observed the impact of an attempted suicide on both registrars and fellow interns in the context of a hospital setting during the second day of his clinical psychology internship. Research shows that the psychological impact of patient suicide can also affect an intern’s professional development (Brown, 1987). In the United States, between 11% (Kleespies et al., 1993) and 17% (Kleespies et al., 1990) of psychology interns experience the suicide of a patient. Brian Thompson (cited in Fang et al., 2007) provides the following personal account written in response to the suicide of one of his patients during his first year of residency:

“Initially, after the news I was shocked. Then, over the coming weeks, I felt even more guilt over the suicide, wondering what I did wrong and what I could have done differently to prevent this tragedy. I even questioned my career choice. Finally, I feel
that in reaction to this suicide I became even more cautious, perhaps overly cautious, when initiating treatment plans for patients, admitting more patients from the emergency room to the inpatient unit, and keeping patients in the hospital longer before discharging them.”

To the researchers’ knowledge, no study has been done or completed in the South African context among psychology interns who experienced the loss of a patient to suicide.

2.3.2.5 Post-suicide growth

The danger and possible limitations of a section on the professional impact of patient suicide is that the emphasis will only be on the individuals who had adverse effects following the suicide of a patient. Traumatic experience can paradoxically present a multitude of opportunities for new growth (Grad cited in Wasserman & Wasserman 2009). Tedeschi and Calhoun (2004) note that traumatic experience often present opportunities for personal growth and transformation.

Many therapists successfully advance through the process of grief after the suicide of their patient as the intensity of feelings pass and they start to find new meaning in what has occurred (Grad cited in Wasserman & Wasserman, 2009; Darden & Rutter, 2011; Moody, 2010; Rossouw, 2009). Gutin et al. (2011) report that after the suicide, clinicians tend to have a more realistic appraisal and expectations in relation to their clinical competence. Fuentes and Cruz (2009) found that some of the factors that influence the individual’s process of posttraumatic growth were

- the ability to integrate and find adaptive ways of coping with the experience,
- perceived social support, and
- openness to discuss the traumatic event with supportive others.
At a more personal level, therapists who feel that they have found new meaning and processed their own grief express a desire to support others with similar experience (Grad cited in Wasserman & Wasserman, 2009; Balon, 2007).

2.3.2.6 International research on the topic

At present, there is an abundance of international research available on therapists that have lost a patient to suicide (Rothes et al., 2013; Wurst, Kunz, Skipper, Wolfersdorf, Beine, Vogel, Muller, Petitjean & Thon, 2013; Grad cited in Wasserman & Wasserman, 2009; Farberow, 2005; Schultz, 2005; Weiner, 2005; Ting et al., 2006; Darden, 2008; Darden & Rutter, 2011; Moody, 2010; Rossouw, 2009). Most of the research, however, focuses on quantifying these experience by means of questionnaires and statistical analysis. The above-mentioned research was conducted among a variety of mental health professionals, including psychologists, psychiatrists and social workers.

Research specifically pertaining to the in-depth analysis of the qualitative experience of psychologists following the suicide of a patient is negligible (Darden & Rutter, 2011; Grad cited in Wasserman & Wasserman, 2009). In the process of surveying the literature about the experience of psychologists who have experienced the suicide of a patient, curiosity emerged about the transferability of these studies to the South African context. More specifically, what the experience of South African psychologists are following the suicide of their patient.

2.3.2.7 South African research on the topic

Two studies have been completed on similar topics to this study in the South African context. Both Magagula (2002) and Engelbrecht (2004) conducted their research at the University of Johannesburg as part of their Masters degree in Clinical Psychology. The participants for Magagula’s (2002) study on “Therapists’ experience of clients’ suicide attempts: an exploratory study” consisted of therapists who experienced the attempted suicide of their patients. The current study chose
participants who experienced the completed suicide of their patient and therefore had different sample criteria. Engelbrecht’s (2004) study, “Dialoguing with suicide: the therapist’s personal experience of a client’s completed suicide” was a social constructionist, narrative representation of her topic and consisted of four participants who were at different levels of their training as psychologists. The present study’s population was six qualified psychologists who had at least five years of experience in practising psychotherapy.

Considering the high incidence of suicide in South Africa, the high probability that these individuals were in the process of psychotherapy and the lack of research on psychologists who have experienced the suicide of a patient, it is clear that a gap exists in the research that this study aimed to address.

2.4 POST-VENTION GUIDELINES (OR THE LACK THEREOF) FOR PSYCHOLOGISTS ASSIST THEM IN DEALING WITH THE SUICIDE OF THEIR PATIENT

2.4.1 The Need for Post-vention Guidelines and/or a Framework of Reference

“Post-vention” refers to those activities developed by, with or for suicide survivors in order to facilitate recovery after suicide, as well as to prevent adverse outcomes, including suicidal behaviour (Andriessen, 2009). Despite all the research mentioned, there have been little efforts to integrate the research findings into the clinical training programmes to provide post-vention guidelines to psychologists when confronted with the suicide of their patient (Gutin et al., 2011). Studies show that mental health professionals doing their internship remain vulnerable to the traumatic effects of a patient suicide, partly due to a lack of preparation (Gill, 2012; Fang et al., 2007; Ruskin, Sakinofsky, Bagby, Dickens & Sousa, 2007). In a study conducted by Kleespies et al. (1993), only 40% of the participants reported that their clinical training provided the necessary knowledge and skills that could be applied in anticipation of the suicide of their patients (Lafayette & Stern, 2004). It is only when they are confronted with the suicide of one of their patients that they become aware of how ill-prepared they really are (Balon, 2007). Balon (2007) further laments the fact that literature and guidelines for mental health professionals in dealing with
suicide are lacking, noting that “... even the Comprehensive Textbook of Suicidology devoted only about half of one page of its 650 pages to this topic.”

In the South African context, no guidelines or a framework of reference are available for psychologists who have experienced the suicide of their patient. It is therefore evident from the literature that there is a need for more comprehensive guidelines with regard to the reality of patient suicide and the possible challenges that might emerge.

2.4.2 Current Research and/or Guidelines

The resources available to assist therapists in dealing with the aftermath of the suicide of their patient have increased in recent years (Grad, 2005, 2009; Plakun & Tillman, 2005; Spiegelman & Werth, 2005; Gutin, McGann & Jordan, 2011). Individuals differ in their reactions and the depth of their response to a patient’s suicide (Grad, n.d.). Grad (n.d.) found that the way individuals react to the suicide of their patient is influenced by factors such as

- personal traits,
- personal and professional experience and knowledge,
- their understanding and anticipation of the suicide, and
- their own current emotional state and phase of life.

The process and needs are therefore different for every psychologist following the suicide of their patient. Grad (cited in Wasserman & Wasserman, 2009) comments: “The therapist’s bereavement after a patient has committed suicide is too individual and too personal to fit into a framework of rigid procedures.” When considering guidelines, the management of the individual or team needs to be flexible.
2.4.3 Support Resources and their Helpfulness

Rothes et al. (2013) found that the support resource that professionals used most often is colleagues, followed by contact with the family of the patient and their own family. However, Grad (cited in Wasserman & Wasserman, 2009) notes that the procedures followed in the use of these resources often determine the degree of their helpfulness.

2.4.3.1 Helpful procedures

Among psychiatrists who experienced the suicide of a patient, they reported that the team case review was the most helpful resource, followed by the support of colleagues and other professionals who treated the suicidal patient (Rothes et al., 2013). Dewar, Alexander, Klein, Gray and Eagles, (2000) found that team case reviews or psychological autopsies, which are aimed at reflection and learning, are helpful. However, when these reviews are about “finding fault” or blaming, it might leave the individual experiencing a lack of support and isolation. For this reason, Hendin et al. (2000) question the helpfulness of these reviews.

In research that Ellis and Dickey (1998) conducted among intern psychologists, they found that after the suicide of a patient, the following three basic needs need to be fulfilled:

- **administrative**: the adverse patient events need to be monitored and documented in order to improve quality;
- **educational**: assessment of the suicide-related knowledge of the trainee and supervision to take remedial steps if required; and
- **emotional**: support required by the therapist after the trauma of losing a patient to suicide.
Grad (cited in Wasserman & Wasserman, 2009) noted that of these three basic needs, emotional needs were often not met for both institution and the therapist. Balon (2007) describes his personal experience as follows:

“As a resident coping with patient suicide, I was not totally left alone. We did the psychological autopsy and I was ‘cleared by my senior colleagues of any wrong doing.’ Yet, nobody really talked to me about how I felt, what I thought about my role in the patient’s suicide, my feelings of incompetence, and what I should do following a patient suicide.”

Although there are divergent views in the literature with regard to what constitute helpful resources, there is agreement that the psychologist, having lost a patient to suicide, needs an opportunity to verbalise and express his or her experience (Figueroa & Dalack, 2013). Sharing their emotions with family and friends, a close team of colleagues or individual colleagues and supervisors, was most helpful (Figueroa & Dalack, 2013; Valente, 2003; Balon, 2007). In a study done by Rothes et al. (2013), 41% of the psychiatrists stated the existence of support systems in their workplace to assist professionals who experienced the suicide of a patient. These included team meetings, discussion or self-help groups, a hospital suicide protocol or procedures in case of suicide, psychotherapy and supervision (Rothes et al., 2013).

Dyregrov et al. (2012) found that some suicide survivors find help in religious activities. Literature suggests that religious belief and being part of a faith community can often act as a “buffer” against the adverse effects of a traumatic event (Paloutzian & Park, 2013; Watts & Nye, 2006; Hood, Hill & Spilka, 2009). To the researcher’s knowledge, no research has been conducted into the religious or spiritual impact that a suicide has on a psychologist or the use of spirituality as a coping mechanism following the suicide. This presents an opportunity for further research.
2.4.3.2 Unhelpful procedures

Literature suggests that when the resources available to a mental health professional are used to blame or shame the individual, this could be detrimental to the recovery process following the suicide of a patient (Alexander et al., 2000; Hendin et al., 2004). An example of such an occurrence might be when the result of a group discussion or psychological autopsy leads to blaming or public shaming of the individual instead of providing clarity and comfort about the case. Grad (in Wasserman & Wasserman, 2009) contends that fears of litigation for both the clinician and the institution or hospital often leads to a ‘witch hunt’, which might include legal and disciplinary proceedings that add to the distress experienced by the team or individual involved.

Rothes et al. (2013) found that supervisors were considered unhelpful by 40% of those who made use of their support after the suicide of a patient, while Darden and Rutter (2011) recommend that psychologists find supervisors that can be proactive in the event of client suicide. Courtenay and Stephens (2001) found that outside counsellors who have been employed to assist were found unhelpful. However, Hendin et al. (2004) propose that an independent institution assist the mental health professionals after the suicide of a patient.

These contradictory findings are indicative of the complexity with regard to assisting a psychologist after the suicide of his or her patient. Chapter 5 will aim to develop post-vention guidelines that could serve as a framework of reference for psychologists in dealing with the suicide of their patient.

2.5 CONCLUSION

The aim of chapter 2 was to provide the context of the study and also survey literature relevant to this study. The phenomenon of suicide was discussed by exploring the suicidal process and epidemiology of suicide. Existing literature on the experience of psychologists after the suicide of their patient was then surveyed with special reference to the personal and professional impact of the suicide, post-suicide
growth and international and South African research into the topic. Finally, the literature with regard to guidelines for psychologists in dealing with the suicide of a patient was discussed by emphasising the need for guidelines and helpful and unhelpful procedures.

In chapter 3, the research design and methodology are discussed, as well as the ethical guidelines and measures of trustworthiness that were implemented through the course of this study.
CHAPTER 3: RESEARCH DESIGN AND METHOD

“All choreographers make a statement and begin, explicitly or implicitly, with a question: What do I want to say in this dance? In much the same way, the qualitative researcher begins with a similar question: What do I want to know in this study” (Janesick, 2003)?

3.1 INTRODUCTION

Chapter 1 provided an orientation toward the purpose and objectives of the study, as well as an overview of the research process that was followed. Chapter 2 provided the context of the study by means of an exploration of the relevant literature. The aim of the present chapter is to describe the research design and method. The research process is defined and clarified.

3.2 THE RESEARCH OBJECTIVES

The two objectives of the study were to

- explore and describe the experience of psychologists after the suicide of their patient; and
- develop guidelines as a framework of reference to assist psychologists in dealing with the suicide of their patient.

3.3 RESEARCH DESIGN

The aim of the present study was to explore the experience of psychologists after the suicide of a patient. The research design used in this study can be described as a qualitative (Denzin & Lincoln, 2011; Creswell, 2009), exploratory (Babbie & Mouton, 2010), descriptive (Babbie, 2012) and contextual (Creswell, 2009; Guba & Lincoln, 2013) design. The research design is now further described.
3.3.1 Qualitative Research

Denzin and Lincoln, (2011:5) define qualitative research as “an interpretive, naturalistic approach to the world”. Mack, Woodsong, MacQueen, Guest and Namely (2005) note that the strength of qualitative research is found in its ability to provide complex textual descriptions of how individuals experience a given research problem or issue. In line with the objectives and purpose of this study, qualitative research was preferred because it allowed for an in-depth description and understanding of the experience of psychologists after the suicide of their patient. The qualitative data gathering and data analysis processes are described in section 3.5.1 in this chapter.

3.3.2 Exploratory

An exploratory research design focuses on identifying new categories of meaning by exploring areas of study in which little research has been done (Marshal & Rossman, 2006). Babbie and Mouton (2010) similarly note that one of the main rationales for using an exploratory design would be to explore an unknown area of research in order to gain new insight into the phenomena being studied. Having experienced the attempted suicide of a patient during his internship, observing the reactions of his colleagues and listening to their accounts of patients who had either completed suicide or attempted suicide, the researcher became curious about the experience of psychologists after the suicide of a patient. In the process of exploring the topic by means of a preliminary literature review, the need for exploratory research emerged. An exploratory study was therefore appropriate for this study, as the focus was on providing an in-depth understanding of the experience of psychologists after the suicide of their patient.
3.3.3 Descriptive

Descriptive study designs are able to generate a greater depth of knowledge in a particular area of research (Burns et al., 2012; Creswell, 2012). In the present study, a descriptive design was necessitated by the need for and the purpose of the study. The focus was on obtaining a rich, in-depth description of the experience of psychologists after the suicide of their patient. During the research process, data was collected by means of in-depth, semi-structured interviews with the participants using a descriptive approach to ensure a truthful reflection of the experience of the psychologists of the research phenomenon. Field notes were additionally made to note observations of emotional responses and personal reflections on the content being presented in the interview. The focus of the study was to provide a dense or thick description of emerging themes and categories related to the experience of the participants (Babbie & Mouton, 2010).

3.3.4 Contextual

In keeping with an ecosystemic, social constructionist theoretical framework, this study aimed to describe and understand the experience of psychologists after the suicide of their patient in the context that it occurred (Creswell, 2009). The contextual research design as a style of research aims to find the meanings that people ascribe their own and other’s behaviour in a specific context (Creswell, 2012).

As noted in chapter 2, section 2.3, psychologists engage regularly with suicidal patients in the context of psychotherapy. By facilitating in-depth, semi-structured interviews with the participants in the context of their practice or office in a government hospital, the researcher sought to enter the “field of research” in order to provide a context-rich description of the experience of psychologists following the suicide of a patient.
3.4 RESEARCH METHOD

Once a research design and strategy have been chosen, the attention shifts to the research method (Visagie, 2009). The present study was conducted in two mutually inclusive phases.

- **Phase one** of this study was an exploration and description of the experience of psychologists after the suicide of their patient.
- **Phase two** focused on the development of guidelines as a framework of reference to assist psychologists in dealing with the suicide of their patient.

The research methods followed during these phases are discussed below.

*Phase 1: An exploration and description of the experience of psychologists after the suicide of their patient*

This phase includes population and participant selection, the data collection and analysis processes, ethical considerations and concludes with the measures to ensure trustworthiness.

3.4.1 Population and Participant Selection

For this study, the population was South African psychologists and the sample consisted of five psychologists from KwaZulu-Natal and one from Gauteng who experienced the suicide of their patients.

3.4.1.1 Participant selection strategy

In this study, a purposive sampling strategy was used in the selection of participants. Purposive sampling is a sampling technique in which all the participants are chosen with a particular purpose and selection criteria in mind (Babbie & Mouton, 2010). Because the researcher is based in Durban, KwaZulu-Natal, the initial strategy was
to find participants who met the selection criteria from the KwaZulu-Natal province. The rationale for the initial selection strategy was to minimise logistical organisation, for example travelling distance to interviews, in the research process (Babbie & Mouton, 2010). Furthermore, the researcher had access to a network of psychologists in KwaZulu-Natal. Two purposive sampling strategies were implemented to “gain entry” to these participants and the research field. Firstly, an e-mail was sent out to a network of psychologists called the Durban Practicing Psychologists Group (DPPG), outlining the research topic and sampling criteria, to which four Caucasian, female psychologists from KwaZulu-Natal responded. A second e-mail was sent to DPPG requesting psychologists to participate in the study, to which there was no response. The small sample size necessitated the implementation of a second purposive participant selection strategy to increase the trustworthiness of the study. Two female psychologists, one Indian from KwaZulu-Natal and the other Caucasian from Gauteng, whom the researcher knew had experienced the suicide of their patient were contacted directly and requested to participate in the study.

3.4.1.2 Participant selection criteria

Sampling criteria outline the characteristics of those who participate in the study (Burns et al., 2012). For the purpose of this research, the sampling criteria discussed below were used.

a) Qualified clinical or counselling psychologist

According to the Health Professions Council of South Africa (HPCSA), to qualify as a psychologist one needs to have completed the following:

- master’s degree in clinical psychology (clinical psychologists) or counselling psychology (counselling psychologists) at an HPCSA-accredited institution;
- one year internship as clinical psychologist or counselling psychologist at an HPCSA-accredited institution;
• one year community service year at an HPCSA-accredited institution \textit{(only clinical psychologists)}; and

• written the HPCSA board examination for either clinical psychology or counselling psychology.

Both clinical and counselling psychologists are exposed to suicidal patients as part of their day-to-day practice as psychotherapists.

\textbf{b) Minimum of five years experience in psychotherapy}

As noted in section 2.3 of chapter 2, most of the research on the topic has been conducted among trainee and intern psychologists. The aim of this study was therefore to explore a different sample of psychologists.

\textbf{c) Had experienced the suicide of their patient, with a minimum of one year that passed between the incident and the research interview}

As described in section 2.2 of chapter 2, the initial post-suicide grief reactions are often severe. Therefore, the selection criteria included an accommodation period of one year between the suicide of their patient and the interview as a measure of non-maleficence, thereby minimising the possible harm to the participants.

\textbf{d) Able to understand and express themselves in Afrikaans or English}

The researcher is proficient in both these languages; therefore the participants had the opportunity to have the “conversations” in either Afrikaans or English.

\textbf{e) Willing to participate in the research}

In the participant selection process, four potential participants declined to participate due to the sensitive nature of the topic. The participants were provided with an outline of the study and selection criteria in order to give \textit{informed} consent, as discussed in section 3.4 of this chapter.
3.4.1.3 Sample size

Sample size depends on both the focus of the research questions and the population being researched (Babbie, 2012). In the present study, the participants comprised six psychologists, as determined by data saturation (Creswell, 2012). Evidence of data saturation was that themes began recurring during interview 4, but two more interviews were conducted to ensure data saturation. Little new information was gathered from the ensuing interviews (Greeff, 2009).

3.4.2 Data Collection Process

Data collection consists of gathering information relevant to addressing the research objectives, while simultaneously analysing the data (Greeff, 2009; Creswell, 2012). In the present study, data was collected by means of “meaning-making” conversations with the co-creators of this study, namely the literature, participants and an independent coder, as well as field notes. The data collection process is described below by referring to the co-creators of meaning.

3.4.2.1 The researcher as instrument of research

The qualitative researcher’s role is that of primary research instrument in the data gathering process (Banda, 2010). As an instrument of research, the qualitative researcher’s aim is to explore things in their natural settings in an attempt to understand phenomena in terms of the socially constructed meanings that the participants attach to them (Denzin & Lincoln, 2011). Rossman and Rallis (2011) outline the following characteristics of qualitative researchers:

- observe social worlds in context and holistically;
- engage in a systematic and critical reflection on the conduct of the research; and
- show awareness of their own epistemological and ontological frameworks.
In the present study, the researcher was both a facilitator and a co-creator of meaning in the “conversations” with the literature, participants and independent coder. A conscious effort was made to establish rapport prior to the initial in-depth, semi-structured interviews to ensure that the participants felt safe and comfortable when sharing their experience by means of prolonged engagement methods, as described section 3.5 of this chapter.

In order to facilitate a meaningful explorative process, the field of research was entered from a “not-knowing” position with curiosity and openness to a new shared reality that would emerge from the conversations with the co-creators. The participants were therefore positioned as experts in their own experience of reality. In the meaning-making conversations, the researcher used communication skills such as active listening, paraphrasing, probing, reflecting, clarifying, minimal encouragers and summarising to encourage the participants to describe their experience in-depth (De Vos et al., 2009).

3.4.2.2 The literature

As discussed in section 1.2 of chapter 1, the introduction to the topic of the present study was because of a personal experience. It was after this experience that the co-creation “conversation” with the voices in the literature started. As described in section 2.2 of chapter 2, the initial “conversation” with the literature was about understanding suicide, the suicidal process and suicide incidence. The “conversation” progressed to psychologists who experienced the suicide of their patient and opportunities for further exploration emerged, as described in section 2.3 of chapter 2. The next topic of conversation in the co-meaning-making process with the literature was guidelines to assist psychologists in dealing with the suicide of their patient as described in section 2.4 of chapter 2. In chapters 4 and 5, the other co-creators of meaning, namely the participants and independent coder, found their voice by means of the findings; literature joined the “conversation” by contextualising the findings.
3.4.2.3 The participants: initial in-depth, semi-structured interviews and field notes

The first conversation with the six participants, who had experienced the suicide of their patient, consisted of an in-depth, semi-structured interview during which field notes were made.

a) The interview questions

The semi-structured interview questions (appendix 2) emerged by means of a process of co-creation with the literature, particularly Darden and Rutter (2011), as outlined in chapter 2. The aim of the research questions was to gather rich, descriptive data about the experience of psychologists after the suicide of their patient. Prior to the interview, the data gathering process was discussed with the participants to ensure that they were informed of the ethical and confidentiality parameters of the study as described in section 3.4 of this chapter.

The questions were phrased in an opened-ended style to invite the participants into an active meaning-making process. The semi-structured format of the interview served only as a guideline; flexibility and openness was maintained concerning the natural process that unfolded during the interviews (Creswell, 2012). The questions that follow were asked during the semi-structured interview.

Contextual questions
- How long ago did the suicide occur?
- How long had you been working with this client?
- When in your career did the suicide occur?
- What was the diagnosis of the client who committed suicide?
- Were there any legal ramifications?
- How did you find out about the suicide?
Initial emotional reactions
- What were your initial feelings?

Impact on personal life
- How was your personal life affected?

Impact on professional life
- What, if anything, would you have done differently concerning the treatment of this patient?
- How was your professional life affected?
- Has your professional practice changed surrounding the ways in which you manage suicidal patients?

Recovery process
- What helped you cope with the suicide?
- What hindered your recovery?

New awareness
- As we talk, has this brought up a new awareness for you, or anything unexpected?

All the interviews were digitally recorded, downloaded to the researcher’s home computer, backed up to an external hard drive (both of which are password protected) and then deleted from the recording device as a measure to ensure confidentiality.

b) Field notes

Groenewald (2004) contends that a researcher requires a system for documenting his or her observations. In the present study, the researcher was sensitive to the participants’ emotional and verbal responses during the interviews and reflected on his own emotions following these interviews. These observations and personal
reflections were written down as field notes after every interview. The field notes consisted of the following (Silverman, 2011):

- **observational notes**: reflections about what was observed during the interview;
- **methodological notes**: critical reflections on the research process;
- **personal notes**: reflections on my own reactions and experience; and
- **theoretical notes**: systematic attempts made to derive meaning from the observational notes.

### 3.4.2.4 The independent coder

The in-depth, semi-structured interviews with the participants were transcribed verbatim and independently coded by the researcher and an *independent coder*, using Tesch’s (Creswell, 2009) open and descriptive method. Following the independent coding process, the researcher and the independent coder had an open-ended “meaning-making” conversation, which lasted 30 minutes, by telephone. The purpose of this conversation was to create a new shared reality about the themes and categories that emerged from the data, thereby adding new layers of meaning to the data. Additionally, this method was also employed to enhance the trustworthiness of the study, as discussed in section 3.5 of this chapter.

### 3.4.2.5 The participants: meaning-making conversations

After the conversation with the independent coder, another round of meaning-making conversations was facilitated with the participants in order to create additional layers of meaning and to further enhance the trustworthiness of the study. These open-ended meaning-making conversations consisted of a 20- to 30-minute phone call during which the participants were invited, as co-creators of meaning in this study, to comment on and/or add to the experience that emerged from the initial interviews. Field notes were kept as mentioned above (see appendix 5). The same recording
and confidentiality precautions were followed as described in the initial in-depth, semi-structured interviews section of this chapter.

### 3.4.3 The Data Analysis Process

Creswell (2012) contends that qualitative data analysis occurs concurrently with data collection rather than in linear, sequential manner. Qualitative research includes a systematic process of categorising objects, individuals or events in terms of their characteristics as it emerges from the data (Babbie & Mouton, 2010).

In the present study, the data collected from the in-depth, semi-structured interviews with the participants were transcribed verbatim shortly after the interviews (within seven days) to raise the credibility of the research (Creswell, 2012). As part of the co-creation-of-meaning process, both the researcher and an independent coder applied Tesch’s open and descriptive coding technique (Creswell, 2009) independently to the six qualitative interviews. This was done as a means of triangulation to enhance the credibility of the findings (appendix Coding report). The following six steps were followed (adapted from Creswell, 2009):

1. the coder obtained a sense of the whole by reading through the transcriptions independently. Ideas that came to mind were jotted down;
2. the coder then selected an interview reflecting on the underlying meaning of the information;
3. when the coder completed this task for several participants, each interview was coded separately; thereafter a list was made of all the topics. Similar topics were clustered together in columns, which were arranged into major topics, unique topics and leftovers;
4. the coder took the list and returned to the data. The coder tried out a preliminary organising scheme to determine whether new categories and codes emerged;
5. the coder found the most descriptive wording for the topics and turned them into categories, then endeavoured to reduce the total list of categories by grouping together topics that related to each other; and
6. the data belonging to each category was assembled in one place and a preliminary analysis performed, followed by a meaning-making conversation between the researcher and the coder.

The *independent coder* was not provided with any themes or categories previously elicited from the data. Having both completed their data analysis and coding independently, using Tesch’s method, a meaning-making conversation took place between the *researcher* and the *independent coder* with regard to the themes and categories that emerged from the data (Creswell, 2009). The findings that emerged from our new (shared) reality were taken back to the *participants* for a next round of meaning-making conversations to confirm the findings. The meaning-making conversations with the *participants* were analysed by listening to the recordings and making field notes (see appendix 5) of extra layers of meaning that emerged.

**PHASE 2: DEVELOP GUIDELINES AS A FRAMEWORK OF REFERENCE TO ASSIST PSYCHOLOGISTS IN DEALING WITH THE SUICIDE OF THEIR PATIENT**

As previously described, *phase 1 and phase 2* are mutually inclusive, but are, for the sake of conceptual clarity, described separately. The guidelines to assist psychologists in dealing with the suicide of their patient were developed *both* during and after *phase 1* of the present study. In *phase 1*, the co-creators of the study described methods that were used to deal with the suicide of their patient. As described in section 2.4 of chapter 2, the voices in the *literature* shared helpful as well as unhelpful methods for dealing with the suicide, while the *participants* described different coping strategies they implemented after the suicide of their patient. These *methods* and *coping strategies* were noted as practical *actions* taken.

The guidelines to assist psychologists in dealing with the suicide of their patient were then developed based on the findings of *phase 1*, as described and discussed in chapter 4. The themes, categories and subcategories from the findings were used to formulate *specific guidelines* and *practical actions* to serve as a framework of reference for psychologists in dealing with the suicide of their patient.
3.5 ETHICAL CONSIDERATIONS

Ethical guidelines serve as standards and a basis on which each researcher ought to evaluate his own conduct (Creswell, 2012). The ethical measures used as the standard by which the research was conducted are discussed in the paragraphs that follow.

3.5.1 Competency of the Researcher

The researcher ensured that he was competent and adequately skilled to undertake this research by studying the research methodology and using his experience as intern clinical psychologist to create an environment that was personal, safe and professional. Apart from two years in-depth training as a masters student in both qualitative and quantitative research methodology, two postgraduate research workshops were attended, one at the University of Johannesburg and the other at the University of South Africa, focusing on the qualitative research process. The researcher contacted the supervisors of this study, who are experienced in qualitative research, regularly to enquire when he was uncertain or needed further guidance.

3.5.2 Non-maleficence and Beneficence

The concept of non-maleficence states that we should not harm one another (Creswell, 2012). Due to the sensitive nature of the topic, it was identified as a potential risk of this study that the participants, in describing their experience, might experience retraumatisation of the suicide of their patient. As part of the participant selection criteria, a one-year period between the suicide and the interview was required to have lapsed to accommodate for any complicated grief reactions. After each interview, time was allotted for debriefing as part of prolonged engagement. Further provisions that were made to minimise the risks of possible physical and/or emotional damage (De Vos et al, 2009) were as follows:
• the venue for the interviews was in a private, safe place;
• the participants were aware that they may at any time withdraw from the study and/or enquire about the progress of the study;
• the participants were invited to inquire about the progress of the study at any time; and
• Babbie and Mouton (2010) contend that there should be no unnecessary references to their personal lives (Babbie & Mouton, 2010).

Beneficence refers to an obligation on the researcher to maximise possible benefits and to minimise any possible harm (Creswell, 2012). Burns et al. (2012) further comment that the focus of research should be on acting for the good of the participant. There was consensus among the participants that their main objective for agreeing to participate was the relevance of the topic to psychologists and the lack of research into the topic in the South African context. The participants understood that sharing their experience was beneficial to other psychologists who had a patient who committed suicide. After phase 1 of the study, the participants were informed of the findings of phase 1 by means of the meaning-making conversations, which further contributed to the scientific body of knowledge in the field of psychology.

3.5.3 Informed Consent

The goal of this study and the procedures that were to be followed were discussed with the participants prior to the onset of the interviews. The researcher gave a complete explanation of the total investigation, without pressure or unnecessary interference, in clear and understandable language (De Vos et al., 2009). At the start of the recorded interviews, each of the participants was asked to confirm

• voluntarily participation,
• that they understand the procedures to be followed during the study,
• anonymity, confidentiality and privacy measures that were to be followed as discussed in section 3.4.2 of this chapter, and
• that they have the opportunity to withdraw at any time.
The participants were given an informed consent form (see appendix...) to sign in order to confirm that the above-mentioned has been explained to them.

### 3.5.4 Confidentiality

Due to the sensitive nature of the topic, the assurance of confidentiality was of utmost importance to the study. In the context of the study, confidentiality meant that even though the interviews contained personal details of either the participant or the patient that committed suicide, the researcher would keep this information in confidence or secret from the public (Creswell, 2012). Prior to the involvement of the independent coder, the researcher read through the transcribed interviews to ensure that the identifying information was removed to ensure the anonymity of the participants and the patients. The *independent coder* was also required to sign a confidentiality agreement (see appendix 3). As discussed in section 3.4.2 of this chapter, all the interviews were digitally recorded, downloaded to the researcher’s home computer, backed up to an external hard drive (both of which are password protected) and then deleted from the recording device as a measure of data security. The data will be stored for five years after the publication of the findings.

### 3.6 MEASURES TO ENSURE TRUSTWORTHINESS

The approach of Guba and Lincoln (1985) was used during the research process to ensure trustworthiness and qualitative research rigour. The four strategies (Lincoln and Guba, 1985) that were used are discussed in the paragraphs that follow.

#### 3.6.1 Credibility

Credibility reflects the truth-value or believability of the information and findings of the participants, as well as the context in which the study is undertaken (De Vos et al., 2009). Truth-value was ensured by the implementation of the strategies of
credibility. Guba and Lincoln (1985) discuss techniques that were used in this study to ensure more credible findings. These techniques will now be discussed.

3.6.1.1 Prolonged engagement

The data collection and analysis process was conducted in phases that lasted eight months. During the initial in-depth, semi-structured interview, a reasonable period of time was spent with each of the participants before the onset of the in-depth interviews in order to build a relationship of trust (Lincoln & Guba, 1985) and to allow the participants to ask any questions they might have had relating to the study. As discussed in section 4.2 of chapter 4, the initial in-depth, semi-structured interview conversation totalled three and a half hours. After the conclusion of the interview, the participants were given another 30 minutes to share the emotional reactions they experienced during the interview and were then invited to inform the researcher of any new insights that emerged in the days or weeks subsequent to the interviews.

The participants were contacted by e-mail three months after the initial conversation to enquire whether any new insights emerged. The aim of the prolonged engagement by means of persistent communication was to allow the participants ample opportunity to share their experience.

The next round of meaning-making conversations took place by telephone six months after the initial interview, allowing the participants the opportunity to reflect on their experience. As discussed in section 4.2 of chapter 4, these meaning-making conversations totalled two and a half hours. Most of the participants could not recall the content of the initial meaning-making conversation, which allowed for new insight into and expressions of such experience to emerge.

3.6.1.2 Triangulation

Triangulation was achieved by using multiple methods of data collection (De Vos et al., 2009). The triangulation methods that were used during the present study were
data triangulation by means of a literature review, in-depth, semi-structured interviews with field notes and further meaning-making conversations with an independent coder and the participants. Investigator triangulation was obtained by means of consensus conversations about the data-gathering and data-analysis processes with both my supervisors and an independent coder.

3.6.1.3 Reflexivity

In the present study, the process of meaning-making necessitated a continuous and critical process of reflection on the interaction between me and the co-creators of this study in order to increase the credibility of the findings. A reflexive journal of the research process was kept during the data collection process, which included personal reflections and field notes from the various phases of data collection (appendix 5). These reflections and field notes were considered during the data analysis process and integrated when the findings were formulated.

3.6.1.4 Peer examination

Persistent communication with the supervisors of this study, who are experienced in qualitative research, ensured constant feedback in phases 1 and 2. The research process was scrutinised with regard to design, methodology and the findings to ensure research rigour and conceptual clarity. Additionally, peer examination was obtained formally and informally by means of discussions with impartial colleagues regarding the research process and findings.

3.6.1.5 Member checking

Member checking is a technique that consists of continually “testing” with the participants with regard to data collection, findings of data analysis, interpretations and conclusions (Visagie, 2009). Member checking applies the use of participants to check the language used – an idea that the research is “trying to get it right”
(Lichtman, 2010). In this study, follow-up meaning-making conversations with all the participants, as described in section 3.4.2 in this chapter, were conducted to confirm the findings of phase 1. This strategy ensured that the participants’ experience were accurately reflected in the data (Creswell, 2012).

3.6.1.6 Structural coherence and creating a chain of evidence

Structural coherence entails the integration of the “masses of loosely connected data” in the present study to create a logical, holistic picture (Krefting, 1991). The establishment of structural coherence ensures a thread that runs through the research process and that no inconsistencies exist between the data and the interpretations (De Vos et al., 2009). In the present study, structural coherence was obtained by means of a densely described research design and method, including measures to ensure trustworthiness and dense description of findings to eliminate inconsistencies (Visagie, 2009). The findings of phase 1 and phase 2, as described in chapters 4 and 5, were supported by direct quotations from the literature, participants and independent coder.

3.6.1.7 Referential adequacy

Referential adequacy was ensured by providing a trail of documents, attached as appendices, to invite other voices in the literature to critically assess the research process, ethical aspects adhered to and the findings (Visagie, 2009).

3.6.2 Transferability

Qualitative research is interested in the transferability of findings (Babbie & Mouton, 2010). According to Creswell (2009), transferability is described as the application of one set of findings to another context. In order to achieve transferability, a large sample is not required, as would be the case in quantitative research, but rather the purposeful selection of a sample.
Transferability was ensured during the present study by purposefully selecting psychologists that experienced the suicide of a patient. This allowed for a dense description of the methodology to ensure transferability by other members in similar contexts (Creswell, 2009).

### 3.6.3 Dependability

Babbie and Mouton (2010) note that dependability refers to whether a study provides evidence that its findings would be similar if it were to be repeated with the same sample in the same context. The criteria of dependability and research rigour were ensured by obtaining credible findings (Denzin & Lincoln, 2011). Techniques that were used to increase the dependability in this study include:

- triangulation (De Vos et al., 2009),
- prolonged engagement by means of e-mail communication and another round of meaning-making conversations with the participants,
- contextualising the findings in the available literature, and
- regular consultation and supervision by the supervisors during the data analysis process with regard to the quality of the interviews, coding procedures and preliminary data analysis processes.

As well as
- the use of an independent coder in the stepwise replication process of Tesch’s open and descriptive coding method (Creswell, 2009).

### 3.6.4 Confirmability

It is important that the researcher should create a trail of evidence that reflects consistency throughout the research process (Visagie, 2009). Confirmability refers to whether the findings of the study can be confirmed by another similar study (De Vos et al., 2009). During the present study, confirmability was ensured by the use of an
independent coder during the data analysis process, as previously discussed, and continuous consultation with the supervisors who are experts in qualitative research.

3.7 CONCLUSION

This chapter sought to provide clarity with regard to the research design and methods used to address the research objectives. The data collection and data analysis processes were described, as well as the ethical measures that were followed. Research rigour was ensured by following the trustworthiness principles of credibility, transferability, dependability and confirmability.

The next chapters focus on the research findings and a framework of reference to assist psychologists in dealing with the suicide of their patient.
CHAPTER 4: DESCRIPTION AND DISCUSSION OF RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter focuses on the findings obtained from the exploratory and descriptive qualitative study as described in chapter 3. The findings are discussed in depth and are structured around the research purpose and objectives of this study as outlined in chapter 1.

As an introduction to the research findings, the participants are introduced as the co-creators of meaning in this study to provide the context of the findings. The findings are then described as themes, categories and sub-categories, with quotes from both the initial interviews and meaning-making conversations to confirm the findings of the research. These findings will be discussed by creating further meaning with another group of co-creators (the relevant literature). Finally, the chapter will conclude with a summary.

4.2 THE CO-CREATORS OF A (NEW) SHARED REALITY

Working in a social constructionist ontological framework, meaning is found in the context in which it is expressed (Gergen, 2009; Burr, 2003). Reality by its nature is therefore subjective, because every individual constructs his or her reality based on how he or she perceives the world to be. When individuals share their realities with one another, a new shared reality is formed with new meanings.

The participants shared their realities of the research phenomenon during the initial semi-structured interviews that lasted 30 to 40 minutes each. As part of the meaning-making process, the researcher and an independent coder individually transcribed and then coded the raw data by means of Tesch’s open and descriptive data analysis method. This was followed by a next round of meaning-making conversations with the participants and an independent coder that lasted 20 to 30 minutes each, in order to confirm the findings, thus creating a new shared reality.
The participants, as well as the independent coder, will now be introduced as co-creators of the shared reality of this study. As discussed in chapter 3, ethical practice and confidentiality guidelines were followed to ensure that none of the participants or patients could be identified by the information provided in this section.

The sample of the study consisted of six psychologists who had experienced the suicide of a patient.

**Holly**: Five years elapsed since the suicide. The duration of the therapeutic relationship was two and a half years. Holly did not see the patient for a couple of months prior to the suicide and was surprised, but not shocked, when the patient’s best friend phoned her two days after the suicide to inform her that the patient drowned herself. The suicide occurred in Holly’s fifth year after qualification as a psychologist and her second year of private practice. The patient was diagnosed with major depressive disorder and the committed suicide was by taking an overdose of prescription medication and alcohol.

**Samantha**: Three years have gone by since the suicide. Samantha had been seeing the patient’s child for therapy when she recommended that the patient come for a session as well. Samantha saw the patient for two sessions prior to his suicide. The patient’s spouse phoned Samantha “hysterically” to inform her that the patient had shot himself. The unexpected suicide occurred in Samantha’s first year of private practice. The patient was not formally diagnosed, but there were reported adjustment difficulties, as well as substance abuse.

**Jane**: The suicide was committed just over a year ago. Jane had been seeing the patient for five sessions. The patient’s doctor informed Jane that the patient had shot himself. The suicide was committed in her third year of private practice. The patient was diagnosed with an anxiety disorder, but he also presented with depressive symptoms.

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3 The participants chose their own pseudonyms
Ayala: Thirteen years have gone by since the suicide. Ayala had been seeing the patient for psychotherapy for a month when he fed the exhaust pipe fumes into his car with the garage door and car doors locked. Ayala recalled that the patient was her first patient as a private practitioner. The patient did not have a formal diagnosis, but presented with symptoms of depression and anxiety.

Cynthia: The patient committed suicide 20 years ago. Cynthia had been working with the patient in a psychiatric hospital setting and was informed by the hospital staff that he committed suicide by being hit by a train after laying on the railroad tracks. The suicide was committed one year after Cynthia's internship. The patient was diagnosed with severe major depressive disorder.

Grace: It has been eight years since the patient committed suicide. Grace had been seeing the patient in psychotherapy for four months when the patient's spouse phoned her, telling her that the patient drank lethal dosages of poison and was lying in hospital in a brain-dead state. Grace had been in private practice for 10 years at the time of the suicide. The patient was diagnosed with major depressive disorder and she had a history of parasuicide attempts.

Table 4.1 – A summary of the gender, age, ethnicity, years of practice⁴ (YOP) and context⁵ of the participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Holly</th>
<th>Samantha</th>
<th>Jane</th>
<th>Ayala</th>
<th>Cynthia</th>
<th>Grace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Age</td>
<td>44</td>
<td>31</td>
<td>33</td>
<td>55</td>
<td>45</td>
<td>44</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Indian</td>
<td>Caucasian</td>
</tr>
<tr>
<td>YOP</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Patient diagnosis</td>
<td>Major Depressive Disorder</td>
<td>No formal diagnosis</td>
<td>No formal diagnosis</td>
<td>No formal diagnosis</td>
<td>Major Depressive Disorder</td>
<td>Major Depressive Disorder</td>
</tr>
</tbody>
</table>

⁴ At the time of the suicide
⁵ At the time of the suicide
<table>
<thead>
<tr>
<th>Method of suicide:</th>
<th>Overdose/Drowned</th>
<th>Shot</th>
<th>Shot</th>
<th>Gassed</th>
<th>Layed on train tracks</th>
<th>Poison</th>
</tr>
</thead>
</table>

**Felicity (independent coder):** Felicity was invited, as an experienced meaning-maker, to co-create meaning with the researcher. The process of co-creation took place over a period of two weeks while we wrestled with the raw data to find new meanings by sharing our realities. These conversations set the platform for further meaning-making conversations with the other co-creators, the participants and the literature.

### 4.3 DESCRIPTION AND DISCUSSION OF RESEARCH FINDINGS

The findings will be presented as a central storyline with six main themes and categories under each theme. Evidence of these findings will be confirmed by quotes from the initial interviews, field notes, meaning-making conversations and other means of correspondence that took place between the two meaning-makers to illustrate prolonged engagement.

#### 4.3.1 The Central Storyline

The participants described the suicide of their patient as a multifaceted experience consisting of exposure to the “the sting of death”, thus being propelled into a myriad of emotions and the often suffocating sense of responsibility for the suicide and the lingering presence of their patient. Thrown into the isolation of having an (unwanted) affair with the suicide and experiencing the paradox of being both a suicide survivor and a professional, they found solace and sanctuary with colleagues and family as well as in faith. From the wounds of the traumatic experience emerged a healing wisdom.

**Table 4.2 - A summary of the themes, categories and sub-categories of the experience of psychologists after the suicide of their patient.**

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### THEMES, CATEGORIES AND SUB-CATEGORIES

<table>
<thead>
<tr>
<th>Theme 1: The sting of death</th>
<th>Category 1: Initial “shock”, “disbelief” and “relief”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2: The aftershock</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-category 1:</strong> Anger and betrayal</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-category 2:</strong> Feeling unprepared, traumatised and helpless</td>
<td></td>
</tr>
<tr>
<td>Category 3: Sadness and loss</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2: The noose of responsibility</th>
<th>Category 1: The choke of guilt and part responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2: Self-protective stance vs. blurring of ethical boundaries</td>
<td></td>
</tr>
<tr>
<td>Category 3: Heightened vigilance and anxiety shown toward patients</td>
<td></td>
</tr>
<tr>
<td>Category 4: Psychological autopsy: second-guessing and self-doubt</td>
<td></td>
</tr>
<tr>
<td>Category 5: A need for personal and professional mitigation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 3: Having an (UNWANTED) affair with the suicide</th>
<th>Category 1: Isolation and social withdrawal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Theme 4: THE paradoxical dance</th>
<th>Category 1: “I’m not anxious” (while trembling inside)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2: “There were no signs” (while doubting if there were)</td>
<td></td>
</tr>
<tr>
<td>Category 3: “I exhausted all avenues” (while asking whether there was another avenue they could have explored)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 5: Solace and sanctuary</th>
<th>Category 1: Increased use of collegial and peer support and/or turning to supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2: Support from spouses, family and friends</td>
<td></td>
</tr>
<tr>
<td>Category 3: Seeking spiritual or religious sanctuary</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 6: The wounded healers</th>
<th>Category 1: From survivor to witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2: From wounds to healing wisdom</td>
<td></td>
</tr>
</tbody>
</table>

The above themes, categories and sub-categories are discussed in more detail below.
4.3.1.1 Theme 1: The sting of death

The “sting” of death represents the participant’s initial reaction of shock and disbelief on receiving the news of their patient’s suicide. This is accompanied by a grappling to come to terms with the suicide, particularly at a spiritual and existential level. Participants also experience the event as a being a traumatic one and express feelings of anger, of having been manipulated and of profound sadness and loss over it.

- Category 1: Initial “shock”, “disbelief” and “relief”

The range of emotions that the psychologists experienced on hearing the news that one of their patients had committed suicide, included “shock”, “disbelief”, “guilt”, “anger”, “sadness”, “powerlessness”, “horror” and “relief”. The process of describing these emotions during the interviews was often overwhelming and even cathartic for some of the participants. One field note from my interview with Holly reads:

“When she showed me the funeral letter she started crying and we had to interrupt the interview for her to compose herself. It was raw emotion. She had never shared what happened with another psychologist.”

When asked about their initial reactions, all but one of the participants used the word “shock” in their first sentence. Jane described her experience as follows:

“... it was shock, it was total and utter shock uhm, I remember uhm, saying to, to the doctor uhm, that I think she’s wrong ... is she sure this is the right patient uhm, you know and uhm, and actually then, probably quite a lot of uhm, disbelief in the sense of how could he do this and also why uhm, I had a lot of questions about why ...”

The others also expressed their initial reactions as:

Samantha: “... just shock and then guilt, lots of guilt, I was just replaying everything ...”
Cynthia: “I was shocked, I was taken aback ... I was very devastated ...”

Grace: “... when I heard it my heart was very sore immediately, I felt very shocked ...

Ayala: “I was absolutely shocked ...”

Ayala further described her experience of disbelief:

“... because there were no symptoms at all that he would, that he was, he was the kind of candidate for, for suicide ... it came at me from nowhere.”

During the meaning-making conversation with an independent coder, there was consensus about the theme of “shock” and “disbelief”. These findings coincide with Ting et al.’s (2006) research that reports that psychologists experience feelings of shock, surprise and disbelief after the suicide of their patient (Grad, 2009; Weiner, 2005; Tsai et al., 2012; Coverdale et al., 2007; Yousaf et al., 2002; Gill, 2012; Rothes et al., 2013). However, we shared different realities with regard to Holly’s reaction to the suicide. Holly was the only participant who did not report feelings of surprise or shock. She reported an “understanding” that the suffering the patient had endured just became too much and that suicide was a dignified death for a “proud lady”:

“I have a feeling that I understand why she did it, everything crashed down ... I understood why she did it.”

An inconsistency was observed during the session between what Holly was saying and the tears that were streaming down her face. On reflecting this inconsistency, she used the following phrase: “I understand why she did it ...” The following day she sent me an e-mail, asking:
“My lack of feeling guilty ... is that how it is ... or is it a theme among those psychologists who have lost patients to suicide, implying that it is more of a defence mechanism?”

She asked this question again during our meaning-making conversation:

“Is it a defence mechanism or am I just being emotionally lazy?”

During our meaning-making conversation, the new reality that emerged for her was that she experienced “deep sadness” and “relief”, rather than “shock” and “disbelief”:

“I had another patient nearly kill himself ... I had to talk him down over the telephone with a gun in his hand for 40 minutes ... I was angry at him and shocked, but with (patient’s name) I felt deep sadness when I heard the news. I just went phew ... She didn’t need to suffer anymore ... I was relieved that her suffering was over.”

Wurst et al. (2013) found that a small percentage of their participants experienced relief after the suicide of a patient and that of all the different emotions that were described, relief was the only emotion that did not decrease with time.

- **Category 2: The aftershock**

Feelings of “shock” and “disbelief” about the suicide were soon followed by a grappling to come to terms with it, particularly at a spiritual and existential level. Some of the participants described their struggle as follows:

**Cynthia:** “... it’s was like, did this really happen?”

**Ayala:** “... it did bring up question in terms of the meaning of life ... existential questions came up very prominently.”

**Jane:** “... I just couldn’t understand why, why he had done it you know?”

- **Sub-category 1: Anger and betrayal**
In the process of grappling to come to terms with the suicide, some of the participants expressed feelings of anger. For both of them, their anger was directed toward the patient for manipulating and betraying them. **Ayala** described her sense of betrayal in the following words:

“He was going to do it I think, he used me ... that’s where the anger came in, I felt he used me to get psychic strength to be able to commit suicide ... I felt quite used and I felt quite angry.”

**Jane** also expressed her feelings of anger:

“I also actually remember being quite angry with him ... because he was uhm, leaving his wife ... it was difficult to process feelings of anger towards him”

Anger was frequently described among mental health professionals who had lost a patient to suicide (Moody, 2010; Rothes et al., 2013; Ting et al., 2006). Along with the anger, a sense of betrayal for not contacting the mental health professional prior to the suicide has often been reported among the participants (Hendin et al., 2000; Ting et al., 2006). As one of the participants in this study suggested, the literature suggests that one of the reasons therapists experience a sense of betrayal is because they felt “used” by the patient (Pilkington & Etkin, 2003; Hendin et al., 2000).

**Sub-category 2: Feeling unprepared, traumatised and helpless**

On hearing the news and having to deal with the emotions in the time that followed, some of the participants felt unprepared, traumatised and expressed feelings of helplessness. **Samantha** described her feelings after hearing the news of the suicide as follows:

“... how did I miss this ... I didn’t even know what else I could have done but I felt physically ill, I just wanted to, like I had to pull over, I started crying uhm, and actually
those feelings lasted for quite a while afterwards, I really went into a bit of a decline …”

Ayala experienced the suicide as traumatising and something that nearly made her quit the profession:

“... it really did rock my foundation ...”
“... it came at me from nowhere …”
“Well it was close to hanging up my couch ... I thought well this is it.”

For Grace the trauma of experiencing the suicide was focussed on the sense of helplessness that she experienced:

“... and I think there’s a sense of helplessness or powerlessness to turn back the clock for them ...”

Cynthia reflected on the initial feelings and described her fear of working with suicidal patients after the traumatic experience of losing a patient:

“I was taken aback ... I was very devastated because you’re losing a patient ... you didn’t want to go through that whole trauma and emotional thing again ...”

During the meaning-making conversation, Cynthia further elaborated:

“In a lot of ways, you become the patient ... The feelings of helplessness become quite overwhelming ... You can’t get through such an experience alone.”

For most of the participants, the suicide exposed an emotional and professional vulnerability of which they were not aware. The participants felt ill-prepared for the trauma of losing a patient to suicide. The theme of feeling unprepared, traumatised and helpless is in line with other literature that suggests that mental health professionals remain vulnerable to the traumatic effects of a patient suicide partly due to a lack of preparation (Gill, 2012; Fang et al., 2007; Ruskin, Sakinofsky, Bagby, Dickens & Sousa, 2007). Some of the participants experienced a sense of helplessness with regard to the suicide, wishing that they could turn back the clock.
Ting et al. (2006) and Darden and Rutter (2011) report that when a patient commits suicide, it often leaves the therapist with a sense of unresolved helplessness.

- **Category 3: Sadness and loss**

All the participants mentioned sadness and loss that they have been carrying with them since the suicide. **Cynthia** described how she experienced the loss as a lingering presence in her daily life:

“... people who look like him I think, you know are there it wasn’t a hallucination, I knew he was dead, it was just like oh, was that him.”

**Cynthia** further described her sadness and loss as follows:

“... so I think you know, that was also hurtful in the sense it was such a brutal way to go so it wasn’t just he took pills and kind of death was easy, it was the brutal nature of the suicide that was quite shocking.”

**Holly** and **Ayala** also expressed a lingering presence of the deceased patient:

**Ayala**: “... a lot of sadness ... it was hard to sit with his wife cause I was the last person that he’d spoken to before he killed himself, so it was very difficult.”

She further described:

“I was left with his presence in my therapeutic space and I, I missed him, I felt sad that he was not there”

**Holly**: “... I carry her in me” (starts to cry).

For **Grace** there was a residual sadness that she has been carrying with her since the suicide:

“... when I heard it my heart was very sore immediately”
“... just the sadness that I’ve carried inside of myself for them (the family of the patient).”

Jane and Holly did not describe sadness during their initial interviews, but vividly shared their sadness and their conflicting emotions during the meaning-making conversations:

Jane: “I felt incredibly sad, but didn’t feel it was my place to grieve ... I was wondering whether I should be mourning the death of a patient as a professional?”

Holly: “I feel a deep sadness ...”

The findings of the present study are in line with the literature that suggests that sadness and a sense of loss are two of the reactions that are regularly reported by mental health professionals following the suicide of a patient (Grad, 2009; Weiner, 2005). Expressions of sadness and loss among therapists ranged from uncontrollable crying, depression, devastation, sleep disturbances, intense sadness and an inability to perform professionally (Grad, 2009; Weiner, 2005).

4.3.1.2 Theme 2: The “noose” of responsibility

The “noose” of responsibility encompasses the participant’s sense of being partly to blame for their patient’s suicide. This is revealed in the participants’ self-professed feelings of guilt, their adoption of a defensive and self-protective stance with ethical boundaries sometimes being blurred and by self-doubt. This seemed to affect their relationships with their patients in that they were more vigilant towards them and also expressed an aversion to taking on new high-risk patients.

• Category 1: The “choke” of guilt and responsibility

Several of the participants expressed feelings of guilt and felt partly responsible. Samantha described the mixed emotions that she experienced as follows:
“... shock and then guilt, lots of guilt, I was just replaying everything, could I have done this something, should I have done something more, how did I miss this, I’ve done you know, maybe I should, I didn’t even know what else I could have done ...”

“I did feel like I’d been in the wrong ...”

Samantha mentioned guilt and feeling responsible as some of the key factors that hindered her healing process:

“... the guilt and feeling responsible for the fact that you lost this person.”

Two other participants shared Samantha’s experience.

Ayala: “… part of me felt that I had (responsibility), because I’d given him the energy to do it.”

Grace: “… I still felt responsible to make sure that there’s nothing else that I could still have done.”

Holly and Jane did not report feelings of guilt because they felt that professionally they had done what they could.

Holly: “Absolutely, but somehow I don’t feel uhm, guilt, because I truly believed that I did the best I could with, with what I had.”

Jane: “… I suppose I was lucky in the sense that this patient in particular just did not ... fit the profile. He, there was no, there was just nothing uhm, you know that I, that I could have done ...”

During our meaning-making conversation, Grace further clarified her experience as follows:

“... I don’t feel guilt or shame ... maybe then ... I see it as a choice they made and the time that I had with them as a gift ...”
Grad and Michel (2005) found that psychologists often experience overwhelming guilt and a sense of personal responsibility for the suicide of their patient. Feelings of guilt and responsibility were found in most of the literature that was surveyed (Coverdale et al., 2007; Rothes et al., 2013; Tsai et al., 2012; Yousaf et al., 2002; Gill, 2012). In the present study, some of the participants felt guilty and responsible, as most of the literature suggests, but some did not experience any guilt, as they respected the patient’s “choice” to take his or her own life. Similarly, Darden and Rutter (2011) found that their participants did not experience any guilt, because they viewed the suicide as a “choice” that the patient made. These discrepancies in the literature present an area that warrants further research.

- **Category 2: Self-protective stance and blurring of ethical boundaries**

A distinction was drawn between a self-protective stance prior to the suicide and after the suicide. Most participants took a self-protective stance prior to the suicide by explaining that they acted “ethically” during psychotherapy and therefore had minimised the probability of further litigation or professional stigmatisation. **Holly** was the only participant who blurred the ethical boundaries. However, after the suicide, some of the participants who had a self-protective stance prior to the suicide also felt a need for a self-protective stance after the suicide due to feelings of personal responsibility, social stigmatisation as “the psychologist who lost a patient to suicide”, and fear of disciplinary action and litigation.

**Ayala** found solace in the fact that she had kept within her ethical boundaries:

“I did everything that I knew professionally uhm, in the session I was very professional, I was very ethical. I just had to keep reminding myself that I worked in a very ethical, professional way and I hadn’t slipped up in any way and I think that’s what kept me going, it wasn’t, it wasn’t my fault.”

**Jane** described her protective stance prior to and after the suicide during the meaning-making conversation as follows:
“When you’re in private practice, it’s just you making sure you’ve made the right decision ... You go through everything to make sure you acted ethically”

“... you can’t go to a peer supervision session and volunteer that a patient committed suicide, because you’re not sure how people will react ...”

Cynthia also expressed her rationale for taking a self-protective stance with future patients:

“... you just didn’t want to be in that same position again so it was also part protection of yourself as an individual”

Holly blurred ethical boundaries and took risks for the sake of the patient. She described her process and struggle as follows:

“I did step out the line, I saw what (the patient) did from when she was about (age) on and off on and off and so I hadn’t seen her for six months to a year and I got a phone call, I’m in trouble ... so I met with her at (public place) ... she works there and (the patient) ... She started talking about the sexual abuse that started bubbling out and so she went into a nine (suicide scale) so then I initiated vigilance from the work place and home and then she went into a 10. (Psychiatric hospital) was at the end of the year they couldn’t take her ... the hospitals couldn’t take her, they couldn’t hold her, uhm, we tried that, she’s also OCD so imagine going to (hospital name) ... so literally what I did is she came and stayed in my playroom that was next to my office for a month to six weeks ... it freaked my other colleagues out and eventually I went to cut the blinds ... the pulling thing for the blinds that they don’t work to make sure ... I once took a hammer, a little wooden hammer, away cause she was hurting herself ... essentially I stepped out the (line), I don’t know if I’ll do it for other patients, it exhausted me ...”

When faced with an actively suicidal patient, without the resources available to ensure his or her safety, psychologists are faced with an ethical dilemma. The question is whether they should cross ethical boundaries for the sake of the patient or maintain a self-protective stance. During the present study, some of the
participants took a self-protective “ethical” stance prior to and after the suicide, while others blurred the ethical boundaries. Osafo, Knizek, Akotia and Hjelmeland (2012) explain that few studies have examined the attitudes of psychologists toward suicide, much less their pre- and post-suicide ethical stance. The predominant focus in the literature is on the psychological autopsy (Chachamovich, Haggarty, Cargo, Hicks, Kirmayer & Turecki, 2013; Cavanagh, Carson, Sharpe & Lawrie, 2003; Cooper, 1999), which only takes place after the suicide of the patient. In the present study, this retrospective exploration of the suicide of a patient assisted the psychologists in practically reflecting on their own ethical position throughout the therapeutic relationship with the patient.

- Category 3: Heightened vigilance and anxiety shown toward patients

Having experienced the suicide of a patient, all the participants reported heightened vigilance with regard to the potential suicide risk of patients. The emotions associated with this increase in vigilance included anger, fear, anxiety and with one participant reporting paranoia.

Ayala described the anger that she still feels whenever a patient mentions suicidal ideation:

“I mean business, because I know what it’s like to sit, sit with the unresolved threats of a client committing suicide, so I do get angry and I say … if you kill yourself I’m going to kill you, I get very angry and then I do, I do, I say I’m writing a suicide contract can you please sign it.”

“… whenever I, a, a client mentions suicide now, I get very angry.”

“[I] became hyper vigilant for my clients.”

Cynthia, Jane, Samantha and Ayala reported experiencing intense fear, anxiety and paranoia:
Cynthia: “... I became almost like paranoid at some level patients might try to kill themselves ... you worried but you’re still worried because the thing is it’s so unpredictable ... so you become more vigilant.”

Jane: “... if I started to hear a similar pattern a similar history in some of my clients I started to get fearful uhm, that it would happen again ...”

Samantha: “I’m very uhm, anxious around suicidal clients.”

Ayala: “I was actually poop scared of the next person that came through the door. I thought is there a hidden agenda here and, and I’m not seeing it ... I almost wanted to do sort of ... a suicide assessment on the first interview ...”

Grace and Cynthia reported that they spent more time investigating the suicidal ideation and intent with patients:

Cynthia: “... a good few sessions had to be spent working through, through that with other patients who may have developed similar ideas or who had similar ideas.”

Grace: “... with everybody who sat in front of me for a while to make sure that with them too there’s nothing that I’m missing you know.”

After the suicide of their patient, all the participants reported heightened vigilance with regard to the potential suicide risk of patients. Furthermore, an aversion was expressed to taking on new high-risk patients because of fear and anxiety about losing another patient. Chemtob et al. (1988) and Horn (1994) found that clinicians exhibit changes in behaviour such as hyper-vigilance and an increased focus on suicidal themes, assessments and potential. In a more recent study, Rothes et al. (2013) report that more than half of the psychiatrists who answered the question related to increased vigilance after the suicide of their patient, described that they were more attentive and/or more vigilant to potential suicidal ideation in their patients. Increased post-suicide vigilance is well documented (Gill, 2012; Coverdale et al., 2007; Grad, 2009; Tsai et al., 2012; Yousaf et al., 2002).
• Category 4: Psychological autopsy: second-guessing and self-doubt

In short, a psychological autopsy is a procedure for investigating an individual’s suicide by reconstructing what the person thought, felt and did preceding his or her suicide (Brockman, 2012). All of the participants reported doing a psychological autopsy by themselves, where they tracked the sessions with the patient, notes that they took and different conversations with family members in order to make sense of the suicide. In this process, some of the participants described a haunting sense of second-guessing and doubting whether they did not miss something. The participants described their feelings as follows:

**Holly:** “I think I was doing the right thing.”

“Maybe that’s another thing I could have done.”

During the meaning-making conversation, **Holly** further elaborated on this:

“Since we last spoke I have asked myself the question over and over again ... was there something I missed ... Could I have done more?”

**Samantha:** “... maybe I could have spent more time on it.”

“... could I have done this something, should I have done something more?”

**Samantha** also introduced this theme during our meaning-making conversation:

“... I felt I should have done more ... I didn’t ask enough questions ...”

**Cynthia** described how she did the psychological autopsy:

“... the first thing I did was went through the files and every single thing, I had like a time line type thing.”

“... from there you go to second guessing yourself to think what you could have done.”

“... for a while it was like constantly like you know, double checking.”

“... you still think you, you know could you have done something to prevent that, it was preventable.”
Jane described her struggle with her persistent self-doubt and having to continue to see new patients in psychotherapy as follows:

“I think I just doubted everything that I was doing ... I felt like I had professionally I had changed ... from like a naive therapist into somebody who had you know, who, who suddenly has had the worst possible outcome ... it questioned my therapeutic self, it questioned my diagnostic skills, it questioned ... whether or not I could really read a patient, why didn’t I get the sense of this ...”

“... I was now scared and I was doubting myself and questioning myself and you know so it was, ja, it was quite difficult to balance ...”

Grace ruminated on the suicide, second-guessing the process that she followed prior to the suicide:

“I have thought about that over and over and over again and I do not know what I could do differently.”

“... wasn’t there another angle of looking at it that I also could have visited, did I miss anything, what was there and I turned this thing like the Rubik’s cube to every side and I couldn’t see anything.”

The intensity of self-doubt became so overwhelming that Ayala considered leaving the profession:

“... should I hang up my couch and go farming and should I take up pottery and should I just not be a psychologist?”

“I may have listened or tried to listen more carefully and attunedly to what he was saying.”

Most of the participants reported ruminating on the suicide for weeks and sometimes months, often second-guessing themselves and doubting their professional
competence. Hendin et al.’s (2000) study found that among therapists of 26 patients who had committed suicide, self-doubt was one of the major emotional reactions. More recently, Skodlar and Welz (2013) and Darden and Rutter (2011) found that self-doubt was among the emotions reported by mental health professionals following the suicide of their patient. Grad (2009) suggests that formal psychological autopsies have proven helpful in alleviating some of the self-doubt. Guidelines on psychological autopsies are discussed in the next chapter.

- **Category 5: The need for personal and/or professional mitigation or absolution**

Having to bear the “noose” of responsibility, all the participants expressed a need for personal and/or professional mitigation. Some of the participants sought personal mitigation with their families by sharing their emotional turmoil, while others reflected on the suicide with the family of the patient, colleagues, peers and/or supervisors.

**Cynthia** described how she was assured by her medical colleagues in the hospital setting that she should not take the suicide personally:

“... don’t blame yourself you know, the medical, do not blame yourself, it doesn’t have anything to do with you ... assurance from my medical colleagues only helped so much ...”

**Holly** reflected on the suicide with her supervisor and concluded as follows:

“... I couldn’t give a band aid for it, it was reality it’s not my responsibility her reality.”

**Jane** scheduled a follow-up appointment with the patient’s wife:

“... although he was depressed he just wasn’t exhibiting any, any signs in terms of actual suicide, suicidal ideation ... I have also since had a, a meeting with his wife ... I think we both came away with the sense of there really was nothing that there really was nothing that we could have done ...”
Ayala and Grace reflected on the suicide personally:

**Ayala**: “... I don’t think there’s anything that I could have done to prevent it; I think he had a plan long before he came to see me”

**Ayala**: “... stepping back from it uhm, to help gain some objectivity to say that I didn’t aid and abet the suicide …”

**Grace**: “... you push it away from you, because you need to remember to handle it clinically.”

This theme presents an opportunity for further research, because despite an extensive search, no literature\(^6\) was found on the psychologists’ need for mitigation following the suicide of their patient. The expression of this need by means of increased familial and collegial support is discussed later in this chapter.

### 4.3.1.3 Theme 3: Having an (unwanted) affair with the suicide

The participants all experienced the weight of having to carry the “secret” of an event of such magnitude. The participants had an (unwanted) affair with the suicide by keeping this “secret” from their primary support structures; mainly for confidentiality reasons, but also to prevent vicarious traumatisation. However, this professional trauma “bled” into their personal lives and caused feelings of loneliness and isolation, with some participants experiencing “disconnection” for up to two months from their spouses and other primary support structures. The uncertainty about how their colleagues would react contributed to feelings of professional isolation with fears of being blamed or held responsible.

- **Category 1: Isolation and social withdrawal**

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\(^6\) The search for literature included Google Scholar, the University of South Africa and University of Johannesburg online libraries, which include numerous local and international databases of online journals and dissertations
The effects of the patient’s suicide were far-reaching and not easily contained within the “walls of work”, often spilling over into the participants’ personal lives. The participants were faced with bearing the “secret” of the suicide of their patient due to ethical reasons, as well as in an attempt to “protect” their family and friends from the vicarious traumatisation of the cynical and brutal nature of the suicide.

**Cynthia** described her feelings of isolation and withdrawal from her primary support structures as follows:

“... I felt quite isolated from the people in my, my life because they talk about work you know moaning about work, because they so stressed because of deadlines or something like that and I was just like come off it ... how do you talk to normal people about a patient killing themselves and I think that’s the reality of our work, things that we see and do here that we can’t talk about outside to people who are not professionals so they knew I was upset about the death of the patient but you know, you couldn’t talk about all this stuff with them you know uhm, so that was also in the sense a pretty lonely business ...”

**Cynthia** further elaborated on this during our meaning-making conversation:

“... when you are going through it, you are not sure how many others have experienced it ... you are too scared to ask ...”

In line with **Cynthia’s** experience, **Samantha** explained as follows:

“... I think that feeling like you’re the only one that has gone through it because I don’t think psychologists really it’s not recently spoken about it’s not disclosed ... I withdrew quite a lot from people ... it goes back to the sense of isolation that you can’t talk about it to anyone ...”

**Jane** and **Ayala** described how they felt disconnected from their primary support structure. They “shared” with their partners, but still felt that they were personally isolated:
Jane: “... I just remember not really being, I just wasn’t present for a while ... I had to get back into my own therapy ... just so that I actually could cope because I couldn’t explain it to anyone and I also couldn’t necessarily explain it in detail ...”

Jane: “... I actually felt very alone because I couldn’t tell people ... I couldn’t tell people what was wrong ... I couldn’t tell people why you know I was upset or uhm, ja, just it was very difficult not to be able to give an explanation you know ...”

Ayala: “... I became quite withdrawn so I didn’t want to uhm, I didn’t want to speak to my partner too much about it ... I tended to be quite withdrawn, introspective ... my communication with my partner was affected ...”

During our meaning-making conversation, Holly described the experience as watching from behind a one-way mirror:

“... it was like I was behind a one-way mirror and watching everyone else ... I couldn’t go to them ...”

Grace did not describe isolation from her family members, but described the suicide as a “private, lonely struggle”. She found her strength and “primary support structure” to be her faith:

“I think I was a little bit depressed after that for a while, I also sat with the sadness you know then I went and I just sat in front of the Lord and I took my flute and I worshiped a bit and then I just spoke to Him about her life ... I just gave her over and the Lord filled me with his peace ... but over a time, since then there were you know it, it comes up again and you think about it again.”

Ellis and Patel (2012) found that therapists often grieved in isolation due to confidentiality issues and/or fear of professional stigma. As a result, most of the participants struggled with feelings of loneliness and isolation, with some participants withdrawing socially, as they experienced disconnection from their spouses, family, friends and colleagues. Darden and Rutter (2011) explain that the “professional silence” that is ethically expected from a psychologist causes shame and isolation on
the part of the grieving therapist, reinforcing feelings of responsibility. Similarly, Doka (2002) describes that the emotional turmoil related to this sense of being left to carry the burden on their own proved to be one of the biggest obstacles in the process of making meaning out of the patient suicide.

4.3.1.4 Theme 4: The paradoxical dance

The paradoxical dance captures the ambivalent realities and explanations made by the participants as they wrestle with and try to come to terms with their patient’s suicide. Most of the participants experienced a paradoxical dance between their personal emotional realities and what they perceived to be “clinically” or “professionally” acceptable. Having experienced the suicide of their patient, psychologists are often expected to deal with their anxiety about losing another patient to suicide and continue seeing patients as if they were not personally affected (Vawda, 2013), Personal communication).

This theme includes the previous three categories that integrate the previous three themes by presenting them as part of a complex network of emotions and not as separate reactions.

- Category 1: “I’m not anxious” (while trembling inside)

The first paradoxical “dance” was observed in the experience of three of the participants with regard to their levels of anxiety. They found themselves in a paradox of being anxious without being able to acknowledge it as such.

Grace described this dance during our initial interview as follows:

“... because you need to remember to handle it clinically ... I think in the time that I was turning this Rubik’s cube into every angle possible ... I probably did that in therapy as well with everybody who sat in front of me for a while.”

Grace resolved this anxiety paradox through her faith:
“... I honoured her choice, because she chose to end the pain ... I don’t experience anxiety when a patient says they want to kill themselves ... They have a right to choose a new life ... an eternal life.”

During the initial interview, Ayala did not acknowledge that she became anxious when confronted with a suicidal patient:

“I don’t fall apart and, and get anxious about every patient that comes, and think oh my word, oh my word, this patient’s going to commit suicide …”

... But, paradoxically she also reported the following:

“... when I hear the words it’s like I’m all to a red rag ... as somebody mentions the word suicide I bring out, I bring out all the support and the reinforces and papers and the, I bring everything out ... I also say it makes me very angry when you say that ... because if you do kill yourself I will kill you.”

During our meaning-making conversation, Ayala clarified her experience as follows:

“... men become angry and women become anxious ... when I have a suicidal patient, I become both ... Kind of like a yin and yang mix ...”

Samantha encapsulates this dance in one sentence:

“... maybe not paranoid, maybe paranoid, maybe not paranoid ...”

After our meaning-making conversation, Holly was faced with a suicidal patient and sent me an e-mail describing her experience:

“Fear crept into my heart ... will I cope as well as I did before if this happens again (successful suicide)???... one can’t underestimate the loss of ‘professional face’. Being in private practice espec[i]ally one has to keep up a face to have referrals come your way ...”
The first paradoxical dance was the dissonance between some of the participants’ conscious denial of anxiety about treating future suicidal patients and their descriptions of fear, anxiety and, in one participant, “paranoia”. Some of the participants described feelings of anger, hyper-vigilance and active avoidance of suicidal patients, yet they denied or vaguely acknowledged the impact that it had on their treatment of future suicidal patients. The above-mentioned emotions of fear, anxiety and anger were previously described in this discussion (Darden & Rutter, 2011; Coverdale et al., 2007; Rothes et al., 2013; Tsai et al., 2012; Yousaf et al., 2002; Gill, 2012). However, despite an extensive search for literature\(^7\), no explorations of these paradoxes were found. This gap in the academic body of knowledge presents an opportunity for more research to be conducted into this area.

- **Category 2:** “There were no signs” *(while doubting if there were)*

Three of the participants reported that they did not observe any signs that suggested suicide risk; yet seemed to also doubt whether there were indeed any signs. This “dance” between certainty and doubt was evident in the descriptions of **Grace**, **Ayala** and **Samantha**.

**Grace:** “*There must have been something or maybe there wasn’t …*”

**Ayala:** “*… there was no sign, none ..! I’m sure there was, but I didn’t see it.*”

She further elaborated during our meaning-making conversation:

“*I just don’t know what I missed … I checked everything out … I just needed someone to tell me that there was nothing that I missed …*”

**Samantha:** “*… cause he wasn’t presenting as sui[cidal].., cause he had presented as suicidal in the first session.*”

\(^7\) The search for literature included Google Scholar, the University of South Africa and University of Johannesburg online libraries, which include numerous local and international databases of online journals and dissertations
During our meaning-making conversation, Ayala’s paradoxical dance of “there were no signs” and doubting whether there were, impacted on her identity as a psychologist. Having worked in a suicide centre, the patient who committed suicide was her first patient as a private practitioner. She described her experience during our meaning-making conversation as follows:

“... It was my first patient ... I ticked all the boxes ... There were no signs ... I thought, my goodness, how could I have missed it ...”

A key element in the day-to-day work of a psychologist is the ability to clinically assess “signs and symptoms” by observing a patient’s behaviour and listening to his or her verbal communication (Pillay, 2013). Many psychologists base their diagnosis and treatment of patients on these “signs and symptoms”. Therefore, the acknowledgement of some of the participants that they did not observe any signs and symptoms of suicidal ideation or suicidal intent prior to the suicide of their patient, is a manner of saying: “My professional observations were accurate.” However, these acknowledgements of accuracy were often followed by doubtfulness whether they “missed something”. This paradoxical dance is therefore about being confidently certain about what they observed and yet describing deep uncertainty in their observations.

- **Category 3:** “I exhausted all avenues” (while asking whether there was another avenue they could have explored)

Category 2 of this theme was about a paradoxical dance that emerged about what the participant observed (or did not). Category 3 emerged as a paradoxical dance about what the participants did (or did not do). Holly described her experience during our meaning-making conversation as follows:

“... we had tried our best and I didn’t know what else and she didn’t know what else to do ... Maybe that’s another thing I could have done.”

Ayala also described this dance:
“... I may have listened or tried to listen more carefully and attunedly to what he was saying but I don’t know if I could have done that, I don’t think there’s anything that I could have done to prevent it ...”

During our meaning-making conversation, Grace described her journey with what she did and/or could have done as follows:

“... you always wonder what you could have done differently ... I respect their choice of a new reality ...”

The third paradoxical dance was about the participants’ actions (or lack thereof). Some of the participants reported that they had “done what they could”, but continuously described things they could have done different in the course of therapy. The mechanism of the paradox dance was similar to the second paradox with regard the confident certainty about their actions on the one hand and deep uncertainty about whether they could have done something more.

4.3.1.5 Theme 5: Solace and sanctuary

Solace and sanctuary highlights the participant’s self-expressed need for collegial, family and peer support. The participants expressed a need to deal with the personal emotional trauma as well as to make professional sense of it by way of supervision. As discussed in theme 3, the participants often found themselves isolated from their primary support structures and needed to look to peers and colleagues for support.

- Category 1: Increased use of collegial and peer support and/or turning to supervision and therapy

The participants differed with regard to where they found solace following the suicide. Some found their peers to be inaccessible due to fear of being judged or stigmatised, while others found their peers to be emotionally supportive. Four of the

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8 Peers refer to other psychologists and colleagues to other mental health professionals e.g. nurses and psychiatrists.
participants sought supervision during their process of making meaning out of the suicides. The purpose of supervision was to deal with the practicality of the suicide by means of psychological autopsies.

**Holly** found solace in the fact that she had worked with a whole team of professionals colleagues:

“... she’d seen our local MO (medical officer), she’d seen our consulting psychiatrist, she had then gone to a psychiatrist ... she’d been to a homeopath, she’d been to a specialist physician ... she then also started going to church and gave her life to the Lord ...”

However, **Holly** did not experience her peers as supportive, due to her belief that the suicide of a patient was a “taboo subject”. **Holly** further described:

“... there was no space for that ... when other psychologists hear that your patient committed suicide they start twitching ... I did not feel safe with them ...”

**Holly’s** main source of support was her conversations with the nursing staff (who are also her close friends) at the hospital where she works. One of these colleagues accompanied her to the patient’s funeral.

Similarly, **Samantha** felt this sense of isolation from her peers, because she wasn’t sure how they would react. She sought supervision to deal with the emotional impact of the suicide:

“... feeling like you’re the only one that has gone through it because I don’t think psychologists really it’s not recently spoken about it’s not disclosed ...”

“I went for one supervision session and, and that really helped hugely ... I knew I had to get back into my own therapy ...”

On reflection, she reported the following during our meaning-making conversation:
“Supervision helped me deal with the suicide practically, but I never dealt with it emotionally ... I should have gone for therapy ... maybe I still should go ...”

Similarly, Cynthia described that even though she had the opportunity to make sense of what had happened through support from colleagues in the hospital context where she worked, she did not feel she was emotionally supported.

Cynthia: “... I had some friends there, a psychiatrist ... we spoke about it and then toilet humour set in at some point in time from the psychiatrist ... it would have been supportive, if we had the people who were involved in this including nursing staff, all sat and have a debriefing kind of group, cause the psychiatrist, the intern and I went into a little huddle but it was just our little huddle ...”
She described her need for more emotional support as follows:

“... think it would be nice if there’d been some kind of formal uhm, taking away from probably institutional level if ... like another therapist or another psychologist within the system coming to say ja, you know do you want me to talk about this or I think we should talk about this, so that didn’t happen ...”

Jane and Ayala had a different experience to Holly and Samantha in the sense that they experienced overwhelming support from both their peers and supervisors:

Jane: “I still always rely on colleagues ... had a supervision meeting coming up ... I actually presented the case to colleagues ... that was incredibly empowering in terms of you know, their take on, on, on what had happened on whether or not it could, the suicide could have been prevented ... I’ve found that there was a lot of support from colleagues ...”

Ayala: “... the support of colleagues was amazing, my colleagues and friends who are also psychologists were very supportive and so I had a place where I was able to work through it you know and I also had a very, very good supervisor that I went to. I was in supervision at the time anyway uhm, and I worked through the difficult feelings associated with my supervisor so I would say the support that I had was really, really paramount.”
Rothes et al. (2013) report that among psychiatrists who experienced the suicide of a patient, the team case review was the most helpful resource, followed by the support of colleagues and other professionals who treated the suicidal patient (Rothes et al., 2013). Alexander, Klein, Gray, Dewar and Eagles (2000) found that team case reviews or psychological autopsies that are aimed at reflection and learning is helpful.
• Category 2: Support from spouses, family and friends

As described in theme 3, the participants all experienced a sense of isolation from their primary support structures. However, all the participants experienced support from family members and friends “at a distance”.

**Jane** described that although she found solace in her husband and immediate family, she still felt a need to protect them from what had happened:

“... I couldn’t tell people what was wrong, obviously other that my husband and my immediate, immediate family ...”

“... my husband also, because he had to know about what had happened, he was incredibly supportive ...”

During our meaning-making conversation, **Jane** further elaborated:

“... you can only share so much with those closest to you ... you have to protect them as well ...”

**Cynthia** did not disclose the details of the suicide to her family and friends, but she described their support as being one of the important factors in her recovery process:

“I got a lot of support from my family and some of my friends ... I think my family understood and they were quite supportive so they kind of left me alone but also included me in things like: ‘come and have your food now’, and all that kind of stuff you know, they made things that they knew I like to eat ...”

**Grace’s** patient was a teacher by profession and so is **Grace’s** mother. Grace described how sharing with her mother gave her a sense of comfort and support:

“I told a teacher and after I told the teacher, I think I told my mom uhm, and then I went and I just sat in front of the Lord … and I just gave her over ...”
• **Category 3: Seeking spiritual and/or religious sanctuary**

After the suicide, the participants sought spiritual and/or religious sanctuary by attempting to make sense of their personal spirituality journey and society’s religious intolerance with regard to mental illness and suicide. **Holly** and **Jane** described their struggle with the dichotomous thinking often found in religion with regards to mental illness:

**Holly:** “I’ve just recently likened it to cancer as talking about it just recently you don’t blame someone from having cancer and that depression and it was, it, circumstances were breaking her down and it just the cancer it just overtook her. So, my spiritual journey ... in my heart I, I have an, a deeper understanding of, of the cancer of a psychological problem ... I suppose it’s also trusting my God that he is if I can see it this way he can see it even more thoroughly and trust that he can judge, ja, fairly.”

**Jane:** “... the dynamics of the case I think challenged me more spiritually ... I became actually quite angry in, in terms of religion and in terms of the non-acceptance of what mental health or mental illness is ... I don’t believe in, in rigidity uhm, and I’m afraid that this, this whole event actually highlighted that for me you know, it, it further confirmed that we cannot be that spiritually rigid uhm, especially when it comes to mental health ...”

**Cynthia’s** patient was a Hindu and she was concerned that he would not receive a proper burial:

“I wasn’t angry with God or anything like that ... from a religious perspective you know the Muslims say that you’re not allowed to be buried in the graveyard in consecrated ground if you have committed suicide ... he (the patient) was Hindu ... I would hope that he would have, that there wouldn’t be any uhm, prescriptions in terms of what would happen to him uhm, his remains ... I was very spiritual in those days ...”
The sanctuary that Grace found in her personal spirituality was previously discussed. She further described:

“... that was a new spiritual place for the Lord to take me to ... waiting on the Holy Spirit to talk to me, to say to me well this is what I think it is and relying on his voice to give me meaning.”

Dyregrov et al. (2012) found that some suicide survivors find help in religious activities. In the present study, most of the participants described being part of a church and reported that this was one of the factors that assisted them in dealing with the suicide. The literature suggests that religious belief and being part of a faith community can often act as a “buffer” against the adverse effects of a traumatic event (Paloutzian & Park, 2013; Watts & Nye, 2006; Hood, Hill & Spilka, 2009).

4.3.1.6 Theme 6: The wounded healers

Having experienced the suicide of their patient, all the participants indicated going through different phases and/or stages in dealing with the suicide, as described in themes 1 to 5. In the process of healing the wounds of this traumatic experience, two movements were observed. The first movement (presented as category 1 in this theme) was from being a survivor to a witness to the patient’s life. The second movement (presented as category 2 in this theme) was from wounds to wisdom and healing.

- **Category 1: From survivor to witness**

In the complex and protracted process of healing, a movement was observed in some of the participants from being a survivor of the suicide, as discussed in chapter 2, to being witness to the relationship they had with the patient. Mediated by the support of colleagues, peers, supervisors and family, and attenuated by time and insight gained, the participants started healing the wounds of having lost a patient through suicide.
Some of the participants described the process as follows:

**Jane:** “... it was a very difficult process ...”

**Cynthia:** “... but it was a process of, of coming to grips with it ... I still am upset about it at some level.”

**Ayala:** “… it had to run its course, it was a process.”

The healing process progressed from the disappointment of a premature end to the therapeutic relationship to an acceptance and understanding that the patient made a decision that they had no control over.

**Holly:** “I can’t say you can be peaceful about a suicide but a deep understanding ... I have a feeling that I understand why she did it”

**Grace:** “... it felt as if I was standing in between her, the shadow of who she was, who wasn’t there anymore ... so, eventually you just let your, you open your fingers and you let it go, there is a place in you that realizes that it’s past.”

**Grace:** “... I can make sense of it, I can understand at a certain level that for her, her pain had stopped ...”

**Cynthia:** “… you know early in my career, let’s save them because that’s how you’ve been trained … but nobody tells you that you know there’s sometimes choices that people make that can be destructive once but it’s their choice and you have to respect that ... you become a little bit more uhm, accepting of people’s choices ...”

The lingering presence of the deceased patient, as described in theme 1, initially caused distress, but in the healing process became a welcome presence for some of the participants. **Grace** and **Holly** described in an endearing fashion that they still carry the patient with them in their hearts:
Grace: “... I really love pearls ... I carry the experience we had together in my heart like a little bag of pearls ...”

Holly: “... I’ve told you that she carries on, I, I’m also an elephant I carry things forever ... every now and again I will see someone that makes me think of her and or I drive past her home ... it’s her memory ... her legacy stays on, you know.”

- Category 2: From wounds to healing wisdom

The second movement was from the wounds of hard lessons learned to healing wisdom and new insights gained. The term “healing wisdom” is used here to indicate that the wisdom gained was not only at a personal level, but also contributed to their therapeutic ability to provide a healing environment for their patients. Jane described her movement from wounds to wisdom as follows:

Jane: “... I had changed from like a naive therapist into somebody who had you know, who, who suddenly has had the worst possible outcome ... it’s actually helped me develop ... we can only do what we can and we need to often let go of this belief that we can save everyone ...”

During our meaning-making conversation, Jane further described:

“... it has made me a better therapist ... the intensity my clients bring to therapy doesn’t scare me anymore ...”

Ayala expressed her gratitude toward the deceased patient for the healing wisdom she has gained:

Ayala: “… he’s still with me, he’s still in my psyche and his very much with me every time somebody mentions suicide so, I’d like to thank him for that.”

For Cynthia, the suicide started an academic journey into suicidal behaviour:
Cynthia: “... and then (I) became interested in the whole area of the suicidal behaviour as the research thing ...”

Her academic journey has made her one of the national authorities on suicidology. Cynthia works in a government hospital where she supervises intern clinical psychologists. Cynthia’s healing wisdom is found in supervision:

“You know I had to make meaning of this whole thing for myself ... I don’t want others to have to go through that ... someone needs to prepare them (the interns) and be there for them if a suicide happens ...”

And in how Cynthia deals with her patients:

“You want the best for the patient ... you always hope that you’re wrong, but now I am just so much more prepared ...”

4.5 CONCLUSION

Chapter 4 explored and described the experience of psychologists after the suicide of their patient. In chapter 5, guidelines are developed as a framework of reference to psychologists in dealing with the suicide of their patient.
CHAPTER 5: GUIDELINES, RECOMMENDATIONS, LIMITATIONS, AND CONCLUSION

“The timing of death, like the ending of a story, gives a changed meaning to what preceded it” (Bateson, 2004).

5.1 INTRODUCTION

In chapter 4, the themes, categories and subcategories of the experience of psychologists after the suicide of their patient were described and discussed. In this chapter, these findings are used to develop guidelines that will assist psychologists in dealing with the suicide of their patient. The limitations of the study are indicated and suggestions are offered for further exploration of the topic.

5.2 POST-VENTION GUIDELINES

As described in section 2.4 of chapter 2, post-vention guidelines focus on activities developed by, with or for suicide survivors in order to facilitate recovery after suicide, as well as to prevent adverse outcomes, including suicidal behaviour (Andriessen, 2009).

- The post-suicide process

The present study found that, following the suicide of their patient, the participants were propelled into a myriad of acutely distressing emotions. They often described a suffocating sense of responsibility for the suicide and the lingering presence of their patient. The participants experienced feelings of guilt and self-doubt, often questioning their own professional competence. The post-suicide process was described as being both a personally and professionally isolating event, due to the sense of having to carry the burden of the suicide alone for ethical reasons and fear of social stigmatisation. The participants appeared to grapple with the paradoxical dance between their personal emotional realities and what they perceived to be clinically or professionally acceptable. Having gone through the traumatic experience
of losing a patient to suicide, most of the participants eventually found new wisdom, which helped them become wounded healers. Table 5.1 presents a summary of the themes and post-vention guidelines.

Table 5.1 - A summary of the themes and post-vention guidelines

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As described in section 3.4 of chapter 3, post-vention guidelines and practical actions were developed, based on the findings of phase 1 of the present study. These guidelines and practical actions are described below.

5.2.1 Theme 1: Dealing with the “Sting of Death”

5.2.1.1 Guideline 1: Open up to yourself

In a study done by the Norwegian Bereavement Project, most respondents stated that openness had been their most important coping strategy following a suicide in
the short- and long-term (Dyregrov et al., 2012). *Openness* here refers to being honest and clear about the

- emotional turmoil of the loss, and
- need for help and support.

During our meaning-making conversation, **Cynthia** stated the following:

“... psychologists react in one of two ways to a suicide ... some just block it out and others become too emotional ... almost falling apart ... there needs to be a balance.”

**Cynthia** described that some individuals become a “victim” of the suicide, while others choose to deny it; ultimately, there needs to be a balance. The danger that **Cynthia** warns about is that psychologists might become so overwhelmed after the suicide that they become emotionally incapacitated and do not take proactive action in their recovery process.

For reasons previously discussed, the challenge for a psychologist is where, when and with whom they should have these “open” conversations. The following guidelines are suggested:

- **Action 1: Keep a reflexive journal**

The literature suggests that one of the initial reactions to suicide is denial (Skodlar & Welz, 2013; Darden & Rutter, 2011). The opposite of denial is openness to self (Dyregrov et al., 2012). “Openness to self” entails an honest self-appraisal of the emotional impact of suicide and the help and support required. In the present study, all the participants reported some form of “conversation” with self. **Jane** described this as follows during our meaning-making conversation:

“... I had to take time to figure it out ... my mind had to process something so significant ...”
During our meaning-making conversation, Ayala described that one of the ways in which she dealt with the impact of the suicide was keeping a reflective journal:

“... my journal ... it kept me sane when there was no-one else that I could talk to ...”

Similarly, Grace noted the following:

“... I journaled about it ...”

Dyregrov et al. (2012) note that putting feelings and thoughts into words helps individuals to process their sadness, confusion, anger or sense of abandonment. Valente (2003) suggests that it is helpful to therapists to write a narrative of the suicide. Keeping a reflective journal is therefore one of the ways in which psychologists can deal with the “sting of death”.

- **Action 2: Go for individual therapy**

Grad (2009) notes that it is important for a therapist to make time and have a setting to acknowledge, express and understand their own feelings after the suicide. For some of the participants, entering into individual therapy with another psychologist provided a safe space where an open conversation could take place. Even though the participants were still bound by some ethical guidelines with regard to disclosure of the patient’s details, they needed a person to whom they could authentically express their emotions. Jane described that she went for individual therapy soon after the suicide:

“I had to get back into my own therapy ... just so that I actually could cope because I couldn’t explain it to anyone and I also couldn’t necessarily explain it in detail ...”

Jane further described:

“... I’d seen somebody for quite a while ... I actually contacted her again and said can I come and see you ... Please can I come and see you and I think that also really, really helped ...”
During our meaning-making conversation Samantha noted:

“... I should have gone for therapy ... maybe I still should go ...”

The participants that went for individual therapy described that it was a very helpful tool in their recovery process, especially during the “sting of death” phase. It was described as meeting an emotional need, which supervision did not meet.

- **Action 3: Commit to supervision**

Supervisors play an important role in providing practical guidance to psychologists throughout the post-vention process (Fang et al., 2007). Samantha described the role that supervision played in her recovery process as follows:

“Supervision helped me deal with the suicide practically ...”

Sacks, Kibel and Cohen (1987), as well as Ruskin et al. (2004), note that supervision should commence immediately after the suicide to offer emotional and professional support. Sacks et al. (1987) found that when supervisors share their sense of responsibility and guilt, residents feel relieved and less isolated.

In the present study, the participants experienced the conversations with their supervisors as normalising the experience and reducing the stigma of suicide. All the participants had some form of supervision, whether it was with colleagues or more formally, with a supervisor. Ayala experienced supervision as very helpful:

“... I was in supervision at the time anyway uhm, and I worked through the difficult feelings associated with my supervisor so I would say the support that I had was really, really paramount.”

The supervision process assisted the participants by providing them with another “space” to openly express their emotions.
• **Action 4: Find and use online support groups for psychologists**

Advances in technology have made it possible for psychologists to access support from other mental health professionals from all over the world. For example, the American Association of Suicidology has a section on their website devoted to clinician survivors ([http://www.suicidology.org/suicide-survivors/suicide-clinician-survivors](http://www.suicidology.org/suicide-survivors/suicide-clinician-survivors)). Psychologists who experienced the suicide of their patient can share their experience anonymously, and others who have had similar experience can respond. Furthermore, they have a list of resources that a psychologist can access. During their meaning-making conversations Jane and Samantha expressed their need to have spoken to other psychologists who experienced the suicide of their patient.

**Samantha:** “I didn’t know how to get in touch with someone that had experienced the suicide of a patient ... I really wish I could have ...”

**Jane:** “You become part of like a secret club amongst psychologists ... no one talks about it ... it would have been useful to have shared with someone who had a similar experience ...”

In the South African context, no such resources exist. The researcher registered the Internet domain of [www.suicidology.co.za](http://www.suicidology.co.za) in his name and is in process of designing a website to cater for the needs of, among others, psychologists who experienced the suicide of their patient.

5.2.1.2 **Guideline 2: Keep your balance**

• **Action 1: Engage in physical activity**

Physical activity mobilises personal resources, promotes positive thinking and emotions, and increases faith in one’s own ability to cope with negative events (Dyregrov et al., 2012). Bender, Nagy, Barna, Tefner, Kadas and Geher (2007) report on the crucial role that exercise plays in physical health. They report that
exercise helps the body to produce endorphins, which has been found to have a positive effect on psychological health. In the Norwegian Bereavement Study, more than half of the young people and adults indicated that working out, going for a walk or other forms of physical activity assisted them in dealing with the suicide of a loved one (Dyregrov et al., 2012).

As discussed in chapter 2, the physiological impact of the suicide leaves one’s body vulnerable to the adverse effects of the stress caused by the suicide. An essential element of dealing with the “sting of death” is therefore to ensure that one remains physically active.

- **Action 2: Use religious and/or spiritual activities to anchor yourself**

Dyregrov et al. (2012) found that some suicide survivors find help in religious activities. In the present study, most of the participants used spiritual activities to assist them in dealing with the suicide of their patient. Grace was quite particular about her religious activities:

“... I just sat in front of the Lord and I took my flute and I worshiped a bit and then I just spoke to Him about her life ... I just gave her over and the Lord filled me with his peace ... “

For Grace, prayer, worshipping God through music and her belief that her patient made a “choice for a new life ... eternal life ...” assisted her in dealing with the “sting of death”.

Most of the participants described being part of a church and reported that this was one of the factors that assisted them in dealing with the suicide. The literature suggests that religious belief and being part of a faith community can often act as a “buffer” against the adverse effects of a traumatic event (Paloutzian & Park, 2013; Watts & Nye, 2006; Hood, Hill & Spilka, 2009).

- **Action 3: Think carefully about rituals and/or ceremonies**
All the participants in the present study were confronted with the question whether they should go to the funeral or not. The only participant that went to the funeral of her patient was Holly. The other participants did not attend their patient’s funeral for ethical reasons and fear of facing the patient’s family. One could argue that professionally it is the “right thing” to not go to the funeral in order to maintain the boundaries, but it appears to be not that simple. In this study, much has been said about the impact that the suicide has on a psychologist. It is often considered as traumatic as the death of a family member or a friend. The importance of having some form of a “saying goodbye” ritual or ceremony following the death of a loved one has been well documented (McGann, Gutin & Jordan, 2011; Aldridge & Barrero, 2012).

Because parting rituals or ceremonies are different for every person, it is suggested that psychologists discuss these closure rituals with a supervisor or therapist. The idea will be to co-create tailor-made ritual(s) or ceremony(s) to assist the psychologist in dealing with the “sting of death” following the suicide.

5.2.2 Theme 2: Dealing with the Noose of Responsibility

5.2.2.1 Guideline 1: Initiate a psychological autopsy

Most of the participants reported doing some form of psychological autopsy. This included

- going through the patient’s file again,
- speaking to family members,
- speaking to other health professionals involved in treating the patient,
- reflecting on the suicide with a supervisor, and
- reflecting on the suicide with colleagues.

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9 As described in section 2.2 of chapter 2
During our meaning-making conversations, a prominent theme that emerged was the different psychological autopsy procedures that were followed in private practice and in government hospital settings. Jane described this as follows:

“When you’re in private practice, it’s just you and the insurance company making sure you’ve made the right decision ... it’s an individual decision ... in hospitals you are supported by a group of colleagues who can share the responsibility ... you are more protected ...”

Cynthia noted as follows:

“... in a private practice, I don’t know what you would do ... hospitals we’re in the same boat ... How do you make meaning of something so big when you have no support. When you take time off, you lose money ... Where will you find the time and money to process it?”

One of the challenges that emerged from the meaning-making conversations was doing a psychological autopsy when you are in private practice. Samantha described this as follows:

“... in private you have to be more proactive and you have to initiate the process ... No one is going to do it for you ...”

In government hospital settings, these psychological autopsies happen for different purposes. An internal investigation is usually conducted by the hospital to determine whether there was any negligence on behalf of the health professionals, which could have litigation implications for the hospital (Vawda, 2013), personal communication). In the department where the patient was treated, conversations between health professionals involved the treatment of the deceased patient, practical reflection on the treatment, diagnosis and timeline of suicidal process to determine whether there was anything they missed or could have done differently.

As part of a protocol after the suicide of a patient, Grad (2009) recommends the actions below.
• **Action 1:** *Organise a meeting* for everybody who treated the patient to reflect on the patient and his or her treatment.

• **Action 2:** *Appoint a supervisor* to structure the debriefing and to avoid blame and self-blame.

• **Action 3:** *Appoint a consultant* to listen to the patient’s history and treatment and seek to reach consensus about the suicidal act.

• **Action 4 (in private practice):** Make contact with the medical insurance company.

Although Grad’s (2009) protocol can serve as guidelines for both private and government hospital settings, the logistics of these four actions often require more organisation in private practice. However, most of the participants found that doing a psychological autopsy helped them to get more closure and decreased their sense of guilt.

### 5.2.2.2 Guideline 2: Focus on emotional recovery

Having experienced the “sting of death” immediately after the suicide, most of the participants entered a phase of finding new meaning from what had happened and of recovering emotionally. Talseth et al. (2000) report that therapists generally progress into a second phase after the initial shock of the suicide of their patient, which might include feelings of guilt, anger, anxiety, depression and a sense of professional incompetence (Talseth et al., 2000; Kleespies, 2009; Ting, Sanders, Jacobsen & Power, 2006).

• **Action 1: Seek healing conversations**

Dyregrov et al. (2012) warn against the effects of what they call “co-ruminating” by spending excessive amounts of time talking to individuals who were also adversely affected by the suicide. In order to avoid this, it is recommended that external help in the form of supervision or colleagues be sought in facilitating healing conversations. **Cynthia** concurs with this suggestion:
“I really feel you need someone from outside the situation to help with the psychological autopsy ...”

As previously described and discussed, individual therapy during the “sting of death” phase was often cathartic in nature where emotions such as shock, disbelief, horror and a sense of helplessness were described. In the present study, most of the participants went for short-term individual therapy to contain their acutely distressing emotions. However, the literature suggests that many mental health professionals need longer-term intervention to emotionally recover after the suicide (Balon, 2007; Coverdale et al., 2007; Darden & Rutter, 2011). During our meaning-making conversation, Samantha described this as follows:

“... I should go for counselling ... maybe I’m still in denial or something ... it (the suicide) haunts me sometimes ...”

Psychologists need to be aware of their own emotional recovery process and be proactive when they become “stuck” in the grief process. Cynthia described this as follows:

“... take care of yourself ... if you feel like you got stuck speak to someone ...”

Other sources of “healing conversations” are those with your family, friends and colleagues. These conversations are now further discussed.

5.2.3 Theme 3: Dealing with the (Unwanted) Affair with the Suicide

5.2.3.1 Guideline 1: Trust your family and close friends

As a guideline, the findings of the present study suggest that psychologists need to be open about the emotional turmoil they are experiencing with family members the trust, and need to allow them to give support.
• **Action 1: Be honest about the emotional impact of the suicide**

Most of the participants reported that their family observed that something significant had happened. However, the dilemma that emerged from the meaning-making conversations was to what extent the details could be shared with the participant’s family. **Cynthia** described the support she received from her family as follows:

“... I think my family understood and they were quite supportive so they kind of left me alone but also included me in things like: ‘come and have your food now’, and all that kind of stuff you know, they made things that they knew I like to eat ....”

During our meaning-making conversation, **Cynthia** further elaborated and stressed the importance of “allowing” your family to help you:

“... your family needs to know what you are going through ... not the gory detail, but you must allow them to help you.”

• **Action 2: Invite emotional support from family and close friends**

What Cynthia was suggesting, is that her family did not need to know the details of the case to support her emotionally. A distinction was therefore drawn between emotional support and breaching confidentiality.

**Jane** trusted her husband and friends with her emotional turmoil. She noted the following:

“... I couldn’t tell people what was wrong obviously other that my husband and my immediate, immediate family ...”

**Jane** therefore further differentiates between close family and distant family. **Ayala** agreed with this when she expressed the support she received from her family during our meaning-making conversation:
“... the emotional support from my partner helped me through the worst of it ...”

Most of the participants in this study found the emotional support of their family members valuable in alleviating some of the feelings of isolation. The experience of family members of a psychologist after the suicide of their patient presents an opportunity for further research.

5.2.3.2 Guideline 2: Reach out to other psychologists (peers)

As previously discussed, some participants experienced isolation from other psychologists due to fear of stigmatisation. However, the participants who did reach out to other psychologists found it to be emotionally and professionally comforting. The literature suggests that support from peers and colleagues after the suicide of a patient is an important part of the healing process (Valente, 2003; Chemtob et al., 1989). This topic has been described and discussed previously in the present study.

- **Action 1: Look for peers to do a psychological autopsy with**

When considering guidelines, the question then emerged about where and when, as well as which peers to confide in. **Jane** presented the case to a group of peers and a supervisor as part of group supervision:

“... took a lot of courage, but I eventually presented the case in group supervision setting ... We went through the whole case together ... I needed my colleagues to tell me that I hadn’t messed up ...”

**Jane** was describing a group psychological autopsy. Rothes et al. (2013) and Alexander et al. (2000) found “case reviews” with peers to be the most helpful following the suicide of a patient. In the present study, the rationale for reaching out to peers appeared to be a need for affirmation that they did not “miss something”.

Two other ways of reaching out to peers that have been discussed are supervision and individual therapy. The literature suggests that supervision and individual
therapy are helpful ways in which to deal with the suicide (Balon, 2007; Rothes et al., 2013).

5.2.4 Theme 4: Dealing with the Paradoxical Dances

Snyders (2011, personal communication) notes that two ways to escape a paradox is to either “call it by name” or “leave the room”. Calling the paradox by name dissolves the paradox by openly commenting on the seeming contradictions. Leaving the paradoxical room, as a manner of speaking, requires an individual to find the “door” or exit out of the paradoxical situation, thereby rendering the paradox redundant. These are further discussed.

5.2.4.1 Guideline 1: Call the paradox by name

In the present study, none of the participants were aware that they were caught in these paradoxes. It is suggested that the guidelines previously recommended will allow psychologists to call the paradox by name by means of openness with self, a therapist and/or a supervisor.

- **Action 1: Be open with yourself**

*Keeping a reflexive journal* was previously discussed. As a guideline for dealing with these paradoxical dances, being open with him- or herself allows a psychologist to call his or her personal doubts, fears and emotions by name, thereby nullifying the paradoxical dance.

- **Action 2: Confide in a therapist and/or a supervisor**

The role of individual therapy and supervision in openness has already been discussed. As a guideline for dealing with these paradoxical dances, openness with

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10 The meaning of the term in this context has previously been discussed
a therapist and/or a supervisor provide contexts for a psychologist in which to call their feelings of guilt, shame and feelings of professional inadequacy by name and to take off the mask of “my professional observations/actions were accurate”.

5.2.4.2 Guideline 2: Leave the paradoxical room

In the present study, the participants found different means (or “doors”) of exiting these paradoxes. It is suggested that the guidelines previously recommended will allow psychologists to leave the paradoxical room by means of conducting psychological autopsies with peers or colleagues.

- **Action 1: Do a psychological autopsy with peers**

The “walls” of the paradoxical room were maintained by fears of professional stigmatisation and shame. The mental processes that maintain these fears were previously discussed in this research. The participants who were part of a psychological autopsy with peers exited the paradoxical room by finding acceptance where they expected rejection and finding affirmation where they expected shame.

The process of scrutinising the therapeutic process with fellow psychologists objectified and normalised the patient’s suicide process. During our meaning-making conversation, Ayala described how she exited the paradoxical room as follows:

“... we (other psychologists) reflected on the whole case ... I realised that he had planned this long ago ...”

5.3. CHALLENGES ENCOUNTERED DURING THE STUDY

The challenges refer to obstacles that were encountered during the research process. These are described below.
5.3.1 Selection of Participants

The initial sample for the study was clinical psychologists who experienced the suicide of their patient while the patient was still in therapy. After an extensive search, not enough participants were found that met the sampling criteria. In the initial, informal research process, as described in chapter 1, section 1.2.2., numerous clinical psychologists were contacted, of which 4 were male, but due to the sensitive nature of the topic, few of them were open to the suggestion to have a conversation about the suicide of their patient. The reluctance of these male psychologist’s reluctance to speak about the suicide of their patient is in line with the findings of Jacobson et al. (2004) and Grad et al. (1997). The gender difference with regard to post-suicide reactions presents an opportunity for further research. Therefore, the sampling criteria had to be adapted to accommodate counselling psychologists, who also see patients for psychotherapy. Some of the participants in the present study were willing to participate, but their patient had no longer been in therapy with them at the time of the suicide. The sampling criteria were adapted to include these participants.

5.3.2 Time and Distance

The participants were from two different provinces, namely KwaZulu-Natal and Gauteng. It was often challenging to find a time and venue that were suitable for both the researcher and the participants. For example, the initial interviews were conducted in person, but the second round of meaning-making conversations was conducted by telephone, as one of the participants resides in Gauteng and the researcher wanted to standardise the procedure.

5.4 LIMITATIONS OF THE STUDY

5.4.1 Lack of Comparable Research
Most of the literature used during this study is about the experience of various mental health professionals after the suicide of their patient. These included resident psychiatrists, intern clinical psychologists, social workers, psychiatrists and psychologists. Furthermore, this was only the second study about the topic in the South African context and the first one in the last nine years. The present study is therefore limited by a lack of comparable research among psychologists to analyse and compare the findings.

5.4.2 Transferability of the Findings

The participants were from both private practice and government hospitals. The findings and guidelines suggest that the practical functioning and work environment of these two settings are significantly different. The difference in context is a variable that limits the transferability of the findings. All the participants were female, which limits the findings to a specific gender.

5.5 RECOMMENDATIONS

Following the present study, recommendations for further exploration focus on suicidology research opportunities, education about suicide and psychologist’s practice. These recommendations are described below.

5.5.1 Suicidology Research

The opportunities for further research have been alluded to during the course of the present study. The recommended areas for further research are summarised as follows:

- psychologists’ post-suicide isolation and withdrawal;
- the need for personal and professional mitigation;
• the experience of a psychologist’s family members after the suicide of their patient;
• differences in experience between male/female psychologists;
• an ecosystemic exploration of the paradoxical dances;
• different contexts: private practice and government hospitals; and
• implementation of post-vention guidelines.

These are the recommended areas for further research relevant to this study. However, because there is a dearth of qualitative suicidology research in the South African context, it presents numerous other possible areas of exploration.

5.5.2 Suicide Education

Psychologists should be equipped with the knowledge about how to deal with the suicide of their patient. Universities need to provide trainee psychologists with a post-suicide framework of reference; supervisors could use these guidelines to educate and guide psychologists where required. Furthermore, education with regard to suicide risk assessment and suicidal patient protocols should be formalised in government hospitals as well as private practice settings.

5.5.3 Psychologists’ Practice

5.5.3.1 Increased awareness and resources

More communication is required to increase awareness with regard to available resources for psychologists who experienced the suicide of their patient. The researcher is in the process of developing a website (www.suicidology.co.za) to serve as an Internet-based forum where psychologists can find resources in the form of literature and share their experience anonymously. One of the proposed functionalities will be the psychologists to apply to be part of an online psychological autopsy group. Information will also be provided about psychological autopsy groups in the psychologists’ area.
5.5.3.2 Formalised protocols

At present, there is no formalised protocol with regard to treating suicidal patients in private practice. The difficulty is therefore that psychologists often “learn as they go along” rather than having a framework or protocol to work from before they are faced with treating an acutely suicidal patient. Most government hospital settings do have a post-suicide protocol, but these are usually focused on the administrative side of losing a patient to suicide rather than on the health professionals that treated the patient. As Cynthia notes:

“... it’s just so much paperwork and red tape ... at least we made counselling services available. Nobody did that for us you know ...”

5.6. CONCLUSION

In this chapter, a further layer of meaning was added to the present study by developing post-vention guidelines to assist psychologists in dealing with the suicide of their patient. In this study, these guidelines emerged from meaning-making “conversations” with the literature, participants and an independent coder as co-creators of a new reality. In the process of co-creating meaning, sensitivity to the circular nature of interactions, multi-verse realities and the not-knowing position of the researcher, new (shared) realities emerged as the meaning-making conversations evolved. The different stages of meaning-making conversations, as described in chapters 3, 4 and 5, was not only a measure of trustworthiness, but also an invitation to the readers of this study to further healing conversations.

For most of the participants, the meaning-making conversations embodied the healing impact of the guidelines described in this chapter. Jane and Holly described their reason for participating in the present study during our meaning-making conversation as follows:
Jane: “I heard that someone was willing to listen, so I grabbed the opportunity ...”

Holly: “... this was the first time I’ve spoken about this (the suicide) to a colleague ... ... it has helped me heal ...”

The participants described finding solace and healing in the research process. In the initial interview, the participants had the opportunity to share their experience, which gave them the opportunity to reflect on the suicide of their patient by doing psychological autopsies. However, it became clear during the follow-up meaning-making conversations that the initial interview was a catalyst for new conversations with supervisors, colleagues and peers. Family and friends of the participants were asked about their experience of observing the emotional turmoil in the period after the suicide, and some of the participants decided to initiate individual therapy.

For the participants, the suicide of their patient changed the meaning of therapy and life for them in irrevocable ways. All of them carry the wounds and the memory of the patient in their hearts, and it is from these wounds that others now find healing through therapy, supervision and hopefully, through this research. The participants truly are wounded healers.
REFERENCE LIST


Banda, M. P. (2010). Experience of women who are part of a blended family in a community. (Masters dissertation, University of Johannesburg).


(Eds.), *Grief after suicide: understanding the consequences and caring for the survivors* (pp. 133-155). New York: Routledge.


**Website**

APPENDIX 1: INFORMED CONSENT

THE EXPERIENCE OF PSYCHOLOGISTS AFTER THE SUICIDE OF THEIR PATIENT

Researcher: Werner Teichert, MA (Clinical Psychology) student at the University of South Africa

I, ___________________________________________________ (participant name),

1. Confirm that the research procedures were explained to me and that I had the opportunity to ask questions.

2. Understand that my participation is voluntary and that I am free to withdraw at any time.

3. Agreed to the recording of both the initial interview and follow-up interview.

Signature: ____________________________ Date: ____________________________
APPENDIX 2: SEMI-STRUCTURED INTERVIEW

Experience of psychologists after the suicide of their patient

In-depth, semi-structured interview

**Contextual questions:**
- How long ago did the suicide occur?
- How long had you been working with this client?
- When in your career did the suicide occur?
- What was the diagnosis of the client who committed suicide?
- Were there any legal ramifications occurred?
- How did you find out about the suicide?

**Initial emotional reactions:**
- What were your initial feelings?

**Impact on personal life:**
- How was your personal life affected?

**Impact on professional life:**
- What, if anything, would you have done differently concerning treatment of this patient?
- How was your professional life affected?
- Has your professional practice changed surrounding the ways in which you manage suicidal patients?

**Recovery process:**
- What helped you cope with the suicide?
- What hindered your recovery?

**New awareness:**
- As we talk, has this brought up a new awareness for you, or anything unexpected?
CONFIDENTIALITY CLAUSE

between

Jennifer Graham

and

Werner Teichert

for the study exploring:

Exploring and describing the experience of psychologists after the suicide of their patient

The research code of ethics mandates that confidentiality should be maintained throughout data collection, data analysis and report writing.

As a research consultant I understand that I have access to confidential information. By signing this statement, I am indicating my understanding of this responsibility and agree to the following:

- I understand that all information obtained or accessed by myself in the course of my work on this project is confidential. I agree not to divulge or otherwise make known to unauthorised persons any of this information, unless specifically authorised to do so.

- I understand that names and any other identifying information about study sites and participants are completely confidential.

- I agree to use the data solely for the purpose stipulated by the client.

- I agree to maintain the confidentiality of the data at all times and keep the data in a secure, password protected location.

- The data will be stored for a period of approximately three years for the client, after which time it will be deleted from the hard drive using a secure delete application which renders the file unrecoverable

Signature

Date

17 - October - 2013
THIS IS TO CERTIFY THAT

Jennifer Graham, in her capacity as a Research Consultant, has co-coded the following qualitative data

for the study:

Exploring and describing the experience of psychologists after the suicide of their patient

I declare that I have had a co-meaning making discussion with Werner Teichert over the major themes of the data. I have also provided him with a report.

Sign: ___________________________ Date: 17 - October - 2013
Coding report for

Werner Teichert

for the study aimed at:

Exploring and describing the experience of psychologists after the suicide of their patient

15th October, 2013

JA Graham: 082 573 9481
CODING METHOD:

Tesch’s inductive, descriptive coding technique (in Creswell, 2007: 158) applied to six qualitative interviews.

The following six steps were followed:

1. The coder obtained a sense of the whole by reading through the transcriptions independently. Ideas that came to mind were jotted down.
2. The coder then selected an interview reflecting on the underlying meaning of the information.
3. When the coder had completed this task for several participants, each interview was coded separately; thereafter a list was made of all the topics. Similar topics were clustered together and formed into columns that were arranged into major topics, unique topics and leftovers.
4. The coder took the list and returned to the data. The coder tried out a preliminary organising scheme to see whether new categories and codes emerged.
5. The coder found the most descriptive wording for the topics and turned them into categories, then endeavored to reduce the total list of categories by grouping together topics that related to each other.
6. The data belonging to each category was assembled in one place and a preliminary analysis performed, followed by a consensus discussion between the researcher and the coder.

JA Graham: 082 573 9481
CODING WAS GUIDED BY THE FOLLOWING RESEARCH QUESTION:

What are the experiences of psychologists after the suicide of their patient?

Table 1: Overview of themes, categories, and evidence of categories reflecting the experiences of psychologists after the suicide of their patient.

Coding framework

Overview:

Theme 1: The ‘sting’ of death represents the participant’s initial reaction of shock and disbelief on receiving the news of their patient’s suicide. This is accompanied by a grappling to come to terms with the suicide, particularly on a spiritual and existential level. Participants also experience the event as a being a traumatic one and express feelings of anger, of having been manipulated, and of profound sadness and loss over it.

Theme 2: The ‘weight’ of responsibility encompasses the participant’s sense of being partly to blame for their patient’s suicide. This is revealed in their self professed feelings of guilt, their adoption of a defensive and self-protective stance, a desire for personal and professional mitigation and/or absolution, and by self-doubt. This seemed to affect their relationships with their patients in that they were more vigilant towards them and also expressed an aversion to taking on new high-risk patients.

Theme 3: The ‘bleed’ of professional life into personal life speaks of the overspill or fall-out that occurs after a patient’s suicide. The nature and magnitude of the event cannot be contained within the ‘walls of work’ and the participants express feelings of loneliness and isolation following the event, with some participants withdrawing socially.

Theme 4: A dialectical ‘dance’ captures the often contradictory statements and explanations made by the participant’s as they wrestle with and try to come to terms with their patient’s suicide.

Theme 5: Solace and sanctuary highlights the participant’s self expressed need for collegial, family and peer support

JA Graham: 082 573 9481
<table>
<thead>
<tr>
<th>Main Themes</th>
<th>Sub-themes</th>
<th>Evidence of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The ‘sting’ of death</td>
<td>1.1. Participants commonly expressed an initial reaction of “shock” and “disbelief”</td>
<td>“my immediate reaction was, was one of shock and disbelief” (P3)</td>
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<tr>
<td></td>
<td></td>
<td>“I was shocked, I was taken aback” (P5)</td>
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<td>“I was absolutely shocked” (P4)</td>
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<td></td>
<td></td>
<td>“it really was completely unexpected” (P3)</td>
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<td></td>
<td>“I felt very shocked” (P6)</td>
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<td>“And disbelief, I just couldn’t believe that, that you know even in retrospect” (P4)</td>
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<tr>
<td></td>
<td>1.2. A grappling to come to terms with patient’s suicide in general, and on a spiritual and/or existential level in particular (frequently manifested as questioning why)</td>
<td>“it’s was like, did this really happen?” (P5)</td>
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<tr>
<td></td>
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<td>“I think she’s wrong I thought she, I said is, is she sure this is the right patient?” (P3)</td>
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<td></td>
<td></td>
<td>“existential questions came up very prominently” (P4)</td>
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<td></td>
<td></td>
<td>“I just couldn’t understand why, why he had done it you know” (P3)</td>
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<td></td>
<td>1.3. Feelings of anger in response to patients suicide and feelings of having been manipulated and/or betrayed</td>
<td>“I also actually remember being quite angry with him” (P3)</td>
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<tr>
<td></td>
<td></td>
<td>“He was going to do it I think, he used me, that’s where the anger came in, I felt he used me to get psychic strength to be able to commit suicide” (P4)</td>
</tr>
</tbody>
</table>

JA Graham: 082 573 9481
| 1.4. Feeling unprepared and profoundly affected/traumatised by the event (exacerbated by the nature of the suicide) | it was very traumatic (P4)  
"I felt physically ill, I just wanted to, like I had to pull over, I started crying uhm, and actually those feelings lasted for quite a while afterwards" (P2)  
"so I felt quite used and I felt quite angry" (P4)  
"it really did rock my foundation" (P4)  
"I was taken aback, I was very devastated because you’re losing a patient” (P5)  
it came at me from nowhere (P4)  
"Well it was close to hanging up my couch I thought well this is it” (P4) |
| 1.5. A sense of sadness and loss (often expressed as a lingering or residual presence) | "just the sadness that I’ve carried inside of myself for them” (P5)  
"so I think you know, that was also hurtful in the sense it was such a brutal way to go so it wasn’t just he took pills and kind of death was easy, it was the brutal nature of the suicide that was quite shocking” (P5)  
"I carry her in me” (starts to cry) (P1)  
"I was left with his presence in my therapeutic space and I, I missed him, I felt sad that he was not there” (P4) |
<table>
<thead>
<tr>
<th>2. The ‘weight’ of responsibility (&quot;on my watch&quot;)</th>
<th>2.1. Feelings of guilt and/or of feeling at least partly responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;when I heard it my heart was very sore immediately&quot; (P6)</td>
<td></td>
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<tr>
<td>&quot;people who look like him I think, you know are there it wasn’t a hallucination, I knew he was dead, it was just like oh, was that him&quot; (P5)</td>
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<tr>
<td>&quot;I’ve always wondered what happened to him&quot; (P6)</td>
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<tr>
<td>&quot;part of me felt that I had, because I’d given him the energy to do it&quot; (P4)</td>
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<tr>
<td>&quot;I did feel like I’d been in the wrong&quot; (P2)</td>
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<tr>
<td>&quot;we are the parents&quot; (P1)</td>
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<tr>
<td>&quot;shock and then guilt, lots of guilt&quot; (P2)</td>
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<tr>
<td>&quot;I did everything that I knew professionally uhm, in the session i was very professional, i was very ethical&quot; (P4)</td>
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<tr>
<td>&quot;you just didn’t want to be in that same position again so it was also part protection of yourself as an individual&quot; (P5)</td>
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<tr>
<td>2.2. Adopting a defensive/self-protective stance (initially and over a protracted length of time)</td>
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<tr>
<td>2.3. Increased concern with and/or heightened vigilance and/or anxiety shown towards patients</td>
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<tr>
<td>&quot;you worried but you’re still worried because the thing is it’s so unpredictable&quot; (P5)</td>
<td></td>
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<tr>
<td>&quot;I’m very uhm, anxious around suicidal clients&quot; (P2)</td>
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<tr>
<td>&quot;I stepped out ... i don’t know if I’ll do it for other patients, it exhausted me&quot;</td>
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JA Graham: 082 573 9481
2.4. Increased conservatism and/or caution in patient selection (manifesting as avoidance and/or fear of high-risk patients)

(P1) “I became hyper vigilant for my clients” (P4)
“so you become more vigilant” (P5)
“with everybody who sat in front of me for a while to make sure that with them too there’s nothing that I’m missing you know” (P6)
“whenever I, a client mentions suicide now, I get very angry” (P4)
“a good few sessions had to be spent working through, through that with other patients who may have develop similar ideas or who had similar ideas” (P5)
“I mean business, because I know what it’s like to sit, sit with the unresolved threats of a client committing suicide, so I do get angry and I say …if you kill yourself I’m going to kill you, I get very angry and then I do, I do, I say I’m writing a suicide contract can you please sign it” (P4)

“I don’t want to deal with suicide clients” (P2)
“It made me definitely very much more cautious, I became almost like paranoid that some level patients might try to kill themselves” (P5)
“I was actually poop
2.5. A need for personal and professional mitigation and/or absolution and a distancing of self from the event

- I’m touched wood because I can’t really survive another suicide (P4)
- “I couldn’t give a band aid for it. It was reality it’s not my responsibility her reality” (P1)
- “I don’t think there’s anything that I could have done to prevent it. I think he had a plan long before he came to see me” (P4)
- “you push it away from you, because you need to remember to handle it clinically” (P6)
- “don’t blame yourself you know, the medical, do not blame yourself. It doesn’t have anything to do with you” (P5)
- “stepping back from it, uhm, to help gain some objectivity to say that I didn’t aid and abet the suicide (P4)

2.6. Second-guessing, self-doubt, and/or reflections on what may have prevented suicide (often manifesting as a seeking after signs and linked to an underlying sense of failure)

- “I think I was doing the right thing” (P1)
- “maybe I could have spent more time on it” (P2)
- “could I have done this something should I have done something more” (P2)
<table>
<thead>
<tr>
<th>3. The ‘bleed’ of professional life into personal life</th>
<th>3.1. Feelings of isolation and aloneness/social withdrawal</th>
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<tbody>
<tr>
<td>“Maybe that’s another thing I could have done” (P1)</td>
<td>“I did become a little bit withdrawn for a while quite introspective and I”</td>
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<tr>
<td>“so for a while it was like constantly like you know, double checking” (P5)</td>
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<tr>
<td>“I have thought about that over and over and over again and I do not know what I could do differently” (P6)</td>
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<td>“the first thing I did was went through the files and every single thing, I had like a time line type thing” (P5)</td>
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<tr>
<td>“Wasn’t there another angle of looking at it that I also could have visited, did I miss anything, what was there and I turned this thing like the rubiks cube to every side and I couldn’t see anything” (P6)</td>
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<tr>
<td>“from there you go to second guessing yourself to think what you could have done” (P5)</td>
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<tr>
<td>“I may have listened or tried to listen more carefully and attentively to what he was saying” (P4)</td>
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<tr>
<td>“still think you, you know could you have done something to prevent that, it was preventable” (P5)</td>
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<td>“should I hang up my couch and go farming and should I take up pottery and should I just not be a psychologist” (P4)</td>
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</table>

JA Graham: 082 573 9481
<p>| | | |</p>
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<tbody>
<tr>
<td></td>
<td>did ruminate quite a lot what I could have done differently” (P4)</td>
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<td></td>
<td>“how do you talk to normal people about a patient killing themselves and I think that’s the reality of our work, things that we see and do here that we can’t talk about outside” (P5)</td>
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<td></td>
<td>“I withdrew quite a lot from people” (P2)</td>
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<td>“I think I was a little bit depressed after that for a while, I also sat with the sadness you know” (P6)</td>
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<td></td>
<td>“as a psychologist I think that’s, that’s what, I mean we are our work and our work is us” (P4)</td>
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<td></td>
<td>“that was also in the sense a pretty lonely business” (P5)</td>
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<td></td>
<td>“I think there was a little bit of withdrawal because I wanted to work through this” (P5)</td>
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<thead>
<tr>
<th>4.</th>
<th>A dialectical ‘dance’</th>
<th>4.1. Anxious/not anxious</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>[Apparent contradictions, vacillations between two opposing beliefs, reflecting the complexities in and the messiness of life experiences]</td>
<td>“I don’t fall apart and, and get anxious about every patient that comes, and thinks oh my word, oh my word, this patient’s going to commit suicide ... when I hear the words it’s like I’m all to a red rag” (P4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“maybe not paranoid, maybe paranoid, maybe not paranoid” (P2)</td>
</tr>
</tbody>
</table>

4.2. Signs/no signs | “There must have been something or maybe there wasn’t” (P6) |

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### 4.3. Exhausted all avenues/could have tried other avenues

“there was no sign, none!... I’m sure there was, but I didn’t see it” (P4)

“cause he wasn’t presenting as sui[cidal]... cause he had presented as suicidal in the first session” (P2)

“we had tried our best and I didn’t know what else... Maybe that’s another thing I could have done” (P1)

### 5. Solace and sanctuary

#### 5.1. Increased use of collegial and peer support and/or turning to supervision

“I had a place where I was able to work through it you know and I also had a very, very good supervisor that I went to” (P4)

“I went for one supervision session and, and that really helped hugely” (P2)

“we had tried our best and I didn’t know what else and she didn’t know what else to do” (P1)

“so we all got together and it’s like how did this happen” (P3)

“...but my communication with my peers was okay” (P4)

### 5.2. Support and comfort drawn from family, spouses and friends/spiritual and/or religious support

“I told a teacher and after I told the teacher, I think I told my mom uhm, and then I went and I just sat in front of the Lord ... and I just gave her over” (P6)

“I got a lot of support from my family and some of my friends” (P5)

“I think the support of colleagues was amazing.

JA Graham: 082 573 9481
<table>
<thead>
<tr>
<th>Growth pains [growing and/or gaining experience through struggle and adversity]</th>
<th>Reconciling an expected/hoped for therapeutic outcome with an unexpected/traumatic therapeutic outcome (by moving towards acceptance, increased understanding, and coming to terms with the loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I can't say you can be peaceful about a suicide but a deep understanding&quot; (P1)</td>
<td></td>
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<tr>
<td>&quot;It felt as if I was standing in between her, the shadow of who she was, who wasn't there anymore and translating from what I knew was happening in her to them&quot; (P6)</td>
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<tr>
<td>&quot;I have a feeling that I understand why she did it&quot; (P2)</td>
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<tr>
<td>&quot;So, eventually you just let your, you open your fingers and you let it go, there is a place in you that realizes that it's past&quot; (P5)</td>
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</tr>
<tr>
<td>&quot;we had tried our best and I didn't know what else and she didn't know what else to do&quot; (P1)</td>
<td></td>
</tr>
<tr>
<td>&quot;you know early in my career, let's save them because that's how you've been trained...but nobody tells you that you know there's sometimes choices that people make that can be destructive once but it's their choice and you have to respect that&quot; (P5)</td>
<td></td>
</tr>
<tr>
<td>&quot;I can make sense of it, I can understand at a certain level that for her, her pain had stopped&quot; (P6)</td>
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<tr>
<td>&quot;you become a little bit more uhm, accepting of people's choices&quot; (P5)</td>
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<td>Text</td>
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</tbody>
</table>
| 6.2. Healing as a complex and protracted process (mediated by support and attenuated by time and insight gained) | “but it was a process of, of coming to grips with it” (P5)  
“it had to run its course, it was a process” (P4)  
“I still am upset about it at some level” (P5) |
| 6.3. Hard lessons learned, insight gained and giving back | “you also feel like there was a new level of wisdom in a sense” (P1)  
“See the patterns between them were there for more than twenty years” (P6)  
“he’s still with me, he’s still in my psyche and his very much with me every time somebody mentions suicide so, I’d like to thank him for that” (P4)  
“and then became interested in the whole area of the suicidal behaviour as the research thing” (P5)  
“I wouldn’t say that they wouldn’t commit suicide, I don’t ever, ever assume that” (P4)  
“It’s left me with an acute awareness of the very fine line between what you see and what you don’t see” (P4) |
| 7. Recommendations 7.1. The need for a greater awareness/acknowledgement of fellow psychologists struggles and giving back to the profession | “I think that as psychologists we must be so responsible and aware of helping our colleagues when things like this
| 7.2. The need for collegial support/supervision and/or and the value of sharing with and/or seeking advice from a more experienced other |

"would definitely ... take it to supervision and try and get someone else’s input to hunt down what I can do differently" (P1)

"I had limited number of sessions cause that was something that kind of, maybe I did, maybe I was like being a bit too trying to move on quicker than he could cope" (P2)

| 7.3. The need to revisit how therapy is done |

happen" (P5)
APPENDIX 5: EXAMPLE OF FIELD NOTES

Some psychologists experienced:

1. Shock and disbelief:
   - It was so sad...
   - The circumstances
   - Difficult as a professional...
   - Where to place self...

2. Anger and betrayal:
   - Someone is actually interested to listen

3. Sadness and loss:
   - It was so sad...
   - The circumstances
   - Difficult as a professional...
   - Where to place self...

4. Guilt and responsibility:
   - It's not your "don't feel guilty and responsible" place to grieve

5. Hyper vigilance/increased conservatism in treating patients:
   - Funeral?
   - & not
6. Second-guessing, self-doubt on reflecting upon the suicide:

"I can't go to a peer supervision and volunteer." 

7. Isolation and social withdrawal:

Primary theme -> Nice talking about that

A lot of practitioners are not open to talk about.

8. A need for personal absolution

9. Peer support and/or supervision

Private setting vs. hospital

Just you talking -> more supported
Sure you've made right decision
Group of colleagues -> shared responsibility
Experience -> individual decisions, shared sense of vs. group decisions

10. Support from family and friends

"nobody could understand why I was feeling."

"I wasn't myself for quite a while."
APPENDIX 6: MEANING-MAKING CONVERSATION GUIDELINES

Meaning-making conversation:

Some psychologists experienced:

1. Shock and disbelief:

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2. Anger and betrayal:

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3. Sadness and loss:

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4. Guilt and responsibility:

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5. Hyper vigilance/increased conservatism in treating patients:
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6. Second-guessing, self-doubt on reflecting upon the suicide:
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7. Isolation and social withdrawal:
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8. A need for personal absolution
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9. Peer support and/or supervision
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10. Support from family and friends

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11. Spiritual and/or religious questions

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12. Healing as a process

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APPENDIX 7: LANGUAGE AND TECHNICAL EDITING CERTIFICATE

10 December 2013

To whom it may concern

I, Marina van der Merwe, ID no. 680420 0110 087, state hereby that I am the editor of Werner Melgeorge Teichert’s dissertation.

I completed a certificate in editing form the University of Pretoria and have more than 18 years’ experience in the industry. I currently work as an editor (in a permanent position) at SITA (State Information Technology Agency), where I have been responsible for editing documentation for the last 13 years.

Best regards

[Signature]

Marina van der Merwe
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