CHAPTER 1

OVERVIEW

1.1 INTRODUCTION

The phenomenon of patient suicide as experienced by therapists could indeed be regarded as one of the most feared events for any therapist (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989). This event is feared not only because of the deep impact it is bound to make on both a personal and professional level, but also because of the difficulty that a therapist generally experiences in emotionally recovering from the trauma of such an event. Therapists, as helpers, are regarded by the general public to be in control of their emotions and able to help themselves because of their perceived knowledge. Often the image that therapists create of themselves mirrors this view. They set the same standards for themselves and leave very little room for error. As such, the suicide of a patient can, within this set of standards, be regarded as the ultimate failure within therapy.

However, such occurrences take place more often than any therapist would like. One study that will be referred to within this thesis states that at one hospital, over a five year time span, patient suicide occurred to one in six intern psychologists working at that institution. This number makes it clear that patient suicide is a common phenomenon. Yet it is an occurrence that is little talked about, much feared although little prepared for (Lester, 1988).

At the institution where the author worked as an intern clinical psychologist, a fellow intern experienced this very dreaded event. The trauma of this event and the experiences of the intern herself became a matter of particular concern for the author. The author was also affected by the event as he was present at the hospital when the event took place. This, to a great degree, is part of the motivation of this study.

1.2 PERSONAL EXPERIENCE

Since it is important to include all aspects correlating to this study, this section of the introductory chapter is framed in more personal terms, moving away for a moment from academic language to describe the author's own experiences:

At the time of the suicide my fellow intern, the patient's therapist was away on leave. The patient was seen by the entire psychiatric team, of which I was part. This factor alone put me, and all of the team, especially close to the event. As a team, we saw the patient minutes before the suicide and concluded from the information gathered from the patient that he did not pose a threat in terms of suicide. For me, as a member of the treatment team and as a person, the event truly shocked me. What was particularly powerful to me was the fact that we had seen the patient alive only minutes before the suicide. I was also present when the phone call was made to inform my colleague that her patient had committed suicide.

There will be certain images that will forever be etched in my memory after the event. The whole hospital was on a heightened state of alert and crowds of people stood waiting around. The impact that it had on the other members of the team was my main motivation for this thesis. Seeing the psychiatrist involved with the patient and other team members in total shock had a powerful effect on me. Later, after I had gone through debriefing with my supervisor, I was able to help with the other team members' debriefing. So one can say that this thesis has a very personal and powerful component to it for me as the author.

The member of the psychiatric team who, on an emotional level, was most directly involved with the person who committed suicide was the psychology intern who was the patient's therapist. It is this intern who will is the subject of this study.

1.3 PROVIDING A VOICE

The main focus of this study will be the experiences of one particular psychology intern who has gone through the experience of having a patient commit suicide. The study will follow her own unique experience as she first retells the story from her point of view, recalling the therapy that she had with her patient, as well as the contact that she had with his family. Her hypothesis regarding the dynamics of the therapeutic relationship as it existed then will also be explored.

Following the intern's own train of thought, the attention is focussed on her own immediate emotions and thoughts after the event. The study focuses here on the difficulties she had on returning to her professional status as she came back to work after her leave. It evaluates the intern's experience of self-doubt, as well as the stages she experienced in therapy which led to the answers she came to regarding this doubt.

Special attention is also devoted to the specific questions the intern struggled with. These questions are specifically important as they form the basis of understanding the self-doubt that the subject experienced, both in form and extent. It forms a link between the intern's recovery from the traumatic event, and the answers to these questions that she generated. Other aspects of the intern's personality, such as opinions towards the subject of death, were re-evaluated. These aspects are also explored.

Finally, the explored aspects and questions that the intern worked with are integrated with existing literature that pertains to this subject. The intern's experiences are compared to those documented in a process open to her by asking if she could identify with documented aspects as they appear. The research consists of interviews conducted in a semi-structured manner to gather information as well as to allow the subject of the study the freedom to express her own views. The study follows the intern's thoughts as they arise within the interviews.

It is important to note that the study is based on the emotions and opinions of one individual. Thus the views are subjective and unique to her as a person. At various points, therefore, her experiences may either correlate with or differ from existing research. Because of the sensitive nature of the investigation, written informed consent was obtained from the relevant parties involved in the study. The views expressed by the intern cannot be considered indicative of any group or institution. This study in no way attempts to create a set of norms in the emotional working of therapists who experienced patient suicide, but rather presents one individual's experience. This may contribute to the field in showing where correlations may take place, although it may also highlight the experience in a more personal light. Some therapists who have gone through similar experiences may identify to some extent with the subject. In this somewhat personal light the study could assist therapists dealing with similar circumstances. The study will be conducted in a qualitative manner using the phenomenological methodology as basis since this fits best with the presentation of experience in this case. A discussion of this methodology is included in chapter three.

1.4 SUMMARY

This study will be structured as follows:

The introduction is followed by a review of the relevant literature in chapter two, showing the statistical prevalence of patient suicide, especially regarding psychology interns. An outline of the phenomenon of suicide and its psychological dynamics is included. This forms a thorough background for the reader in which to place the specific circumstances that make up the subject's views and emotions. Attention is drawn to the impact of suicidality on the therapeutic relationship and how this changes the dynamics of the therapy.

Chapter three focuses on the methodological approach that was employed to conduct the research. The specific methods used, their implications and the pitfalls and dangers to be considered during the research are reviewed.

Chapter four entails a discussion of the research material using the methods reviewed. A thorough analysis of the interview information is made is elicit general themes. This chapter can be reviewed at any time during the study to form a view of the whole.

The final chapter compares the research findings with the literature to find correlations and deviations. Hypotheses are generated regarding the themes that arose in the data analysis. The prevalent themes identified in the initial analysis are then critically evaluated. Anecdotal material as quoted in the interview data is also included. The study concludes with several recommendations for future studies.

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

In order to properly construct an underlying structure from which to move to a possible understanding of the phenomenon under study, it is important to review the relevant literature on suicide. To begin with, a brief overview of the phenomenon of suicide is undertaken. This is followed by the discussion of suicide with reference to its prevalence, dynamics and psychological form. The meta theory of suicide is researched, along with the effect that the deaths of patients and patient suicide has on therapists. On a broader level, attention is drawn to the negative impact that a patient may have on a therapist. Finally, a closer examination is made of the specifics of this particular study, namely, the impact of a patient's suicide on the subject of this study, an intern clinical psychologist.

2.2 HISTORICAL DEFINITION

At first glance, suicide might be thought of as a fairly simple concept, namely, the voluntary ending of one's life. However, some authors have highlighted a few misconceptions about the definition of suicide. For example, if a person takes a gun and shoots himself through the head, this is regarded as suicide. However, when a woman cuts her wrists in an attempt to get her husband's attention, then the intention and goal of this act is not death, although this act is classified as an "attempted suicide" (Gibbs, 1968). Whatever the intention may be, people contemplating suicide will be influenced by their own concept of death.

Gibbs (1968) proposes the following views of death:

1) a complete cessation of all experience
2) a termination of bodily processes without the cessation of experience, an "interruption until the resurrection"

3) a continuation of life under more favourable circumstances

These views may have a bearing on how the person acts in the contemplation of suicide. For example, if the person views death as a step to another world then the thought of suicide may be something that gives hope. Alternatively, someone who views death as the final end of all life, experience and consciousness, may feel fear. Therefore it may be argued that the approach that an individual takes to suicide depends on that person's unique definition of suicide. With regard to a definition of suicide for the purposes of this study, the three definitions of death as stated above by Gibbs (1968) is adopted.

To these definitions or views can be added the important aspect of *will*, that is, to want death, in whatever way that death is understood. It is therefore important to know what the person's view of death may be. This could be a determining factor in finding the *intention* of the person in deciding to commit suicide. The concept of intention raises the issue of distinguishing between different types of suicide.

2.3 TYPES OF SUICIDALITY

Opinions vary among different authors about the specific types of suicide and suicidality that exist. According to Shneideman et al. (1976), people who commit suicide can be divided into four groups, namely, the intentioned, subintentioned, unintentioned and the contraintentioned.

An account of these categories and their subcategories may provide a clearer background understanding of the phenomenon of suicide. Important in such an account is a consideration of the various attitudes towards the ending of one's own life, which range from a non-suicidal person's view through to that of the truly intentional suicidal person. Perhaps this background will aid in understanding the person who committed suicide in the case used in this study. Although the patient is not the focus of this study, this information could aid in the understanding of the dynamics as they might have played out

in his therapy with the intern who is the subject of this research. Shneideman (1976) uses the word "psyde" in his explanations of types of suicide but another author, Gibbs (1968) uses the word "death" in its place. The four categories mentioned above are discussed below.

2.3.1 Intentioned

Shneideman et al. (1976), following Zilboorg (1936), refer to the intentioned as those people who play a direct and conscious role in their own death. These individuals may be divided into "death seekers", "death initiators", "death ignorers" and "death darers". "Death seekers" are people who have consciously verbalised to themselves the wish to end their life. They have planned the method of suicide and it is usually of such a nature that intervention or rescue is either unlikely or impossible. "Death initiators" represent people whose intention is similar to the "death seeker" but do not have a specific plan. Death initiators are certain of death but want to play a part in facilitating the process. Shneideman et al. (1976) cite an example of a terminally ill patient who removed vital life support tubes and, in spite of his condition, climbed over the bedrails, opened the window and threw himself to the ground several stories below.

The next subgroup of the intentioned category is the "death ignorer". It seems that persons within this category do not believe in death as the cessation of consciousness. Although most people would consider that they end their lives, death ignorers simply believe that life will continue in another form. Shneideman et al. (1976) quote this suicide note as an example: "Good-by, kid. You couldn't help it. Tell that brother of yours, when he gets to where I'm going, I hope I'm a foreman down there; I might be able to do something for him" (Shneideman et al., 1976:16).

The fourth subcategory that Shneideman lists is the "death darer". In simple terms, a person who plays Russian roulette would be a "death darer". Another example would be someone who attempts to fly a plane without the necessary skill or training.

2.3.2 Subintentioned

The subintentioned category of suicidality pertains to individuals who play an indirect, covert, partial or unconscious role in their own death (Shneideman et al., 1976). There are also four subgroups within this group: the "death chancer", the "death hastener", the "death capitulator", and the "death experimenter".

The "death chancer" would be the person who leaves death 'up to chance'. Although they are not completely committed to death, they are half-heartedly intent on ending their lives (Shneideman et al., 1976). An example of this would be a person who walks on a ledge on a high building to 'see what happens if the wind blows too hard'.

The "death hastener" refers to people who, through their lifestyle, hasten the inevitable end. This is typically done through the abuse of alcohol or drugs, or through the mismanagement of a chronic condition such as diabetes.

The third subgroup in this category is the "death capitulator". These include people who play a role in the psychosomatic aspect of their own death, and who, in essence, give in to their fear of death. For example, Native Americans and Mexicans in the southwestern U.S. thought that people went to hospital to die. They were subsequently so afraid to go to the hospital that the lack of medical care caused their death.

The last subgroup in this category are the "death experimenters", who often live on the brink of death (Shneideman et al., 1976). Such a person does not wish consciously for death but wishes to live in a chronically altered or "befogged state" (Shneideman et al., 1976, p20). through use of drugs or alcohol, for instance. This "befogged state" differs from the "death hastener" discussed earlier. The "death hastener" wishes consciously for death, whereas the "death experimenter" wishes for a death-like state while remaining alive.

2.3.3 Unintentioned

The next category mentioned by Shneideman is the unintentioned. This refers to people who have no significant part to play in their death.

The first subgroup in this category includes the "death welcomers", who want or even invite death, but do nothing to hasten their end. Terminally ill or elderly people may fall into this category. A slight difference in meaning separates "death acceptors" from "death welcomers". "Death acceptors" have resigned themselves to their fate in a philosophical or heroic way (Shneideman et al., 1976). An example of such people would be firefighters accepting that death is present as a risk of their occupation.

The "death postponer", according to Shneideman et al. (1976), constitutes the category into which most people would fall. Such people do not want death to happen in the foreseeable future or for as long as possible. The "death disdainer" is further on this continuum, in that such persons regard themselves as above or untouchable by death. Shneideman et al. (1976) state that most young people in our society (most probably Western society) would be "death disdainers" for a while.

Lastly in this category is the "death fearer", people who fear death to such a degree that they may even be fearful of conversations on the topic. Possibly this position comes from wishes for omnipotence (Shneideman et al., 1976).

2.3.4 Contraintentioned

The last category that Shneideman speaks of is the contraintentioned. These are persons who effectively use suicidal behaviour for some gain and to mobilise others around them. This category has only two subgroups listed, namely, the "death feigner" and the "death threatener".

Firstly, "death feigners" are people who overtly simulate an suicidal act that has no lethal capacity but is self-destructive. For instance, cutting oneself

with a razor blade (but not lethally), or ingesting some pills (but not enough to cause death). “Death threateners” make up the second subgroup of people who do not intend death to themselves but use the threat of suicide to mobilise someone, usually a significant other, to some desired action (Shneideman et al., 1976). This subgroup brings to mind many of the dynamics and actions of borderline personality disorder, in which such acts of self-mutilation are used for the manipulation of significant others and health care professionals, among others.

The patient who committed suicide in this study would probably fall into the first category, namely intentioned, and in the subgroup of “death seeker”. The suddenness of the act and the lack of overt warning before supports this identification. As with the “death seeker”, the patient in this case had not verbalised his wish to end his life to others. It could be hypothesised that his plan to end his life was set and worked out, from his acting to be hospitalised once again, to the fact that his death was executed in such a way as to make any intervention difficult or even impossible.

This background serves to provide the reader with an underlying understanding of the patient who committed suicide, which may aid an overall comprehension of the intern therapist’s reactions as explored later in this study. The type of suicide also has some impact on how therapists deal with the death of their patients. Consequently, special attention is afforded to this aspect later in this chapter, in which the experiences of therapists as patient suicide survivors are explored. To further explore the current body of knowledge on the phenomenon of suicide, attention is now drawn to the psychology of suicide acts.

2.4 THE PSYCHOLOGY OF SUICIDE ACTS

Shneideman et al. (1976) have found that, in general, acts of suicide are not random, sudden, impulsive or unpredictable. Rather, they have developed gradually over time and been rehearsed in fantasy and in some preceding action. Palmer (1941) reports that in virtually every case found, there were

crises, conflict, ambivalence, mixed emotions and several other determinants which contributed to the patient's suicidal state. Therefore, it seems clear that there is seldom, if ever, only a single cause of suicide, but rather a constellation of multiple determinants that make up the inevitable thrust to go through with this act.

Emotional crises occur from time to time in the lives of all people. However, particularly stressful life events that typically lead to suicide include confrontations with death, ill health, loss of love or changes in social status (Shneideman et al., 1976). These events can be powerful in upsetting people's mental, physical and social balance (Dublin, 1963). Usually, people consider and attempt a multitude of possible solutions. Sometimes people try many and they fail one by one. At such a time, the option of suicide is shunned and feared. However, as other solutions gradually fail, as hope systematically runs out and feelings grow distorted, thoughts turn increasingly often toward suicide (Rogers, 2001). In this state suicide becomes more of a reality. It is fantasised about more and is often played out in the mind. The wishes or fantasies that contribute to this 'solution' are varied and many.

Some psychological factors that are found to contribute to suicidality are wishes for escape, rest, sleep or death as rest. Others include a guilty wish for restitution, self-punishment or sacrifice, and in the hostile sense, that of revenge, power or control (Lees & Stimpson, 2002). There are also erotic wishes of passionate surrender, the ultimate ecstasy or reunion with a dead lover, and finally a hopeful wish for rebirth or a new beginning somewhere else (Shneideman et al., 1976).

2.5 THE THERAPEUTIC CONTEXT AS A SPACE FOR SUICIDAL "ACTING OUT"

In the survey done by Shneideman et al. (1976), approximately 10 percent of the suicide cases had seen a psychiatrist or other mental health specialist within two months of the suicide (see also Wallace, 1973). A few of the therapists had only brief, meaningless encounters with these clients but the majority of them

had a therapeutic relationship which entailed aspects of transference and countertransference. Transference and countertransference are defined as the subconscious projection of emotions from the patient to the therapist and vice versa. Of these, the suicides happened most regularly at times of separation between therapist and patient, such as during interruption of treatment due to travel or the vacation of the therapist (Chapman, 1965). Furthermore, in Schneideman's (1976) study, many of the patients had been recently discharged from psychiatric institutions.

Therapists have agreed that the transference that their patients felt during those times were abandonment or a feeling of "it is hopeless, doctors cannot or will not help me" (Shneideman et al., 1976). In Schneideman's study, these feelings of abandonment played out in such a way that patients in therapy would call the suicide prevention centre run by the team of which Shneideman was part. Frequently the calls would entail such remarks as "my doctor is tired of me", "I don't want to impose on my doctor any longer" or "he doesn't want to see me anymore". The abandonment transference goes both ways: sometimes therapists feel that the patient has abandoned them, as exemplified in remarks such as "he gets too personal and upsets me too much" (Shneideman et al., 1976). Overall, it seems that the most serious suicidal cases which called the suicide prevention centre did so not to 'get back' at their therapist, or to 'show' their therapists, but rather as a way of acting out a transference memory fantasy of abandonment or of being left to die alone (Shneideman et al., 1976).

Another, more rare type of suicide as transferential acting out within the therapeutic relationship is that of malignant masochism (Shneideman et al., 1976). Although rare, it has a devastating impact on the therapist. Here it seems that superego pathology is especially prominent, with patients having a history of either a longed for dead parent or an incorporated hostile parent (Bender & Schilder, 1937) who demands death as the only possibility of ever obtaining love (Shneideman et al., 1976). Shneideman presents the following case in his study:

> "Case 4: A young woman, diagnosed as a schizophrenic, had been a demon in a psychiatric hospital for many months because of her uncontrolled self-destructive behaviour, which included repeated episodes of cutting up her arms and neck with broken glass, bottles, windows, or whatever she could use. Finally, one of the resident doctors took a special interest in her and began to see her every day. After a few months, there was a dramatic change. She stopped cutting herself and began to wash regularly, dress neatly, and use make-up. One day he complimented her on the changes. That night she hanged herself. One element of her history was the story that her mother had savagely abused the girl when she was about three years old, and the mother had a psychotic break" (Shneideman et al., 1976, pp.300-301).

It could be argued that the suicide of a patient in the care of a therapist is strongly linked with the emotion of abandonment. This manifests itself in many ways, from dependant patients feeling hopeless to patients using suicide to malignantly punish their therapist.

2.6 ON THE PHENOMENOLOGY OF SUICIDE

In continuation of the revision and exploration of other authors' views on suicide, Leslie Farber (in Shneideman, 1969) writes about the phenomenology of suicide or the nature of *willing* in regard to suicide. An interesting quote from Nietzsche (in Shneideman, 1969) may have some relevance with regard to patients themselves: "The thought of suicide is a strong consolation; one can get through many a bad night with it" (p.28).

In the current study, the fantasy of suicide probably manifested itself strongly, since reports stated that he fared much better during the two weeks or so prior to the suicide. Farber (in Shneideman, 1969) states that the thought of suicide allows one to challenge one's own life metaphysically (Shneideman, 1969). Farber goes on to make an important distinction between the "act" of suicide and the "life" of suicide. The roles that suicidality creates

to the parties involved must also be considered. These two concepts are considered below.

Schneideman (1969) sees the eventual effort of living the fantasy of suicide as arising from questioning every aspect of life. For persons who kill themselves, the act of suicide resembles a trapdoor, suddenly sprung open (Shneideman, 1969). However, for the psychotherapist it may seem more like a psychological staircase, leading inevitably to only one possible conclusion. This staircase must be travelled backwards by the therapist in the aftermath, reconstructing events in reverse to come to a whole picture of the course of events.

Farber (in Shneideman, 1969) considers this approach to be fruitless. Instead, Farber considers at the life of suicide as a life apart from the eventual act, whether it takes place or not. According to Farber (in Shneideman, 1969), a distinction in quality must be drawn between the "life" and "act" of suicide, much like dreaming and the narration of a dream.

Like dreaming, the "life" and "act" of suicide is nonphenomenal and opposes our attempts to capture it existentially. Such attempts at capture belong to the split between the psychological and the physical (Shneideman, 1969). Similarly, both those who make suicide plans and those who try to intervene either through direct action or attempts at understanding insist on knowing the unknowable (Shneideman, 1969). Through the act of suicide, the person who commits suicide ceases to attempt to enter the state of suicide. The intervener, through an act of successful intervention, has ceased to be privileged to the state of suicide. Simply stated, it seems that suicide is a paradox in that it is a situation that demands to be stopped although it provides both the suicide victim and intervener certain *roles* to fulfil.

Just as there are times when one can talk to a dreamer, so are there times when one talks to a man on the ledge of a building, ready to jump. It is here that one must make the choice: understanding – sleeping in his state; or intervention – waking him to your state. The dreaming state or life of suicide

is further expanded on by Farber (in Shneideman, 1969), who explains that persons who contemplate and plan a suicide while setting their affairs in order or making various arrangements are still in the state of living. Here a strange paradox exists within the suicidal person. They may eat a meal while thinking or asking themselves why they are eating if they are going to die soon (Farber in Shneideman, 1969).

Therefore, the *will* to die and the state in which people find themselves when willing death upon themselves is an important distinction. Farber comments that the assumption is made that such people, being "in the life" of suicide, undergoes the process of questioning their life and every aspect thereof. Who they are, what their life has been about, what they have achieved and where they have failed are relevant issues here (Shneideman, 1969). Being in this state of questioning and trial of their own life, estranged and alienated from the world, suicidal people may use this same *will* to carry them through ordinary life. They must, for instance, *will* themselves to pay attention to conversations they may find futile, given that they will not live much longer. This forcing of a state of mind by conscious will could extend to every aspect of life, even those that should not usually require much effort, such as the simple task of clothing oneself. This state the author calls "willess" (Shneideman, 1969), and is possibly also likened to the relationship between hopelessness and suicide as identified by Beck, Steer, Kovacs and Garrison (1985).

The suicidal patients' will seemingly becomes independent from their other faculties such as imagination, judgement, humour or insight. They must *will* themselves to exist, to do things that previously came without conscious will or effort. Suicide becomes an acceptable resolution to conclusions drawn within this state of questioning life. If they accuse themselves of being timid, then suicide becomes the opportunity to prove their bravery. If they accuse themselves of being dishonest and malicious towards their fellows, then suicide is the opportunity to punish themselves for this and rid the world of a bad person. If the accusation is an unbearable life, then suicide is the way out (Shneideman, 1969). However, if asked why their life is unbearable, the

answer could be that it has to be unbearable because they are contemplating suicide. Consequently, to prove this true, the suicidal person has to commit suicide (Shneideman, 1969). The sad and difficult question that those left behind always seem to ask is: what pushed a person to the point where suicide provides an answer, or what made life so unbearable that the will to die transcended and became stronger than the will to live (Rogers, 2001)?

This question on its own constitutes an entire research topic. Since the scope of this study is the impact of the act of suicide on a therapist, however, this avenue of thought will be left for now in order to move more specifically to the current literature on therapists whose clients commit suicide.

2.7 THE THERAPIST AS A PERSON IN THE THERAPEUTIC SETTING

It seems that at some level, therapists are regarded as working according to a different set of rules than the general population. They are regarded as being able to naturally handle the toxicity of patients, and easily able to cope with life stressors. Unfortunately, this is not true. Therapists are people who are influenced by others just like anybody else. Therefore a patient who is suicidal, for example, can have a profound effect on a therapist. Suicide is the client crisis most commonly encountered by mental health clinicians (Bongmar, 1993; Juhnke, 1994).

In light of this potential effect, the process of therapy with a clearly suicidal patient is called clinical suicidology (Karasu & Bellak, 1980). This form of treatment is distinguished from ordinary psychotherapy, which focuses on feelings, emotional content and unconscious meanings instead of pure content. The emphasis lies with the latent significance of what is being said and its motives rather than on the words themselves (Karasu & Bellak, 1980). The most significant difference between psychotherapy and normal conversation is the presence of transference, where patients project onto the therapist feelings and expectations. In this relationship the therapist is

invested with almost magical healing powers. This transference can at times be therapeutic (Karasu & Bellak, 1980).

However, in clinical suicidology, when the therapy is with persons who pose a lethal threat to themselves, the type of interchange differs. This is to be expected when such a toxic element is introduced. Not only does the focus shift to the lethality of the person, but the transference and countertransference can be potentially *deeper* and *more intense* that would usually be appropriate or even ethical (Karasu & Bellak, 1980). In the guidelines for the management of suicidal patients, the importance of self-management is also stressed. There is almost no time as important for a therapist to consult with peers as during the handling of a suicidal patient. Items that should be included are therapists' own feelings of frustration, anger and helplessness that will most likely be present, their handling of the case and their countertransference (Karasu & Bellak, 1980).

Therapists are also generally advised to limit the number of highly suicidal patients within their patient load. As suicidal patients cause a tremendous amount of stress and require a great deal of investment in time and psychic energy, too many such patients would result in therapists 'spreading themselves too thin' professionally (Karasu & Bellak, 1980). In addition to this, too much stress caused by a high caseload of suicidal clients is also likely to negatively impact on the therapists' other patients.

Although the death of a terminally ill patient, together with the countertransference that a therapist may feel when confronted with this, may not be directly linked to the topic at hand. However, since a suicidal patient is in a "state of death" or "life of suicide", as has been previously argued, there may be similarities in the emotional experiences of therapists with suicidal and terminally ill patients. Schaverien (1999) reports that therapists of terminally ill patients experienced feelings of being an object on which to lean or an ear to listen to, rather than a real person. This author further reports that therapists of terminal patients felt rather like a mother about her child, understanding and accepting the 'child's' needs even when they seemed

unreasonable. From the way and speed with which their patients talked, the therapists felt as they were in the presence of a ravenous child (Schaverien, 1999). A therapist of a suicidal patient may have similar experiences of being viewed as a strong or omnipotent figure that either could magically heal or completely destroy the patient emotionally. They might feel that they have abandoned the patient by not living up this expectation of omnipotence.

Earlier in the chapter, it was mentioned that many suicidal patients feel abandoned by their therapists, and may call a suicide prevention hotline rather that consult with their own therapists. This suggests the power of the dependency that a person in a state of dying may feel toward someone such as a therapist. Therapists in this position subject themselves to the possibility of being elevated to a superhuman object with magical healing powers (Karasu & Bellak, 1980). Such a role puts the therapist in a very precarious position, walking a tightrope between using these feelings of omnipotence vested in them by the patient in a therapeutic way and trying their best not to disappoint them. This is inevitably a futile act as all humans are fallible.

Therapists' relationship with suicidal patients differs in a number of ways from the relationship with non-suicidal clients. Suicidal patients bring to the therapy a level of toxicity. In such a "state of death" or "life of suicide", where thought is bent on dying to the extent that patients think of themselves as dead rather than alive, the therapist may struggle to impart insight. As Karasu and Bellak (1980) point out, this is not therapy where feelings and thoughts can be reflected on, but a state of relationship where feelings, transference and countertransference are much more powerful and much more *toxic*. With the threat of death hanging over the therapist's head, the influence must be so great as to bring the patient to a state where emotions are concretely reacted upon rather than being interpreted for their worth on a therapeutic level. In other words, the therapeutic process ceases. Schaverien (1999) describes how coincidental similarities between herself and the patient struck her and touched her own life. Somehow it seemed that, even as they were in an analytical relationship, supposedly devoid of personal contact, the impact of this relationship was felt deep within her personal life.

It has been already argued that the therapeutic process with a suicidal person is unique in terms of the transference and countertransference. As the patient is living a life of suicide (Shneideman, 1969), a powerful set of dynamics comes into play. This state may render patients seemingly infantile, craving nurturing almost ravenously, and the therapist has to become an omnipotent figure with magical healing powers to be able to contain this. With the real, physical threat of death ever present, a burden is placed on the shoulders of therapists that make them unable to stand away and obtain a meta perspective on the therapeutic dynamics. Being constantly on the lookout for the physical safety of their patient, therapists are not truly able to comment on or elicit insight within patients, as this may be too difficult for them to bear. As it is, emotional insight is often very difficult for patients to achieve. With suicidal patients, the therapists' struggle is merely to contain the patient in this state. This puts patients in a controlling position, and they are able to stop the therapist from going too far or pushing too hard. The impact on therapists is be disheartening and frustrating, as they are not able to do the work that they see must be done in the therapeutic relationship.

2.8 THERAPISTS' REACTIONS TO THE EVENT OF PATIENT SUICIDE

Much research has been done in recent years in the field of suicide (e.g. Blumenthal & Kupfer, 1990; Jacobs, 1999; Maris, Berman, Maltsberger, & Yufit, 1992). In reviewing the literature that exists on therapists and their reactions, a number of correlations show themselves virtually everywhere. Some of these are discussed below.

On experiencing patient suicide, virtually all therapists experience one or all of the following emotional states at varying degrees: shock, grief, guilt, shame, depression, personal inadequacy, increased fear of dealing with suicidal patients, and anger (Litman in Shneideman et al., 1976; Schnur & Levin, 1985; Kleepsies, Penk, & Forsyth, 1993). Other studies showed that feelings such as shock, disbelief, anxiety, frustration and, in some cases,

relief can also be added to this list (Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000; McAdams & Foster, 2000).

Another study that reviews specifically the experiences of psychology interns shows that patient suicide occurred to 16.7% of the interns who worked at the particular hospital from 1983 to 1988 (Kleepsies, Smith & Becker, 1990). This roughly correlates to an incidence of nearly one in six interns who must deal with a patient suicide. Since this statistic is only for one particular institution over a five-year period, the overall statistical picture has the possibility of being even greater.

Moving from statistics to the experiences and stances of therapists, studies show that most therapists who have not experienced patient suicide contemplate this notion with fairly tranquil attitudes. They feel that, although it is to be avoided, death is still an integral part of life. Some more philosophically-minded therapists contend that the constant awareness of death might serve to energise and vitalise a person. One can only take one's own life really seriously when one realises that it is entirely in one's power to end that life (Litman in Shneideman et al., 1976). As suicide in society is a taboo that is shunned and feared, therapists must not stand in total fear of this, as this may impair their professional judgement and ability (Litman in Shneideman et al., 1976).

A few philosophic notions have been put forward to assist therapists to deal with the event of patient suicide. These ideas may help to remove the responsibility from therapists, to place them in a safer place mentally, or simply serve to contain their emotions regarding the events experienced. The following notions are reported in the literature: some may believe that, in a free society, persons have the right to do harm to themselves or kill themselves (Litman in Shneideman et al., 1976). Certain schools of therapy place the therapist in a nondirective, nonresponsible stance towards the patient (Litman in Shneideman et al., 1976). The most extreme example of this stance is that therapy is a quasi-religious death and rebirth of the patients' soul (Litman in Shneideman et al., 1976). In this scenario, suicide may form part of the whole

process. Inevitably then, suicide would not even be frowned upon or discouraged; perhaps, being solipsistic, it could even be encouraged in some cases.

However, away from this end of the spectrum, most therapists seem to consider the suicide of a patient to be a very disturbing event and experience the suicidality of a patient as a complicating and restricting element within therapy. This condition therefore requires special care and consideration (Litman in Shneideman et al., 1976). Therapists naturally react to the suicide of a patient in both a personal manner and in accordance with their specific role in society as therapists. On the personal level there are many varied ways that therapists react since they are individuals in specific relations with other individuals, a situation that evokes a myriad of different possibilities. These reactions range from no involvement or responsibility to virtually total responsibility, depending on the nature of the relationship, whether they worked together for a long time or not; and the strength of the commitment from the therapist's side (Litman in Shneideman et al., 1976).

An example of a stance of no commitment towards the patient would be therapists who refuse a referral when they hear that a patient is suicidal. Upon hearing of the suicide of the patient while with another therapist, such therapists may feel relieved and almost elated. An example from the opposite end of the spectrum is provided by Litman (in Shneideman et al., 1976) who tells of a therapist who, while providing therapy for one of his psychology students, virtually "adopted" her emotionally. After her suicide, he went through weeks of deep mourning and grief. These examples show some of the reactions that therapists may have to the death of their patients. The following segment further explores therapists' reactions to patient suicide, beginning with their initial reactions.

2.9 INITIAL REACTIONS OF THERAPISTS TO PATIENT SUICIDE

Therapists agree that the first or initial reaction to patient suicide is the worst. Litman (in Shneideman et al., 1976) describe feelings of disbelief and shock

such as “I could hardly believe it”, as well as feelings of grief and inadequacy, for example, “I was completely crushed” or “It shook my confidence in what I thought I knew”.

In light of the case examined in this study, it is interesting to note that younger therapists are more likely to experience a strong emotional reaction when confronted with the death of an older patient who reminded them of a parent (Litman in Shneideman et al., 1976; McAdams & Foster, 1999). This is relevant to this study both in terms of the type of therapeutic relationship and the level of experience of the intern in this study. Hendin et al. (2000) also found that shock and disbelief are the most prevalent emotions described by therapists. One therapist described feeling close to posttraumatic stress syndrome after the suicide of a schizophrenic patient. The patient was reacting well to medication and had never threatened to commit suicide in four years of therapy (Hendin et al., 2000).

Investigations have been done into therapists’ awareness of their patients’ suicidal crises. Hendin et al.’s (2000) study compares their feelings to those of soldiers in combat situations. They are aware of imminent mortal danger but do not believe that it will happen to them. When they are wounded, or when someone close to them is killed, they are shocked. Six out of the eight interns interviewed in the Kleepsies study said that their initial feeling was one of shock (Kleepsies et al., 1990). This study also reveals that other emotions, in order of incidence, are guilt or shame, denial, feelings of incompetence, anger, depression, a sense of being blamed, relief and fear.

Therapists whose commitment to their patient stretched to working long term and trying to overcome chronic suicidal tendencies reacted with a sense of personal defeat and suffered periods of hopelessness and depression. Other therapists, who had been working in intensive analysis with their patient, found themselves identifying with their patients in dreams or symptomatic behaviour. For example, a number of therapists reported that a week or so after the death of their patient, they had accidents (Litman in Shneideman et al., 1976). The nature of these reported accidents is not stated. An example in

later studies that supports this is one therapist's account of a dream she had. She dreamt that melting snow was leaking through the roof on the day of her patient's funeral, forcing her to cancel all her appointments. She imagined that the flood was the punishment for her not preventing the suicide. The water represented the tears of the grieving relatives as she met them at the funeral (Hendin et al., 2000).

2.9.1 Guilt

The guilt that therapists show seems to be similar to the guilt felt by the patient's family members (Litman in Shneideman et al., 1976). This guilt takes the shape of questioning one's self, or questioning what had been done, and whether more could have been done. "What was overlooked?" "Was the work done to understand the patient enough?" "Were there issues from my side that worked against the patient seeing or hearing all that was said?". Litman reports that such questions often took the form of more obsessive thoughts such as, "How did I miss it?", or: "If only I could have done something differently" (Litman in Shneideman et al., 1976).

Other studies have shown that 50% of all therapists have feelings of guilt regarding the death of a patient by suicide (Hendin et al., 2000). It is interesting to note that this study found that all but one of the therapists interviewed experienced both guilt and grief. The difference seemed to stem from the intensity of involvement with the patient. The deeper the involvement, the closer the feeling will be to grief (Hendin et al., 2000).

2.9.2 Doubt and inadequacy

Another feeling closely related to guilt is that of self-doubt or inadequacy. Almost half of the therapists interviewed in the Hendin study experienced shattered confidence in their therapeutic abilities (Hendin et al., 2000). This applies particularly to therapists and counsellors in training (Brown, 1987; Kirchberg & Niemeyer, 1991; Rodolfa, Kraft, & Reiley, 1988). More experienced therapists said that they thought that their professional experience

would help them work through such an event more easily. They were quite shocked to find that it indeed did not (Hendin et al., 2000). This links in some way to the earlier notion that therapists take a stance towards the death of a patient in the same way that soldiers regard imminent danger to themselves, namely, that although they are aware of it, they do not believe it will happen to them due to their training and experience (Hendin et al., 2000). Such a stance automatically excludes any emotional preparation for such an event. Hendin (Hendin et al. 2000) found that therapists in training responded by questioning their ability even more; and reported feelings similar to those of therapists in their initial reactions. Trainee therapists stated, for example: "It scared me, terrified me, left me doubting everything I did". The self-doubt extended beyond the professional, and less experienced therapists doubted if they could help anyone, and questioned whether this profession was what they were supposed to do.

Dealing with the painful feelings on a personal level is done in a number of ways. Unlike the families of the deceased, therapists seldom use religion as consolation. They may sometimes take a more outside or philosophical meta-stance towards the issue, such as saying, "It's maybe just as well he died. He did suffer very much". Personal gestures and acts seem to be important, such as spending time with the bereaved family members, or attending the funeral. Hendin et al.'s (2000) study did not allude to the reason that these gestures were important to the therapists. However, it could be hypothesised that such actions give therapists a feeling that there is *something* that they are able to do. Hypothetically, they can no longer help their patient but at least they can show those left behind that they are still available to provide care.

2.9.3 Anger, shame and embarrasment

Anger is also a commonly reported emotion. It seems to be aimed mostly at someone else such as a family member or a medical or psychiatric colleague. Anger expressed overtly and directly to the deceased is rare (Litman in Shneideman et al., 1976). Anger is described to be primarily centred around being rejected as a therapist. There possibly cannot be a more powerful form of rejection of a therapist or therapy than suicide.

The therapists interviewed by Shneideman et al. (1976) showed feelings of anger, as if they experienced that their "work" was destroyed through this act. Some said that they felt angry because, in spite of a deep commitment and trust that developed, the patient could not reach out to them in their most critical time (Hendin et al., 2000). The Hendin study also identified typical feelings of shame and embarrassment. One therapist whose patient was hospitalised shortly before her suicide, and who broke off therapy thereafter, neglected to report the patient's suicide to the hospital psychiatrists out of fear for his professional reputation (Hendin et al., 2000).

2.10 SUPPORT SYSTEMS

Studies show that the help of a fellow professional was of most benefit in helping therapists deal with patient suicide (Litman in Shneideman et al., 1976). The Litman study reports that a helpful course of action would be to review the case with colleagues with the attitude of "what can we learn from this?". Some therapists interviewed felt that if the suicide occurs within a psychiatric hospital or clinic, the impact is easier to bear (Litman in Shneideman et al., 1976), likely because of the "shared responsibility". The therapist is not the only professional who is affected in this instance, and others with a unique understanding are there to offer help.

The support from peers is one of four categories identified by Kleepsies (Kleepsies et al., 1990). Other categories include supervisors (used especially by interns), staff at the facility where the incident occurred and family members. Of these categories the support given by supervisors was rated as the most helpful. All the participants in the Kleepsies study consulted with their supervisors. The support from peers was considered just as helpful, although two of the interns described feeling discomfort about discussing the matter with their fellow interns. The support given by hospital staff was been rated favourably. Those interns who received support from family members rated this less favourably. They felt that family did not understand adequately to give sufficient support (Kleepsies et al., 1990).

In summary, the most important themes that arose in the literature are the common emotions and emotional states that all therapists share: initial feelings of shock and disbelief; and the experience that the first reaction is the worst. Later emotional states include self-doubt and inadequacy. The fact that older or more experienced therapists felt the same doubt, even though they thought that their experience would shield them from this was, particularly interesting. Therapists seem to commonly doubt the very judgement that has been cultivated through long training and sometimes years of experience. This shows that such an event, probably the worst fear of many therapists, holds no more of a threat to young or inexperienced therapists than their senior counterparts. All are equally shattered by such an event.

2.11 SUMMARY

The aim of this chapter was to contribute to an understanding of suicide through the review of relevant literature.

The review of the literature on the dynamics and types of suicide shows that suicide is a very complicated event, especially when attention is drawn to the distinction between the act and the life of suicide. Whether these dynamics are played out with the knowledge of the therapist or, as is often the case, without the therapist knowing, the reactions of therapists are commonly very strong. Shock typifies the initial response. Following this, a range of emotions are prevalent: guilt, shame, anger, self-doubt and blame, to mention a few. These emotions are dealt with in various ways that are particular to the profession and not necessarily common to the average person's perception of recovery. For example, family does not rate highly on the list of preferred support systems.

It was further found that suicide may indeed be the single most threatening and disruptive element and event that can occur in the daily work of a therapist. Patient suicide is also much more common than is perceived by

therapists, and therapist preparation for suicide and its aftermath seems to be feeble at best.

These factors are investigated in relation to the subject of this case study, as this thesis progresses, but the next chapter shows an outline of the approach that is employed within this study, namely, the phenomenological method.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

In order to understand the way in which this research is conducted, it is necessary to define the model that is used as the basis from which to work. Firstly, a basic definition is provided for the word 'phenomenology' and its origins. This is followed by the historical background of phenomenology and the basic principles within this discipline to further inform an understanding of the use of phenomenology as a research model. Aspects to be guarded against in undertaking research from this stance are scrutinised, and relevant terms are described and discussed.

3.2 DEFINITION

The word 'phenomenology' is derived from the Greek words 'phenomenon' and 'logos'. Phenomenon means appearance, or that which shows itself (Misiak & Sexton, 1973). In general, the word refers to the appearance of things, in contrast to the things themselves. This contrast forms the cornerstone of Kant's philosophy, in which he stated that the mind can never know the subject or thing that is studied itself, but only the appearance of the subject. This theory is called phenomenalism (Misiak & Sexton, 1973).

In psychology, phenomena generally means the information of experience that can be described and observed by experiencing the subject at any given time (Misiak & Sexton, 1973). The description of this information of experience is what phenomenology has at its core. How this came about through history and the thoughts of its pioneers will now be explored.

3.3 HISTORICAL BACKGROUND

The founder and most important exponent of phenomenology was Edmund Husserl. For him, phenomenology was the science of phenomena, of subject

as we experience them in our consciousness, and how they present themselves to us (Misiak & Sexton, 1973).

However, to argue that Husserl's school of phenomenology is the only form of that discipline, or that all phenomenology of this century is derived from him would be erroneous, since many divergent orientations have developed that expand on and even go beyond Husserl's groundwork. Husserl focussed on two fundamental issues in his formulation of phenomenology: firstly, the notion of intentionality, as the basis of all mental experience; and secondly, the notions of noematic and noetic foci of intentionality as shapers of our universe (Spinelli, 1989).

Intentionality, from the Latin *intendere* (to stretch forth) is employed by phenomenologists to describe the fundamental action of the mind reaching out to the world and its stimuli in order to translate this world into meaningful experiences (Spinelli, 1989). Therefore it refers to the most basic and first interpretative mental act. Husserl argued that consciousness is always the consciousness of something, some object that is being experienced and which therefore must be translated into a meaningful experience. For example, the experience of worry is that of worrying about something that may happen. The experience of love is directed at something or someone. This process of intentionality asserts that as humans we do not truly have access to the real world as it is. Since we interpret what we experience then this act of interpretation forms the most basic level of consciousness (Spinelli, 1989). An example would be the phenomenon of depression. The knowledge that we have of this phenomenon comes not so much from the phenomenon itself, but from a complex set of interpretations and dealings with the world we live in. Thus, because of this set of interpretations, the question of what the phenomenon of depression really is cannot be truly answered. In phenomenology one cannot truly know the phenomenon since we are limited to our experience of it (Spinelli, 1989).

The next set of terms that Husserl focussed on are the *noema* and *noeses* as correlatory poles, which make up the act of intentionality (Spinelli, 1989). In

its simplest form, *noema* or noematic correlate refers to the "what" of experience, and *noesis* refers to the mode or the "how" of experience. To illustrate the difference, in the *noesis* of experience, one could consider two individuals attending a political speech. The *noema* is the same, in that they both direct their attention to the speaker as the object or focus of experience. However, their *noesis* is different because one individual could agree with what is being said and clap loudly at the end of the speech, while the other may disagree and experience irritation and boo the speaker at the end (Spinelli, 1989).

The noematic focus in this example comprises the content or the argument given by the speaker, as heard by the individuals. The noetic focus, on the other hand, deals with the set of elements that determine how each individual experiences the speech, as either negative, positive, ambivalent or uninterested. These elements make up how each individual responds to the experience. This forms part of the research through relating the data gathered from the experience of the subject under study with the research already done, to find any differences within the noesis of experience of the subject and others that have similar experiences. For example: can the subject relate to the emotion of anger felt by some therapists after the suicide of their patients? To further understand these aspects and others within phenomenology, the following discussion contains a review of phenomenology in terms of its disciplines.

3.4 UNDERSTANDING PHENOMENOLOGY

Phenomenology is not a specific school or doctrine in terms of a specific set of regulatory disciplines. It is rather a movement that includes many doctrines that have, at their core, a common approach or understanding. This review focuses specifically on Husserl's philosophy, as it is used in the research. One concept that Husserl wrote about later in his career, and that only came to light in a posthumous publication, was that of the "Lebenswelt" or "life world". This is the world of experience of everyday life (Misiak & Sexton, 1973). This concept is of particular importance for this study as the author

draws on the world of experience of one individual to paint a picture of her world as it was affected by the events that took place. Here it may be appropriate to remind the reader that the study concentrates on the intern's experience of events, rather than on the events themselves. The phenomenological approach is thus considered appropriate for this study, since the events themselves cannot truly be objectively known, but only the experience of those events by, in this case, the intern psychologist who experienced them.

To understand phenomenology is to ask the oldest and most fundamental question in philosophy, namely: what is the relationship between the objective reality and the mind with which we have thoughts and understandings of that world? (Misiak & Sexton, 1973). The way in which phenomenology attempts to answer this question is based on two aspects. Firstly, that scientific enquiry only has the phenomena of consciousness from which to work, since those are the only givens accessible to us (the only material at our disposal); and secondly, that only phenomena can reveal what the essential nature of things are, or simply what things essentially are (Misiak & Sexton, 1973).

Therefore the only possible approach to the knowledge of things is the exploration of consciousness. Phenomenology is the systematic and full exploration of consciousness. The phenomena of consciousness itself are numerous in terms of things such as feelings, moods, thoughts, images, mental constructs, experiences and events. These aspects of consciousness are explored by the use of the phenomenological method. This consists of examining whatever is found in consciousness, or the data or phenomenon of consciousness (Misiak & Sexton, 1973). The primary aspect that is looked at is the object of consciousness. This consists of all that is perceived, imagined, doubted or loved. The end goal is to attain the essence of things appearing in our consciousness.

This is done in a very systematic manner and comprises a number of steps along the way (Misiak & Sexton, 1973). Spiegelberg distinguishes seven of these steps in his work *Phenomenological movement* (1971). Though not all of

them are used, the most fundamental one is the phenomenological description that is used extensively by psychologists. Three phases of phenomenological description are differentiated. They are phenomenological intuiting, analysing and description (Spiegelberg, 1971). Intuiting implies an intense concentrated gaze at the phenomena, analysing meaning involves finding the various constituents of the phenomena and their relationship, and finally, describing focuses on the intuited and analysed phenomena for understanding by others (Spiegelberg, 1971).

Another step in this process is known as "*Wesensschau*" or, translated from the German, "intuition of senses". The aim of this step or technique is to apprehend the essences of things through the phenomena (Misiak & Sexton, 1973). This is accomplished by looking at several instances that have relation to particular phenomena, for example, looking at different shades of red in order to realize the essence of redness. This "getting to the essence" of things was called eidetic reduction by Husserl (Misiak & Sexton, 1973).

Another important distinction that the field of phenomenology makes is between straightforward experience and reflective experience. Straightforward experience is based on actions in the here and now, as they occur. Therefore straightforward experience is both timeless and ineffable (Spinelli, 1989). It is timeless as it only occurs within the "now" of the experience itself; in fact, time only comes into the equation when the experience is to be explained or described. It is ineffable or indescribable because it cannot be talked about directly. Any attempt at explanation is only possible after the event or experience has already occurred (Spinelli, 1989). Therefore the concept of reflective experience comes to the fore when the explanation and study of phenomena is to be attempted. To apply these phases and techniques as they have been described requires a definite set of rules and disciplines. There are aspects to guard against within the application of the phenomenological approach. These are discussed below.

3.5 RULES IN PHENOMENOLOGY

It is very important in the phenomenological study of things or phenomena to free oneself of any form of bias or preconceived ideas regarding the phenomena studied. This placing on hold of one's own ideas is known as bracketing, as coined by Husserl (Misiak & Sexton, 1973). Husserl used the word *epoché* from the Greek meaning abstention. Only when *epoché* is reached, can the real and fruitful exploration of phenomena be expected (Misiak & Sexton, 1973). Then the phenomena itself is not distorted by the own meanings, ideas and preferences of the researcher.

The phenomenological method can be contained in these three steps: (a) the rule of *epoché*; (b) the rule of description; and (c) the equalisation rule. The first rule or step, as mentioned previously, is the process of setting aside one's own ideas, biases, and so on, before approaching the data. Put differently, the researcher must "bracket" all such facets temporarily in order for the data or phenomenon to be seen as truly 'itself' as possible (Spinelli, 1989). For example, if I meet a person that I have heard much of, the information that I already have undoubtedly forms a set of bias that will influence my perception of that person, even before the first meeting. Were I to set aside those pieces of information before the meeting, it would be possible to form a picture of the person met, based on the information that she herself presents. Though this may be the ultimate goal of the first step of *epoché*, it may simply be impossible to "bracket" all bias. Spinelli (1989) suggest therefore that, with the realisation that the total bracketing of all sets of information is impossible, the attempt should be to bracket as much as possible to get the clearest indication of the object or phenomenon studied. Spinelli (1989) adds that "[t]he process of bracketing has led to an inescapable discovery: that in the process of experience no explanation can be given. Only after the experience has occurred can the phenomenon be described and explained to any degree" (p.102).

The second rule is that of description. At its essence lies the injunction: "Describe, don't explain" (Spinelli, 1989, p.105). If the first step has been

reached by setting aside our own sets of bias about the phenomenon, then one must be careful not to limit oneself with the urge to explain what is being observed. This correlates with the earlier concept of intentionality, where the mind seeks contact with the outside world or phenomena it is observing, and naturally tries to make sense of what it is observing. To do this, it explains the phenomenon to itself. Here the sets of information and bias come to the fore as the equipment used to explain. However, we should rather be totally focussed on our immediate and concrete impressions of what we are observing, taking an approach of analysis that has as its focus description rather than theoretical explanation (Spinelli, 1989).

Spinelli (1989) cites another explanation: Imagine a hypochondriac who responds to any somatic experience by imposing often terribly incapacitory misinterpretations based on the medical hypothesis at his disposal. From the phenomenological perspective this person has failed to apply the second rule of description. Instead of firstly describing his experience, he immediately jumps to explanations and theories, which are mostly wrong and debilitating. A postulation on this example is that we as researchers, through trying too hastily to explain a phenomenon, could imply things in the explanation that could not only be wrong but also debilitating where the phenomenon itself may not be. We must therefore guard against being "hypochondriacs of psychology" by applying the second rule, and not jump to conclusions and explanations too early in the research process.

The last rule is that of equalisation. This requires treating all items with the same level of importance and not imply any hierarchy of importance to items; therefore, to attach equal value and significance to all items that have been described (Spinelli, 1989). Phenomenologists stress that the process of researching is equal to that of piecing together a giant jigsaw puzzle without any prior knowledge of what the picture formed will look like. In this way it is imperative that any and all items of information must be treated with equal importance (at least initially) to avoid the losing of any potentially crucial information (Spinelli, 1989).

Finally it is worth reiterating that in the application of the phenomenological method, the aim is to view all experiences and data as equal and regard them without bias to any form of interpretation according to any set of value systems. In that all experiences are equally valid, phenomenologists have coined the rule of inclusion/exclusion (Spinelli, 1989). This rule states that with the exclusion or bracketing of any personal bias towards any one view, we also include a stance of openness and receptivity toward all experiences.

Another rule followed in this process is be the equal reality rule (Spinelli, 1989). This entails the treatment of all experiences as equally real and valid. This rule can however be applied only as a temporary measure, as it has no fixed end point and the pragmatics of research come into play. With the application of this rule, researchers avoid the imposition of any of their own assumptions and bias towards the interpretation of the phenomenon under study.

3.6 PRACTICAL APPLICATION

Proceeding to the next logical step, that is, putting the background of phenomenology into action, requires a definite scientific technique. This entails the practical mechanics of applying phenomenology to research to facilitate the business of reaching *epoché* and, through the steps mentioned above, to reduce the phenomenon to a set of data about experience that is understandable and accessible to everyone. In this research, this will be achieved by taking the data and applying to it the following steps as is described by Ashworth, Giorgi and de Koning (1986). The first step is the exploration of the whole description as it presents itself without any changes, to attain a sense of the whole statement. This is achieved by reading through the material several times to become thoroughly acquainted with the data.

The second step in the research process is to read through the data (with which the author has become well acquainted within the first step) with the specific aim of distinguishing different “meaning units”. The distinction between these units depends on what phenomenon is being studied. In the case of someone

examining, for example, the phenomenon of learning from an experience about medical practices, then those specific delineated experiences would constitute separate meaning units. In the case of this study, the meaning units that should be distinguished are those experiences that the intern had with regard to the suicide of her patient, and which impacted on her development as a therapist and person (Ashworth et al., 1986).

The third step in this process is to take those meaning units that have been distinguished and reproduce them from the language that has been used by the subject, and which are thus close to her own experience, and reproduce them into language that contains specific psychological terms. An example of steps two and three follows (Giorgi, 1978):

Discriminated meaning units expressed as much as possible in S's language based upon perception that description is a part of learning.	**Discriminated meaning units expressed more directly in psychological language and with respect to relevancy for the phenomenon of learning**
1. At the doctor's office, S receives a prescription for antibiotics to medicate her flu, and instructions on their use.	1. S gets instructions (she desires) from "expert other".
2. S remembers that she has to take one tablet every morning until all three tablets provided have been consumed.	2. Instructions consist of using medication as directed until all is consumed.

In this study, the information gathered consists of interviews with the subject. This constitutes the data to which the above steps will be applied. Therefore, the data in raw form (contained in step one), as expressed in the language of the subject, will be reported verbatim through recorded and transcribed interviews with the subject. The procedure of this analysis remains the same, namely, in step three the descriptive meaning unit in the subject's language is given in psychological language with respect to what phenomenon is specifically studied, namely, her experience of a patient suicide.

The step that represents the biggest difference from the original data is of course step three. Here specific information which not relevant to what is being studied is substituted with more general terms; such as the specific prescription of antibiotics that gets substituted for a simple set of describing that instructions are given for the use of that medication. The specific quantities of medication, the times given and physical acts required are substituted for simpler descriptions of what hopefully encompasses the essence of what is said in the original description (Ashworth et al., 1986). Within this description of material (or rather, the moulding of information to better suit the topic being studied), there is a danger that some information might be lost. It is also possible that some information could be misconstrued or misinterpreted. To guard against the loss of validity of the information we now turn to a discussion of validity and reliability and their application to this study.

3.7 VALIDITY AND RELIABILITY

There exists in the positivist realm of knowledge and research the notion of a fundamental truth and reality. Positivist researchers have created the notions of validity and reliability to reflect their belief in such a single concrete attainable truth (Seale, 1999). This stands in direct opposition to the phenomenological approach which holds that reality is unique to every single mind; we can never really fully experience the world, and can only glimpse it through individual experience. The original meanings of validity and reliability, as well as the changes or modifications that the later qualitative researchers made to these concepts, is discussed below. Validity in the positivist realm refers to the truth or stable social reality (Seale, 1999). The validity of a measurement instrument such as a questionnaire, lies with the socially agreed consensus on the precise meaning of the language used. Thus, a concept such as “alienation” can be broken down into parts such as “loneliness”, “powerlessness” and so on (Rose, 1982).

The result that is to be measured should stand in direct proportion to reality. This, as one can clearly see, is heavily dependant on the overall consensus of the meaning of language. As Cicourel (1964) states, all questions are based on

the assumption that language is a fixed construct that is shared by all. Later research has found this to be untrue, as illustrated by the efforts that later positivist researchers have made to ensure that such a consensus, and therefore validity, exists in their measurement (Seale, 1999).

The concept of internal validity, within the positivist realm, is concerned with the extent to which causal proportions are supported in a study of a particular setting (Seale, 1999). For example, it means to show with certainty that X alone caused Y to vary, and not some other factor or factors. This concept seems to be less prominent in the field of qualitative research, which forms the basis of this particular study. The field of qualitative research has as its concern the question of "what is happening": describing a phenomenon in naturalistic ethnographic studies (Seale, 1999), or to describe without bias the whole phenomenon studied (the first step in phenomenological research). In addition, the question of "how" is asked in qualitative research; how the realities of everyday life come about, as in the ethno-methodological and discourse analytic projects (Seale, 1999).

A rarer question that is addressed in qualitative research is that of *why* things happen, or the causality of things. Qualitative research is increasingly asked to answer this question (Seale, 1999). Seale (1999) argues that within the accounts of 'what' and 'how' questions, the attempt to answer 'why' inevitably creeps in despite the author's explicit intent not to answer this question. This refers back to the concept of interpretation of the consciousness which one experiences. The human mind strives to explain things to itself, even if it seems to have consciously vowed not to. Seale (1999) gives an example of this by quoting an account by Geertz (1993), describing Balinese cockfights: "Jealousy is as much part of Bali as poise, envy as grace, brutality as charm; but without the cockfight, the Balinese would have much less certain understanding of them, which is, presumably, why they value it so highly" (Geertz, 1993, p.102). This quotation is taken from a text that sets out to be, according to the author, an account of a phenomenon; yet it nonetheless attempts to address the question of why. This powerfully illustrates the urge of explanation, even in the absence of intent. This study concerns itself with the account of an intern's

experiences after a patient suicide and does not aim to offer causal explanations. However, it would be judicial to keep in mind that such attempts may nonetheless inadvertently be made.

The next issue is external validity. This concerns itself with the extent to which causal proportions are supported in settings other than the study, in other words, how generalisable the findings are (Seale, 1999). Opinions are polarised about the ability to apply findings of one study to other settings. Some authors flatly refuse to do it, while others accept that it can and should be done. Indeed, there seems to be little point in conducting research if the findings cannot be in some way related to other settings (Seale, 1999). In the field of qualitative research, Seale (1999) proposes the use of extensive and thorough research and descriptions of phenomena. Then, if sufficiently rich accounts exist, readers may conduct their own "thought experiment" to ascertain whether the finding or accounts about a phenomenon can also be applied to other settings. It is then up to readers to draw their own conclusions about a study. This study shares this aim: the findings will be submitted to readers to decide for themselves what can be extrapolated to other settings. Parallels with other studies reported in the literature will also be sought to determine whether a similar phenomenon as has been recorded elsewhere.

The issues of reliability and replicability are rooted within a single knowable reality that the positivist seeks to discern through language (Seale, 1999). Sub-concepts such as inter-rater reliability seek to correlate the findings of different researchers studying the same phenomenon. Differing answers are unacceptable as a single valid answer is the goal of research. This is illustrated very strongly in the literature study where most of the research projects on the phenomenon of suicide of patients find very specific correlations regarding the emotions that therapists experience. However, this logic is flawed if viewed from the constructionist view of multiple realities, which regards the consensus of realities as artificial (Seale, 1999). In this realm the researcher's role would be to merely facilitate the expression of the different realities as experienced by different individuals. This is again indicative of the different poles that form of any view. One must guard against solipsism in the approach to any research. To

walk this line of balance between the extreme poles, the position of LeCompte and Goetz (1982), who distinguish between internal and external reliability, is supported.

The first type of reliability, internal reliability, concerns itself with the common themes that would be found if different researchers were asked to identify themes out of the same set of qualitative interviews. In this approach, both common themes that are shared by all and themes that are less common are revealed. The more common themes represent the core of the study (Seale, 1999). External reliability refers to the consistency of findings in replicated studies. This seems to have proven more difficult in qualitative research than in the quantitative realm. Seale (1999) argues that this is due to the unique set of variables and parameters that the qualitative researcher faces in every study, and not because of some fundamental philosophical or methodological flaw. In short, every quantitative study is unique and dependent on so many variables that full replication seems almost impossible. These variables and the search to add some level of empirical value to qualitative studies has led many authors to distinguish between terms and concepts to aid the creation of that value. These terms are now discussed.

3.8 ALTERNATIVES IN THE QUALITATIVE FIELD

There exists a bewildering array of concepts in the field of validity and reliability within the qualitative field, with a myriad terms such as "successor validity, catalytic validity, interrogated validity, transgressive validity, imperial validity, situated validity and voluptuous validity" (Atheide & Johnson, 1994, p.64), and apparent, instrumental and theoretical validity (Kirk & Miller, 1986). Without discussing the definitions and operational uses of these terms in detail, the author will attempt to capture the overall essence of what is represented by all these terms. Seale (1999) believes that they indicate the difficulty facing a qualitative researcher in obtaining results that are reliable and lasting in this field. In contrast, the qualitative field has far greater consensus about their terms and concepts. According to Lincoln and Guba (1985), the heart of these attempts lies in the establishment of *trustworthiness*.

They have identified four fundamental questions that are asked of research reports:

1. Truth value: How can one establish confidence in the 'truth' of the findings of a particular inquiry for the subjects (respondents) with whom and the context in which the inquiry was carried out?
2. Applicability: How can one determine the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects (respondents)?
3. Consistency: How can one determine whether the findings of an inquiry would be repeated if the inquiry would be replicated with the same (or similar) subjects (respondents) in the same (or similar) context?
4. Neutrality: How can one establish the degree to which the findings of an inquiry are determined by the subjects (respondents) and conditions of the inquiry and not by the biases, motivations, interests or perspectives of the inquirer? (Lincoln & Guba, 1985).

From these questions, Lincoln and Guba established the criteria of internal and external validity, reliability and objectivity. Internal validity seems to be further distanced from the original quantitative, positivistic concept if one studies the question from which it arises (Seale, 1999).

These authors have gone on to establish, through the replacement of these criteria with concepts that are more in line with the qualitative paradigm, four criteria that should be adhered to within the field of qualitative research.

Firstly, the concept of truth-value or internal validity as it appears in the question above is replaced with the concept of credibility. This is constructed through rigorous observation as well as the exposure of the material to a peer member not specifically interested in the topic for review. Lincoln and Guba (1985) also suggest that a part of the research should be earmarked and excluded from the main analysis and then returned to later to see if the concepts are applicable (Lincoln & Guba, 1985). Very importantly, they urge the researcher to do what they call 'member checks', namely, the exposure of

the research material such as interview transcripts and findings to the people with whom the research has been done, to see if they agree or disagree with the way that they have been represented by the researcher (Lincoln & Guba, 1985).

Secondly, transferability replaces applicability or external validity. Transferability refers to what was said earlier about applicability, in that the report and description should be thorough and detailed enough for reader to have enough information from which to draw their own conclusions regarding the extent to which the findings of the research can be useful in other areas (Seale, 1999).

To replace the concept of consistency or reliability, the term dependability is proposed (Lincoln & Guba, 1985). They achieve this by a process called 'auditing' (Seale, 1999). This involves 'auditors' examining the 'audit trail', consisting of the researcher's documentation, methods and decisions for adequacy.

Lastly, the concept of neutrality or objectivity is replaced with conformability. This can also be achieved through the auditing process by giving researchers a self-critical and therefore somewhat meta-perspective on their own research and findings.

3.9 SUMMARY

This chapter discussed the research model that is employed in this study. Importantly, it also warned against the possible dangers that can be encountered while using this model. The safeguards against these common mistakes have been reviewed and will be applied as far as possible to the current study. For example, the work within this study will be reviewed by a supervisor not directly linked to the event being studied. On another level, this chapter also attempted to place readers within the realm of thought that will be central to this study; to elicit the type of logic and reasoning that will be employed as this study progresses. This is expressed in terms such as description first rather that explanation, and the concept of one reality as part

of many. In the case of the current study, the reality described will be that of a single psychology intern. It is the intern's experiences as expressed within the recorded interviews that form the central focus of the next chapter. These experiences are described firstly and as far as possible no attempt will be made to interpret the data until the appropriate time. Steps two and three of the phenomenological process will thus be applied to the raw data gathered from the subject being studied.

CHAPTER 4

DISCUSSION

4.1 INTRODUCTION

This chapter is devoted to the second and third steps in the phenomenological method, namely, dividing the research material into separate meaning units and converting those meaning units into concise psychological language for further study, then identifying prevalent themes. Chapter five continues the process by discussion the main identified themes.

The format of this chapter contains a table in which the raw or naive text is divided into separate units in the first column, with a second column containing the psychological language of that text.

4.2 INTERVIEW 1

1. I don't know how to start. I kind of think I can't just leap from here to there without talking about what happened before. Cause I think what we talked about before leads to how I felt about what happened.	Subject searches for a place from which to begin account choosing to start by giving background information as a platform for understanding later events.
2. Okay, when I first saw X, the psychiatrist, that was the end of January, because he said that he had been very anxious and couldn't sleep and that he was very depressed, referred the first session that I saw him X but I couldn't see any depression. At first I couldn't see that he was depressed. And then I saw him the first time and we didn't really talk about much, he told me that he had been referred and I was on 'spoed'[a] so I talked to him and he told me that he had been suffering from anxiety attacks, but he doesn't know where they come from, and he's very worried about them because he cannot sleep and its very important for him to relax and be with other people.	The reason and background for the initial contact was given as well as the symptoms that the patient had been presenting with. Those symptoms were not immediately apparent to the subject. Also the patient impression and perceived reason for referral was given.
3. He told me that he had been fired from work, and that was a job that he really loved and he was very committed to it. He was an engineer, he worked for the Air Force and later he went to a private company. He was	The subject gives the patients background consisting of his own perceived reasons for his loss of employment.

fired from there, he said that they fired him because they said he was racist, but he wasn't. He had made some remarks that black people were always late and they couldn't keep time and a lot of people complained about that and he was fired.	
4.It was very difficult for him to deal with that and he didn't want to deal with it. He didn't acknowledge the fact that he felt sad about it and that he had lost something, something significant to him.	The patient's reluctance to speak about and avoidance of personal issues is described.

[a]A 'spoed' refers to being on call at the psychiatry department for any incoming referrals from psychiatrists at that particular institution.

5. So from then on I thought okay he's very intellectual and he doesn't want to deal with this emotion. So I was really interested in how he relates to other people. Because I thought maybe if it is like this at work maybe it's like this at home as well.	The subject's thoughts dwell on the dynamics of the patient and how this plays out in interpersonal relationships.
6. Then the following sessions we talked about that, the first seven sessions we concentrated on his work, and I asked him what he did and how he worked with people and he said that there where people that he didn't want to work with because they were difficult and would cancel and the last moment and he didn't like that.	The further exploration of the aforementioned route in therapy is discussed. The patient's feelings regarding other workers and his likes and dislikes about their behaviour is mentioned.

7. So I thought Okay he's a perfectionist and he wants everyone to be that way. So he said no he's not a perfectionist he just wants everybody to do their job so that everything would run smoothly.	The subject reflects her thoughts on the patients personality traits to the patient who then responds honestly but not in agreement
8. And then after I think the sixth or fifth session we talked about his wife, he talked about his relationship with his wife. He didn't really say much like they were having problems but I kind of got the impression that they were, maybe not problems but there were something between them. Because he kept referring to her as if she was this perfect person that did everything for him but he still felt anxious and that he couldn't talk to her, and I was wondering what made her so perfect but she cannot help him and he cannot talk to her.	The therapy moved to more personal issues namely dynamics in relationship the patient's wife. The subject gives her impressions about the patient's feelings towards his wife that he is not verbalising. She also gives her impression about the discrepancy between what he verbalises about his wife and the dynamics of the relationship.
9. And we talked about his wife and he said that his wife wanted to talk to me. And I thought that she doesn't want to talk about him really. I thought that she felt excluded from what she saw as X's relationship with me, and that he's excluding her and that X and I have something that he and she doesn't.	The patient's wife wanted to speak to the subject and she gives her thoughts on the matter namely that she has the impression that the patients' wife feels left out of the therapeutic space between the subject and her patient.

10. So she called me and she came in and we didn't really talk about X we talked about her because she told me that she's scared to sleep at night. She goes to bed at one in the morning sometimes because she's scared to sleep. And I said to her, why now or did you go to therapy before and she said no. I asked did this escalate or has it gone down and she said no it's still the same, and I said to her why did she want to come to therapy now. And she said she just wanted to talk about it, she just wanted someone to talk to about it.	A meeting takes place between subject and patient's wife. The content is however not what the subject expected. In the face of unexpected content the subject asks why this was only brought up now and not in another therapeutic context. Patient responds by simply stating that she wants to talk about it.

11. So I thought okay maybe she wanted that, what X seemed to have, that kind of relationship so I allowed her to talk about it. Then at the end she asked me how X is doing and I told her "ag, it's going, I don't know how it's going but it's going". She said okay but she doesn't want to come in she just wanted to come that one time. So I said that's fine.	The subject gives her thoughts on why her patient responded the way she did being that she also seeks a similar therapeutic space as her husband. She asks how her husband is in therapy and subject responds by not giving any real information.
12. X and I talked about that; that his wife wanted to come for therapy. I don't think he understood why she wanted to come in, to him maybe she was coming in just because she had been having trouble sleeping and al that. Or maybe he did but he just	The subject discusses the meeting between the patient's wife and her giving her impressions as to his understanding of the dynamics. The subject hypothesises that the patient either is unaware of the dynamics or does not want to acknowledge it. They

didn't want to acknowledge that. And we talked about that, and he wanted his wife to come for therapy with him but it seems she didn't want to so I told him to just leave it and maybe we'll do it later.	discuss a possible group therapy including the patients' wife but the patient dismisses it.
13. And that was that and then one day he was supposed to come on Tuesday, he usually came on Tuesday's at nine. The Monday he called me at around ten to eight when I came into the office he called and said that he was in a bad way and he wanted to see me and he felt bad. So I told him to come in and he did.	An emergency meeting is made on account of the patient's negative feeling state.
14. He was al over the place, he couldn't sit down and he was very anxious. And I could see that but I couldn't tell what was going on because he couldn't talk to me he just kept saying he felt bad and he's anxious and everything hurts and his head hurts and he couldn't sleep and whatever. But he couldn't really sit down and talk about it so I just let him walk out of the room and look out of the window, and he asked me all sorts of questions like about my other patients, do I keep a file on him. Do I ever discuss him with somebody else, that kind of thing.	The subject describes that the patient was very anxious in the session but that she could not tell what the matter was since the patient could not calm down. The patient asked whether the subject ever kept him in thought outside their sessions.
15. And then after a while his mood seemed to come down and he sat down	The patient started to calm down and in the discussion it becomes clear that

and we talked about it because I felt like, maybe he felt like I had forgotten when he had left or something so I asked him whether he thinks I forget him when he leaves and he said ja he feels like maybe when he leaves I forget about him until he comes in again.	he has a great fear of being forgotten by the subject.
16. And I asked him what that means to him and he said he thinks that we have a relationship and he doesn't want me to forget him okay and we explored that and talked about that and he was very calm	The subject explores this fear within the patient.
17. and we talked about what had happened throughout the week, why does he think he was feeling that anxious and then he said that he had had a squabble with his wife over the children or something, it wasn't something big but still he felt anxious about it.	The week's event for the patient included an argument with his spouse that could also have contributed to his anxious feeling state.
18. Then he went to see his psychiatrist to get some new medication or something, then before he left he said to me, I feel like staying here for ever, I feel like not going home, just sitting here and talking to you the whole day and not going home.	Just before the end of the session as the patient went for renewed medication he states the wish to stay literally in the therapeutic relationship forever.
19. But I thought okay he's fine, he looks fine. And that was the Monday, the Thursday or the Friday that week	The subject thought that the patient seemed to coping well, the patient however was admitted without telling

he was admitted to the hospital. But he didn't call me, I saw him when he went there, he was there and I went to see him and I asked him what had happened but then he looked much calmer.	the subject. Leaving it to her to find out herself.
20. We talked and he said that it was too hard for him at home and he's not used to doing the chores that that his wife wants him to do so he was bored with that and he wanted something to do, he needed something to do to occupy his time.	The patient stated his reason for admittance as an unbearable home situation. At the centre of this being his relationship with his wife and the demand she puts on him.
21. We had talked before about him retiring anyway because he was 58, so I told him that he was left with only two years anyway and he was going to retire anyway. So it will be that he could catch up with going to the movies with his wife and spending time with her, time that they never really spent together since they were married.	The subject discusses the possibility of eventual and inevitable retirement, stating it in a positive light by making light of the opportunity to rekindle the relationship with his wife.
22. And he said no, they had nothing to talk about anyway because his wife loves to read and watch TV and he doesn't like that. He likes walking in the garden and walking his dogs and that kind of thing but his wife never did that and she went out a lot and he didn't want her to do that.	The patient responds negatively by giving the differences in what he and his wife enjoys doing fir recreation.
23. He wanted them to spend time together but the wife didn't want that	The patient's will to have a relationship with his wife seems to be

so they had different ideas about how they wanted to spend time so it was difficult for them, I think, when he was home because his wife had also complained about that before. That she doesn't know what to do when he's there, he had never been there before ever since they got married.	present but the subject hypothesises about the difficulty due to unfamiliarity that they would have in relating to one another.
24. They got married when she was very young and immediately after they got married X left to work somewhere and ever since then he was al over the country and all over the world.	A short background is given by the subject stating that the patient started travelling extensively shortly after their marriage.
25. They never really spent time together all they talked about when they were newly wed was the kids, the children and then the children grew up, they have two sons, and they got married and moved out of the house and since then they couldn't spend time together to talk because they had nothing to talk about.	The hypothesis about their dynamics given by the subject is that there was a lack of time and that the content of further relating was based on their children and not themselves.
26. So most of the time they spent with friends going to eat out, going out to the movies, that kind of thing but they never spent time together. When the wife is in the bed reading, he's doing something else. When he comes to sleep the wife is stil reading until one in the morning when he is asleep. So he said no he doesn't see how that could work.	The dynamic of their relationship, according to the subject was that time alone together made way for social gatherings and that time alone was not efficiently managed as to get to know one another.
27. So I said to him talk about it, just	The subject suggested communication

talk about it with her and find out, maybe she wants to, and he did. And my supervisor said no, what can they talk about now, what does he want to talk about now. Because he never wanted to talk about anything before, and that was very hard on him.	between them. Her supervisor warned against that stating the lack of common relating material as the reason.
28. And he was very sad, he looked very down. And he asked me what can he do now. And then when he was admitted to the hospital he went away, he went home on weekend pass, and then when he came back Monday he was fine, he said everything was fine at home, he's looking forward to going back home, the medication is working and everything is great so he wants to go back home.	The patient was disheartened upon hearing this, however on going home for the weekend his mood improved.
29. He was discharged on the Friday, but then I said to his psychiatrist he's gonna come back, it won't take him long because the weekend was not "real" what they did was, the kids were over there and the wife's were there. So they spent time with them they didn't spend time together, again.	The subject hypothesised that this would not last due to the fact that the basis of the dynamic at home at that particular time was again centering on the children and is therefore familiar and safe.
30. And he was discharged on Friday. The Saturday he called, he wanted to come back to hospital, the Sunday he called, the Monday he called, the Tuesday he called. He kept calling everyday because he wanted to be admitted again.	The patient was persistent in wanting to return to hospital after his initial discharge.

31. But his doctor didn't want to admit him. And he felt very rejected by that I think because we talked about that the one time and he said that his doctor said that he was like a child and he was very dependent and he didn't like that. And I asked him what he felt about that and he said he felt very scolded by that, by him.	The doctor however did not want to readmit him, causing possible feelings of rejection and punishment.
32. But he said he was fine and that he would cope and, so he was fine. And then, the last week that I saw him, the last two weeks he wanted to be admitted again so I asked him what for because he didn't seem to be having any anxiety attacks or anything he looked fine. So I told him okay let's see the coming week if he still wants to be admitted we can talk to his doctor, but the following week he said he was fine. He felt 100%, and that was the Tuesday, and he said he felt fine and the medication is working.	The patient verbalised his feeling of coping and that things are better but still wanted readmission. The subject suggested that time should be spent on a trial basis to see if he could cope. The patient apparently responded well to this and verbalised that his mood had improved and that medication had a positive effect.
33. And we had spoken about me taking two weeks leave. He said yes that would be the time for him to see if he could cope without me for two weeks, and I said okay if he wanted anything he could call. So that was the Tuesday, the Friday I took leave	The matter of the subject taking leave was raised for the first time, the patient responded by making the time a trial to see if he could cope outside the therapeutic relationship. The reassurance was given of contact in emergencies.
34. and I think the Friday he was readmitted. And ja, over the weekend I didn't know he was readmitted until	The patient was readmitted however without the knowledge of the subject who was not present due to being on

the Tuesday when my supervisor had called me to tell me that he had committed suicide. I didn't know he was admitted because my supervisor said I was going on leave so I couldn't be contacted.	leave. The subject found out that he was readmitted through a phone call from her supervisor informing her of the patient's suicide.
35. And, I don't know, when she said that he had committed suicide I don't know, because I never really felt that he would because we had spoken about it a lot.	The subject searches for words, trying to verbalise her disbelief upon hearing the news of the patient's suicide, also noting that the matter was raised in therapy.
36. Especially because he had told me about how he was brought up and how difficult it was for him because he said that his mother was a very unemotional person. And he wanted that, he needed that from his mother but she never provided him with that, emotional security. So emotionally he was very insecure and immature, I thought that about him.	The subject recalls an element of therapy in which the dynamic between the patient and his mother had been discussed, centering around his need for affection and emotion, not receiving it from his mother, making him emotionally insecure.
37. So, when my supervisor called me, I don't know, it didn't really fit with him. I couldn't see him as doing that.	The subject struggles to understand that the patient committed suicide, feeling that it wasn't behaviour consistent with her image of him.
38. And then I asked her how he did it and she said he jumped from the seventh floor, and somehow I didn't know, it didn't seem like him to do something like that because he was a very religious person and he didn't believe in one taking his own life, he said that it was not the religious way	On finding out the method of suicide the subject finds it even more difficult to understand also in the light of what she knows about the patient's religious beliefs.

of dying. And it wasn't God's way.	
39. So, I don't know, I had mixed emotions about it, I didn't know what to feel I didn't know how I felt about it. I felt, mm I don't know, mm numb, like, I don't want to feel anything. Ja, I felt like I didn't want to feel anything.	The subject verbalises the struggle through many thoughts and emotions and describes a feeling state of numbness and not wanting to feel anything.
40. And I remember at one point I was asking myself how I should feel, should I be angry at him and I couldn't feel that because what he was going through in a way I could understand why he took his own life, I didn't feel angry with him. But I felt sad in a way because I felt like I didn't just lose a patient, I lost somebody that I liked, because I liked him.	The subject recalls a moment in time when she asked herself what emotions she must feel. She considered anger but did not feel that due to understanding the motives and circumstances the patient was experienced. She felt sadness because of the loss of a 'liked' individual more that just a patient.
41. But it was, it was very strange. It was so strange that, I don't know, that he died when I wasn't there. And I felt very guilty about that because I thought, maybe if I had been there maybe that wouldn't have happened.	The subject describes a feeling of strangeness. She also felt guilt in not being there for the patient in this time.
42. Then again I thought if I was there and he had killed himself I would blame myself. So I had a whole lot of emotions, I was scared that, what if I come back and it was blamed on me.	She then contains her thoughts within a statement of "feeling many different emotions", finally settling on the feeling of fear for recrimination.
43. Should I call his wife and what is she gonna say and is she gonna blame me and if she blames me what am I	The subject struggles with the question of calling the patients wife, wondering about the possibility of a

gonna do.	negative response and wondering what to do in such a scenario.
44. And I started doubting myself, I didn't wanna come back to work thinking am I gonna be able to help my clients again. And when another client of mine kills himself what am I gonna do then. So I was feeling a whole lot of stuff at one time and I couldn't deal with any one of them at that time.	The subject also goes through the emotion of self-doubt. Asking herself the question of what to do if such an incident repeats itself. Finally she notes that she did not desire a feeling state of confusion with so many feelings at one time, wanting rather not to experience those feelings at that time.
45. I just felt like, leaving it I just, I didn't want to deal with it because I felt anyway what will I do cause I wasn't even in Pretoria so I thought, ag I'll deal with it when I come back to Pretoria but everyday I thought about it and how am I gonna deal with it and what will the first thing be when I come back and will I call his wife or what. I didn't know what to do.	The subject had the intent of postponing her feeling state because of her geographical separation from events. This however did not work as she continued to wonder and plan what to do when she arrives back at work.
46. So the two weeks that I wasn't here I thought okay when I'm going back to Pretoria I'm gonna come back and work, just work and not think about it. Mm but, I couldn't really stop myself from thinking about it	The subject planned to immerse herself in work upon her return but that was ineffective, as she could not stop her thoughts from going to the events that took place.
47. and I remember even the first week when I was back everyone, every one of my clients had heard about it and they wanted to talk about it and I didn't want to talk about it, I didn't feel ready to talk about it. And,	All of the subject's other clients had heard of the suicide and wanted to speak about it. This was disconcerting to the subject, as she felt not ready to verbalise or work through the events yet.

but we talked about it in therapy and they asked me if I knew anything about it because they heard that he had committed suicide and I told them that's what I heard as well I wasn't here for the two weeks.	
48. And most of them wanted to know why he had done it. Was he depressed, why was he depressed, that kind of thing.	The clients requested information as to the reason and aetiology of the suicide event.
49. I never told them that he was my patient I just talked about him as a person and that he had done that. And I asked myself; is that wrong, should I tell them that he was my patient. Then I felt, they're not asking me if he was my patient so why should I tell them anyway,	The subject did not disclose the information that she was the deceased's therapist, she had asked herself as to the right or wrong of this action containing it through stating that that information simply was not desired by those who enquired about her patient.
50. and then I, I called his wife. And that was very difficult because I kept putting it off. I think I called her after four days when I was here. I called her and I kept preparing myself for the blame and the guilt that I was gonna feel but we talked about it and I called her and she was very nice, actually.	The event of contact with the deceased's wife eventually came after the subject had postponed it several times. She was still struggling with feelings of blame and guilt and was expecting a response in that order, the eventual real response surprised her with its positivity.
51. I told her that I was sorry to hear about X and she asked my why I haven't called and I told her that I was on leave for two weeks I just got back. She told me that ja X told her that I was going on leave.	The content of the exchange centred on the subject's condolences towards the deceased's wife and the question from the wife regarding the time it took for contact to be made.
52. But she was, I don't know, she	The subject's impression emotionally

sounded very, sad, and we talked about X for a while and she asked me how did that happen and that was the question I kept asking myself, how did that happen. And when she asked me I couldn't answer, I didn't know. I told her I don't really know, I'm not really sure why it happened. And I guess that is what I'll always ask myself. Why did it happen? And why did it happen then?	of the wife was a feeling of sadness. The wife also asked the same question as the subject as to why and why then did the suicide take place. The subject, like the wife was incapable of answering this question.
53. And, I don't know, could I have done something maybe to stop it or whatever. And why didn't he call me and stuff like that I will keep asking myself.	The further questions that the subject is struggling with are about her being capable of having done something and why the patient had not contacted her.
54. And then I went for supervision when I got back and we talked about it my supervisor and I for a while, we talked and talked and talked about it, and I felt like I was fine,	The first contact that the subject had with her supervisor was of a positive and containing nature, improving her mood state.
55. and then after supervision the next day I went to the space where he killed himself, and I stood there and I sat there. And still I felt so sad that he died in that way. Nobody was there with him; I wasn't there with him. I felt like I wasn't there with him, for him. And that is the emotion that I can really pick up from all those that I can say that I'm sure that I feel guilty for not being there for him, and being there with him.	After the positive experience of supervision the subject went to the physical place of the suicide incident. Being at the place she felt sadness and sorrow about the circumstances in which the event took place. Connecting in a way with the patient in feeling loneliness. The guilt that she feels stems from the aspect of her not being there in a time that she sees as being very lonely for the patient.

56. Because I felt like in a way I let him become emotional and open up and become vulnerable with me, and I left him for two weeks and nobody was like that to him. And he couldn't be vulnerable with anybody. And then I left and nobody could contain that. And then he felt let down because I feel like I let him down. I don't know, but I feel like I should have been here and ja, I just feel like I should have been here.	The subject feels that she should have been present to contain the patient emotionally. The reason being that she created a space where emotional vulnerability existed and then leaving that space through geographical separation. The guilt centres on the separation that she had made between her and the patient at such a critical time in her view.
57. Nobody's saying than anyway, but I just, I feel like that.	Although no other has apparently verbalised the same thought the subject still struggles with that feeling state.

4.3 INTERVIEW 2

58. Okay, where do I start?	Subject seeking for an appropriate start of point for interview.

How you've worked through it emotionally and people you went to for help.

59. Okay, mm, maybe I should start where I started working with it, emotionally. I think the first thing I did was to call X's family. I did that I talked to his wife and his daughter in law. The first time I did that I think was two weeks after it had happened, after X died.	Subject regards the point of contact between her and the patient's family as the first point of emotional dealing with the events. This occurred two weeks after the event.

What happened in those two weeks?

60. Hm, ugh! A lot I think. During the two weeks I wasn't here I wasn't at work I was on leave. And my supervisor called me, she kept calling and calling. So I spoke to her about it, and I was basically not functioning for the two weeks,	The subject described the time period before returning to work as a confusing time in which she talked with her supervisor but did not seem to take anything in emotionally.
61. I had a lot of questions about what was gonna happen, what did I do wrong, did I do something wrong, why did it happen when I wasn't here. So I had a lot of questions and I couldn't really talk to anybody about them, not then.	The subject had doubts in her mind regarding her professionalism in relation to the patient, wondering what could have been done more, however she did not regard it the correct time to start verbalising her thoughts.

You didn't want to speak to your supervisor about it?

62. No, I didn't I just wanted to deal with it on my own first, and two, I felt like maybe I had done something wrong and I didn't really want anybody to say that I had done something wrong. So I felt that if I talked to somebody about it and they say okay I did this wrong I wouldn't be able to cope with that.	The subject refused to speak to her superior at that time for the reasons that she wanted to work through the emotions on her own first and out of fear for scrutiny and possible fault finding in her work.
63. So, when I came back the first thing I did was talk to my supervisor. I went over to her house and we talked about it, how I felt about it, and what she thought about it. Because I felt by	Upon returning to work the subject seeked help from her superior choosing to talk about the issue at length. Her own thoughts and feelings at this stage centres on what she could

then I must have also done something. Or maybe I didn't do everything.	have done more in her capacity or what she neglected to do.
64. Okay and my supervisor and I talked about what had happened, what she thinks happened.	The superior within dialogue expressed her thoughts on what had occurred in therapy.
65. Okay she had my files when I wasn't here. So, she had access to that, what transpired between X and me so she talked about what she thinks happened and why she thinks X killed himself.	The superior had documentation pertaining to the case and the therapy on which to base her hypotheses.
66. I think she said, according to her she thinks therapy was going good and then I went away. And in a way I had opened X up and then when I wasn't here there was nobody there for him and contain him and all that. So that could have contributed to whatever happened here when I wasn't here.	The superior's thoughts about the events in therapy was that the patient was allowed to share and become vulnerable through this and then was left in this vulnerable state with no containment present through the subject.

How did that sit with you?

67. It was fine, I think. I think I saw that. I think the way I thought about it was that X was a very intellectual person and I had taken him to a place where he wasn't comfortable enough and he hadn't been there before. And in a way I did that and then I left.	The subject gives her interpretation of what the superior had hypothesised adding the intellectual traits of the patient that she had experienced contributing to the intensity of what the patient had felt in this vulnerable time.

Didn't you feel guilty for leaving him at that point?

68. I did, I felt very guilty for leaving	The subject verbalises that she felt

him and I thought I should have been here for him because I was the one that put him there and I should have seen the sort of impact that it would have on him and I shouldn't have gone on leave and all that.	guilt for leaving the patient in this vulnerable state also blaming herself in a way for not having the insight to foresee the intensity that the patient felt in his state.
69. But before I left I told him that if anything happened he could call me if I wasn't here. But I think I should have known that he wasn't the kind of person that would have called me if he needed me. It took a lot for him to do that before. If he needed me it would take him ages before he would call to say that he needs me and all that. And I felt that I should have seen that coming.	In this statement the subject rationalises on the previous feeling of guilt in that she sees the patient as a type of person that would not have seeked out help by coming into contact with her. She also feels that she should have possessed the foresight to be able to recognise that.
70. And, I don't know, that I didn't and maybe I ignored that and I didn't do anything about it. But on the other hand I felt like, if he wanted to kill himself, if he wanted to die, then there was absolutely nothing that I could have done to prevent that, except, I don't know, staying with him. And even if I was here it could have happened, maybe not at hospital, maybe at home maybe somewhere else.	The subject asks herself the question whether she did not pay heed to this knowledge of the patient subconsciously. However she also feels, that there would have been no true way to stop the patient from going through with his intention of death he truly would have wanted it.

So that made you feel better?

71. Ja, it did, and then I talked to my	The subject feels better after these

supervisor about calling X's family and she thought it was a good idea and the following day I did that. I called that and I talked to the daughter in law first and then to the wife.	possible explanations. She spoke to her supervisor about contact with the patient's family and that was responded to positively. She first spoke to the daughter in law and then the wife of the patient.
72. And then I think that made me feel much better after talking to her because I had seen her twice while I was seeing X I felt that maybe we were excluding her or something so I called her in twice just to see how she was doing and all that so we had, already that relationship.	The subject reported a feeling of relief after contact with the patient's wife. There already existed a rapport between the subject and the patient's wife on the basis of two previous meetings geared to include her in the therapeutic process.
73. And, I wanted her to come in but she couldn't 'cause they were doing al sorts of things, after the funeral there was other things they were doing so we talked over the phone I asked her how she was doing, she said she was coping. She also had questions and wanted answers why it happened.	The subject requested the wife's presence for a session but it could not occur due to responsibilities of the wife, the contact over the telephone revealed that the wife also had the need for answers as to the reasons similar to what the subject was feeling.

Did she blame you at all?

74. No, she didn't, she just said that she was wondering why I hadn't called. Because it had been two weeks and nobody called, nobody from the hospital, no one.	The subject did not experience any blame from the patient's wife. She only asked what the reason was for the protracted time before contact was made.
75. And she thought I was going to be the one who called first, and I did, and she wanted to know why I hadn't	The patient's wife thought that the subject would be the first to contact her as she was only after two weeks,

called in two weeks so I told her I wasn't here I was on leave. She had known about it as well.	carrying the knowledge that the subject did go on leave.

You said you that you first talked to your supervisor about it, about calling her. So were you afraid before you called her?

76. Yes I think, I thought, if I do call 'cause I know her, I know X's wife. She's, I don't know, in a way a very hard kind of person. And I thought the first thing she's gonna do is to blame me.	The subject felt anxiety about contact with the patient's wife seeing her as a person that would blame her.
77. Because X came to me for help and then, in a way I see him dying as help for him. But I wasn't sure if she's gonna see it like that.	The subject sees the suicide in some way as therapeutic for the patient, however she did not think that the wife would feel the same way.
78. I didn't know what she was going to say and I was panicking that she might actually blame me and if she was going to do that I was going to go back to blaming myself as well, and I didn't want that.	The subject feared that if the wife blamed her as she was anticipating, it would return her to an emotional space of self-blame as well.
79. But I didn't want her to feel like okay this is what happened and it happened and it's fine and nobody's calling her or saying anything. So we talked about it and she wanted answers as well why it happened what happened in hospital actually and what happened during ward rounds. Why did X kill himself then and not before and what happened in therapy with	The subject felt that the patients' wife should not feel excluded, left without contact from the professional side. The wife also wanted answers as to the content of ward rounds and therapy, seeking answers about why the suicide occurred.

him before I left.	
80. So, we talked a bit about that and I think I gave her the impression, I don't know if it was wrong or right, that I don't know anything either. I know it happened and I have my theories about why it happened but that I wasn't sure why it happened.	The subject created the impression for the wife that she did not have any answers to the questions herself. The subject did not know however how correct this course of action was.
81. I don't think it was one specific thing that led to what happened and I don't know what happened in the ward round because I wasn't there.	The subject's own hypothesis is that there existed a constellation of mitigating factors leading to the suicide not one single reason. As she was not present during ward rounds she could not answer the question as to what happened there.
82. So she said ja her family was taking it very badly but they knew that he was depressed and that there was a possibility that he might kill himself but they felt he was getting better because he was acting much better. They thought he was recovering and then it happened and it was like a shock to them.	The wife verbalised the difficulty with which the family was dealing with the suicide as they had the impression that he was improving, thus the suicide was a shock to them.
83. And then we talked about her, how she was coping and how is it gonna be without X for her and how she was feeling, how she's gonna pick up the pieces and all that.	The next topic of conversation within the subjects' contact with the patient's wife centred on her own emotions and plans for the future.
84. And then she said she might come in, she had to go away and then she might come in. And then she didn't come in I think for two weeks and	The patient's wife expressed the tentative intention to come for a therapeutic session but as she was going to go away she would not be

then I called again. Just to see how she was doing, but she wasn't there, she wasn't home, she was away. And then I said okay if she needs to call she can just call me back and she hasn't called back.	able to do so immediately. After a time the subject attempted contact but could not do so, settling on the thought that the wife could make contact again if she so desires.
85. So that was, ja, when I started recovering from all this but on the other hand it was hell for me to come to work and see other patients. There were other patients waiting for me, and most of my clients knew about what had happened.	The subject describes this as the point in time when she began to recover emotionally from the events but she still experienced difficulty at work, seeing patients that carried knowledge of the suicide.
86. And they talked to me about it and by that time I was seeing a lot of depressed people. And they knew, they had known X and they heard that he had killed himself and that he was seeing a psychologist and that he was depressed.	The clients verbalised their feelings about the suicide and the subject were seeing a number of patients with similar diagnosis as the deceased. The patients also carried the knowledge that the deceased was in therapy.
87. So it happened, I don't know, more that once, I think twice that week that two of my patients heard about what had happened, and wanted to talk to me about it. So we talked about it, they told me that they heard that X had killed himself.	Two other patients of the subject knew the deceased and had heard what happened and wanted to verbalise their emotions on the matter in therapy.
88. One of my patients remarked that she didn't know he was depressed; it was such a shock to see somebody so strong and so dependable kill himself.	One other patient did not see any of the symptoms and to her the event was a shock, as it did not fit with her impression of the deceased.
89. So I, I dealt with it again in therapy. I had to ask them how they	The subject worked with her emotions regarding the suicide again in relation

felt when they found out. It never happened that they wanted to know who the psychologist was. I don't know why it never happened like that. I always kept asking myself if they ask if I know the psychologist I had to say yes it was me or what, I was struggling with that as well.	with her other patients, having to explore their emotions as well. The subject experienced difficulty about what to do when asked who the therapist was that the deceased saw. However this never took place.
90. In a way I kept hoping that it doesn't come up they never asked, you know, do you know who the psychologist is because I felt like I had to be honest and say yes I know it's me and then explore that how they feel about that. But on the other hand I didn't really feel like going into that with them. So I kept hoping that it never comes up and it never did. They never asked so it was kind of good.	The subject hoped not to be placed in a position of addressing the matter of who the therapist of the deceased was as she felt that she must then explore those emotions with it with her clients. She did not want to do this, the scenario never occurred.
91. I think for a month after that it came up a lot in therapy. That X killed himself and that it happened in hospital, was seen by a psychologist and a psychiatrist and he still killed himself. I think most of my clients felt a bit shaken if somebody is in hospital and he's being seen by professionals how can this happen.	The subject of the suicide came up often in the therapeutic sessions that the subject had. The details being known, that the events occurred within and in spite of the context of professional help seemed to be difficult to understand for most of the clients of the subject.
92. They were questioning, I think they were questioning psychology and psychiatry a lot. I had to be there for them and understand what they were going through but then defend the	The subject had to contain the client's feelings as well as their opinions towards the professions of psychology and psychiatry, this felt difficult for her during about a month after the

professions as well so it was a bit tricky for me for that month, the month after that.	event occurred.
93. But in a way I saw that as dealing with it. Going through it because the questions that they had were the questions I had.	The subject saw this process as beneficial in her own emotional dealing with the suicide since her own questioning was similar to those of her clients.
94. And I had to address those questions but from my side I think and see it from their side as well. Because I had gone through that and now I had to be on the other side as a psychologist and then deal with their questions.	The subject felt that this process lended her the perspective of being both dealing with the events as a patient and in a professional capacity as a therapist.
95. And I think it was very good that it happened like that, that they knew about it and they questioned me about it. Because I felt like, in a way I saw it that, in the department it wasn't really dealt with.	The subject saw this as positive in that it leant her an opportunity to work through the events that she did not experience in the department where she worked.
96. It was, okay it happened, and you're fine and we should just go on. And with my clients they wanted to go into it. And that helped me go into it as well.	The way the subject felt the matter was dealt with in the department in a way that left her to work on her own while in therapy with her clients she had to work through it.

You said that in the department it wasn't really dealt with?

97. No. Nobody in the department ever asked me, okay the P.F.'s[a] they, I think, maybe it's maybe it's because I'm an intern and, okay the intern's it	The subject was never approached by any of her superiors within the department to offer help emotionally, however the case was different in

was something different.	relation to her peers.

[a]The terms PF refers to the personnel working at the psychology department on a permanent basis

98. I could talk to them about it and we could sit down and talk and hash it up and talk about it at length.	With her peers the subject could sit, converse and analyse the matter at length.
99. But none of the P.F.'s asked me about it. It was like it never happened and, but I still felt like um, they know what I'm going through.	The subject did not experience any support from her superiors feeling as if they chose to ignore the incident although she felt that they did have some understanding of her experiences.

Would you have wanted them to talk to you?

100. Ja, I would have, actually. Because I felt like my supervisor was the only P.F. who was there for me and she wasn't in the department anymore and she wasn't even here anymore she was on course somewhere else. And I couldn't go to somebody because I felt that people were uncomfortable about it.	The subject expressed the wish that she would receive help from her superiors, apart from her own supervisor, who was not working within the department no one approached her. She felt reluctant to make her own approaches to them as she felt they were discomforted by it.
101. That made me uncomfortable about going to somebody and talk to them about it but I think for me it would have been nicer if one of the P.F.'s came to me and said I know what you're going through or I understand what you're going through	The discomfort the subject experienced from her superiors made it difficult for her to approach them for support. She would have wanted them to approach her and give her the opportunity to verbalise her feelings if she so desired.

and if you need to talk to somebody I am here, you know, you can come and talk to me about it.	
102. But nobody ever did, it was like, it happened and it's hush hush you can't talk about it.	She did not feel this, instead the experience that the subject had was that the event was kept silent.
103. Hhm, I felt very shitty about it. I felt vulnerable about it, I felt like I was a bit cut open and I then left there. You know, and to heal by myself. And I don't know, it just, it just put me on the spot.	The subject felt left to her own devices in a vulnerable place by this experienced attitude towards the events.
104. 'Cause I felt like, whenever I walked in, they would be there and they would see me and I think, I imagine that's how it is when somebody goes through something and you see it you either choose to be there for that person or not to be and they chose not to be there.	The subject felt discomfort in the presence of her superiors as she experienced them as making a choice not to approach her with support.
105. They saw this is what is going on and that I was struggling but they felt, you know, they're not gonna go there.	The subject felt that her superiors had knowledge of her emotional state but did not act on this.
106. So it was a bit hard, that part made it hard for me to come to work and to see patients and to gain back the confidence that I had before. So it was, it was a bit hard for me. That part 'cause I felt that, when I come in somebody was gonna talk to me about it, you know, how I was doing and have a few suggestions how to deal with it	The subject experienced this dynamic with particular difficulty, this in her opinion being a major impediment towards her regaining professional confidence as she expected support and advice from her superiors.

That's what you would have wanted? And actually what you expected?

107. Yes, I think maybe I expected that because I know it happened at psychiatry, but even if it didn't happen like that at psychiatry I expected, to come back for, I don't know just, people to say okay what you're going through is normal and it's gonna happen and it has happened before you're not the only one it has happened to. But we are here, so if you need us we are here for you, but it never happened like that. Except with my supervisor.	The subject expected a supportive response from her department since she received that response at the psychiatry department. Her expectation was the superiors would make contact and offer support in containing her emotions. This the subject did not experience at her department except from her supervisor.

So without saying that, they actually made you feel alone, disconnected?

108. Ja, it was like, I'm there alone and I'm gonna deal with it alone. Although with few interns we could sit down and talk about it.	The subject felt alienated and lonely because of this although she did experience support from a few of her peers.
109. It would have been nice, nicer for me if the P.F.'s were there as well. Because they were more experienced and they've had exposure to this more that us interns had.	The subject wished that support could have come from her superiors as she felt they had more experience with such matters than her peers.

What support did you get from psychiatry's side?

110. From psychiatry's side I think I got more support from there, from that	The subject did experience more emotional support from the psychiatry

side than I got from our department. Especially with the senior staff.	department.
111. The psychiatrist was involved with X as well, he was seeing him as well. So he called me constantly and I called him constantly as well when we were on leave, he took leave as well so we kept contact.	The subject received support through contact with the psychiatrist that treated the deceased.
112. And when I got back he was the first person at psychiatry to say welcome back, I know what you're going through and I'm going through the same thing as well.	The subject's first contact of a supportive nature was from the psychiatrist verbalising that he too was experiencing the same emotions that she was.
113. And it was like hhm a very huge sigh of relief like I know what you're going through and it's okay that you're feeling like this.	The contact with the psychiatrist and identification of emotions with another person was of immense supportive value to the subject.
114. And, the emotions that I was feeling he was feeling as well. And the loss of confidence, the starting to question yourself and asking if anything will be okay ever again those he was going through and we spent days sitting together and talking about it as well.	The emotions that was shared between the subject and psychiatrist was loss of confidence, self doubt and the question of length of emotional recovery
115. So it made me feel so much better that I could do that with somebody who was as involved with the person as I was.	This contact again to the subject was of immense emotional support from someone also involved with her patient.
116. And then the senior psychiatrist asked me how I was doing and it wasn't what me and the psychiatrist was doing it was other factors and we	The subject was approached by a superior within the psychiatric department with reassuring verbalisations of non-blaming as well

should feel bad about it and the senior psychiatrist said if I needed anything, if I needed to talk or anything he was there and I could come to him.	as the invitation to speak about the incident with him.
117. And that was very good as well because I think it made me feel, okay somebody cares, somebody's there. And I think knowing that, knowing that somebody's there for you it made me feel much much better. You know that nobody's blaming me, nobody's questioning my competence so it's fine, I can be fine and go to somebody and talk. That was good as well.	The subject felt comforted by this contact in that she experienced connectedness with another caring individual. She felt comforted by the experience of knowledge of not being held responsible for the incident.

Anything else, now?

118. Hmm, I think, now I'm seeing another patient, much much different from X and but, this week it just came out, or that's how my supervisor saw it that, what is happening now with this client is linking me back to what happened with X.	The subject seems to according to her supervisor, to be replaying some dynamics in relation to another patient who is different from the deceased.
119. Because with this client, he's a very lonely individual and he needs people now, he needs support now and I feel like I want to be there for him and I won't be there for him next week and I feel like this is the one time that he needs me to be there for him, and I cannot be there because I	The subject will again be geographically removed from her patient at a time that she feels that he needs to be contained regarding his experience of loneliness.

have to be somewhere else.	
120. And I feel guilty again about leaving him. And not being there for him especially when he needs me, when I feel like he needs me.	The subject experiences feelings of guilt for not being able to work with her client in a time that she perceives as crucial for him.
121. So mm, I was a bit shaken up about this for this week. I saw him twice this week and I might see him again today.	This dynamic is leading the subject to consult with the patient for three times within one week, she feels discomforted by the events.
122. And this is about me again feeling like if I'm gonna leave he's gonna kill himself or some thing, so I thought maybe I should have him admitted to hospital just for the week, when I'm not here or for two weeks or something. Because I feel like, if he does, he says he won't kill himself but my gut tells me otherwise	Recognising that the dynamics has its source within her the subject nonetheless advises admittance for her patient feeling instinctively that the patient might try and commit suicide.
123. And I feel like, if he does kill himself, and I'm not here, then I would fall apart. So, I decided to have him admitted. If he doesn't want to be admitted, that's fine, but at least I would have done something.	The subject feels that if her patient commits suicide while she is away she would handle it emotionally with great difficulty. Her decision is to refer him for admittal at the psychiatry department, feeling that she did at least do something.
124. Because I think he needs to be admitted, I'm gonna refer him to psychiatry and if he's not admitted, then it's fine. But I didn't want to leave knowing that he will need me next week and I didn't do anything about it.	The subject finds comfort in referral as the course of action that would be in meaning sufficient for doing what is her responsibility.
125. If they think they won't admit	The subject sets herself to abide with

him, he doesn't need to be admitted, that's fine. But at least I did something from my side just to make sure that he has some kind of support, because I think he needs that.	the psychiatry department's decision on admittal. She finds this course of action as sufficient, feeling that doing this is sufficient from her side in terms of what she sees as the needs of her patient.
126. And I feel like that has a lot to do with what happened with X, again. Should I just leave him and go, should I cancel what I'm supposed to do and stay for him? I think for me, maybe it has a lot to do with boundaries. Where or how far am I supposed to go with a client? Should it be like, okay, I have done so much and is that much enough?	The subject relates back to her interaction with the deceased. Questioning the boundaries set in terms of responsibility towards actions regarding the patient. Where to stop, what is too much and so forth.
127. I'm questioning that again: am I doing enough as his psychologist? Maybe I'll never know how far I should go with my clients or how little I should do, but at the moment I feel like I want to give as much as I can to them.	The subject seems to question what her responsibilities are and what the extent in real actions should be of involvement with clients.
128. I think that's important. Maybe it's important for them, but it's also important for me – that I did as much as I could have; there's nothing more that I could have done for this client.	The subject wants to put herself in a position where she could convince herself that the extent of her actions is satisfactory.

So, in a way, that's the question you ask yourself: "Did I do enough for X?"

129. Yes.	The subject agrees that she asks the question of "did I do enough" also in

	terms of her therapy with the deceased

Perhaps as you get reminded of X?

130. Ja, did I do enough or could I have done something more? Because I think with X, the Friday that I left, he was admitted into hospital and I didn't know about it.	The subject stays with the question of whether her actions were sufficient also relating it to the fact that she had no information regarding the deceased's admission to hospital.
131. I saw him on Tuesday and he was fine, and he said he was fine. And he said the two weeks were gonna be like a test to see if he could cope without me.	The patient reassured the subject that he was coping during their last contact. The deceased stated that this time away from therapy would be a test of his coping skills.
132. And he was taken in on Friday, but I wasn't called, because apparently I shouldn't be called because I'm on leave. You know, it was like I don't understand that because I wanted them to have called me to say he has been taken in or something.	The subject questions the rational regarding her not being informed of her patient's admittance if she was not there at the time, her wish would have been to be informed.
133. But maybe if they had done that, I wouldn't have gone on leave. And, I don't know, but I think the question is still gonna be there. Did I do enough for him? Could I have done more? I don't know.	The subject then turns towards the other side seeing the rational behind this policy, as she would have cancelled her leave and taken responsibility for her client. She again sates the question whether she had done enough for her client.

4.4 INTERVIEW 3

So, can you tell me how you, um, coped with it? How you integrated the whole event into your life, either as a, or let's start with, as a therapist?

What do you think were the changes?

134. As a therapist, I think it was more difficult to integrate it as a therapist than it was as a person. Because, as a person, you can accept that: okay, I have limitations and there's only so much I can do and I did my best, but my best wasn't good enough in this. Fine.	The subject, given the distinction between personal and professional lives, experiences the integration of the event into her life as a person easier as a professional given that she is free to accept limitations and faults as a person.
135. But as a therapist, because we are told over and over again that we have to help people, or we put it into our heads that we have to help people, and you feel like, if your patient dies, you didn't help.	As a professional the subject feels reminded repeatedly that she must help another. She feels that she did not accomplish this if a patient dies.
136. In a way, maybe it was help for the client, but that's not the help I had in mind. I think it took me a bit long to recover as a therapist, than it did as a person.	The subject sees the death of her patient at some level as therapeutic but not according to her own designs. This seemed to make her take longer to deal with events as a professional than personally.
137. As a person, I was, I could talk about it and, with other people, with friends, family. I could say: "Fine. I'm fine with it. I understand why it happened" and stuff like that.	In her personal life the subject experienced more freedom to communicate with others and to accept and understand the events.
138. But as a psychologist, it took me back to me and my issues of control – that I couldn't control this. You know, I couldn't do anything about this.	At a professional level the subject experienced her own dynamics of need for control.
139. And I think that it's very	The subject experienced it as difficult

difficult, or it was difficult for me to accept and to say: "Okay, it's fine, it happened and I understand that there was nothing I could do about it" and things like that.	to accept that the events occurred and that she could not do anything about that.
140. But I think it also helped knowing that that kind of thing, where a patient kills themselves, it happens to almost every psychologist, although we don't want that to happen.	The subject viewed the commonality of such events with others in her professional realm as reassuring to her own professional image.
141. But most people have gone through it, and they have recovered from it. But it, it's very difficult. Saying that you will recover is very easy. People say that it's very easily said;	Although she finds comfort in her shared experience with many others in her professional realm, the subject still makes it clear that working through such events presents great difficulty not easily translated into language.
142. but when you go through it, when you think about the family and what they're gonna say, how they're gonna react and your patients, should you tell them when they ask or should you not tell them, things like that. It was a bit difficult.	Taking into account the reactions and decisions to be made in regards to communication with and containing of the family of the deceased and other clients, the subjects sees much difficulty.

Okay, um, many studies have shown that you, or the therapists that go through the patient's suicide, actually have feelings such as: anger, guilt, anxiety, mourning, grief, …. Um, professional inadequacy feelings and so forth. Can you relate to some of those?

143. Ja, I can relate to the guilt and feelings of inadequacy, but not the anger.	The subject shares or relates to emotions of guilt and professional doubt and inadequacy but not feelings

	of anger.
144. Um, the anxiety, yes. When going back to my other patients, I felt very anxious, I didn't want to deal with issues of depression and suicide anymore. I didn't want to see depressed patients.	The subject experienced anxiety especially towards continuing her professional role, wanting to avoid similar therapeutic situations and symptoms.
145. And guilt; I felt like, if I had been there, that wouldn't have happened. I felt like I should have seen or maybe sensed that that was going to happen and I should have stayed. And, um, I felt that I didn't do my job properly and maybe I should have done something else, I should have done something different.	Guilt was prominent for the subject feeling that her presence would have prevented the events from occurring and the she should have foreseen the situation. Professional doubt and a feeling of not doing duty were present.
146. But the anger; I think I didn't feel angry because I could understand. Rationally, I could understand why he did it. He didn't like his life and there was no way out for him. That was the only way out for him. Either to stay anxious and depressed, or to kill himself.	The subject did not feel anger for the deceased, reasoning that this was due to understanding his situation, seeing that he had in her view no other alternative.
147. And I think he wouldn't have survived being anxious and depressed. It was, he felt like a burden to his family and it was too much for him and I completely understood why he killed himself.	The other alternative for the deceased was according to the subject tantamount to emotional death, making her see the logic in his actions.
148. But I still had those guilt feelings and stuff, but I think after time I could very easily say, for him and for me, I	Despite the feelings of guilt that the subject felt she came to the conclusion that the actions of the deceased was

think I feel like it was the best choice for him at that moment when he made it.	the best course for him.

Ja, um, some arguments are put in that therapists, a therapist's role is a non-directive, non-responsible, non-involved kind of a person and others would say that, almost quasi-religiously saying that death is part of life and it is the inevitable outcome and death is but a rebirth of a person into a different guise and everything. And so it could be part of therapy and possibly even a goal of therapy. What do you think of that statement, given your own experiences and what you've just said?

149. Um, I don't know if I would say death is a goal in therapy, but I would say, if as a therapist, you can help a client decide what best to do with their lives, that is a goal for me in therapy.	The subject disagrees with some views that death could be seen as a goal in therapy but states the role of the therapist as guidance in life decisions of clients.
150. If they think killing themselves is okay, and you help them realise that killing themselves is okay, then that is your job. That is what you do.	The subject sees the choice of suicide as part of those choices in which the therapist can provide guidance making it possible for the client to also consider this as an alternative.
151. And if you do it, that's fine. It doesn't matter if the person kill themselves or they decide: "okay, I don't want to be depressed anymore, I want to get up and go do my work".	The choice that the client makes is for the subject the end goal, no matter what that choice may be.

What do you think personally; as just simply you, not as a therapist but just as a person, of suicide as, in therapy, you know. Right or wrong?

152. I think it's, um I think it's a	The subject in her own view regards

judgement call. But for me, I would say, if it's the only way out, you then, you do it. I wouldn't say it's wrong. I can't say it's wrong.	suicide as something that should be seen on every individual case, if she sees suicide as the only alternative than she does not see it as wrong.
153. I feel like, if you want to kill yourself, it's your right to kill yourself. Nobody else can say don't kill yourself, because nobody can know exactly what you are going through.	The subject views the decision of life or death as resting only on the person himself as no other individual has that perspective.

Um, okay, you said you went through anxiety, you went through professional doubt. Um, how did you cope with anxiety?

154. Um, the anxiety, I think I coped with it by talking about it.	The mechanism that the subject used for emotional recovery from anxiety was to verbalise her emotions.
155. But it, I think it took me a while before I actually talked about it and accepted that okay, I'm anxious because this is what happened.	This process of verbalisations however could only start after time has elapsed.
156. I felt like, at first I felt okay, this is too soon for me to come back to work and that is why I am feeling anxious. It's because this has happened and it's too soon for me to come back.	The subject felt apprehensive to return to her professional capacity, as she felt not enough time had elapsed.
157. But then I, after seeing I think two or three patients, I thought maybe I feel anxious because I think I'm not good enough. I'm not competent enough to be seeing clients.	After some time working in therapy again the subject attributed her apprehension to self doubt professionally.

158. And I talked about it with my supervisor and other people. And then I thought, okay, um, my supervisor gave me this article and I went through it and they said it's normal for a person to feel like that after a patient kills themselves.	After verbalisation of her feelings both to superiors and others, the subject was handed an article pertaining to her situation showing that her emotions are normal in such circumstances.
159. So I thought: okay, this is fine and then I continued talking about it and then I went back to my patients and I saw them. And I decided there's nothing I could have done. I wasn't there and I can't keep saying I should've been there.	The subject felt that she was fine and continued to verbalisations about the subject. She returned to her work with the decision that she could not have done anything about what happened. She decided not to repeat to herself that she should have been present for her patient.
160. This is what we tell patients all the time. That you cannot undo what is done, you have to accept it and go on with your life. And I thought that if I can say that to my clients, why can't I say that to myself?	The subject felt that giving advice to clients should also mean that she herself could follow that advice and apply it in her life.

How did your anxiety play out, for instance? How did it manifest?

161. At first, it was, if I felt that a patient was suicidal, I wouldn't ask them about it. I wouldn't flat-out say: "um, I hear you say you are depressed, you feel like killing yourself sometimes?" which I used to do before. If I felt that the patient was suicidal, I will straight-out ask them and they would say yes or no.	Previously the subject addressed the matter of a patient's suicidality directly, verbalising her thoughts.

162. But I felt like, if they said: "Yes, I am suicidal", I wouldn't know what to do with it. I would, what, refer them to a psychiatrist and forever panic that I have to be there, I have to be there for them. So, I completely denied that they were suicidal.	After the events the subject felt lost for knowledge as to what course of action to take if a patient admits to suicidality, the options she saw only brought her panic, resulting in her denying of any suicidality within therapy.
163. Secondly, after then, I would, um, continuously ask them if they were suicidal. They would say "no", and then I would feel like they are lying to me. And then I would continuously ask them – this week, and the following week, and the week after that. That: "I feel like, you ask me, I might be wrong but I feel like you are suicidal". Then they would say: "no" and then I would do the same thing again next week. And then I would see that in my process notes, that I did the same thing three consecutive weeks. Which I think was bad.	After this the subject would be overly attentive about any form of suicidality, verbalising it at every session seeing this in her process notes she considered this as negative.

Do you think that that could have, you know, even encouraged suicide?

164. Ja, that's what I felt. That if I would say to a person, maybe they would think I see that they are suicidal and they are denying it, and they would become suicidal because I'm saying they are suicidal. So I thought.	The subject felt the danger of this attitude imparting suicidality if it was not present at first.

And after that?

165. Um, after that, I would just; I started talking about it – suicide. And then some of my clients would say: no, they are not suicidal, and then I would feel like they are suicidal. And then I would say to them, I would explain that, um, this is how I feel. I feel like you are suicidal.	After the initial form of working with it the subject settled into a format of dealing with suicide within therapy by simply giving her own thoughts and opinion about the matter.
166. And sometimes I would tell them about X, that I had a client before. He said he wasn't suicidal and then I went away for three days and then he killed himself, you know.	The subject would at times recount the events of the deceased, noting that he did not verbalise his suicidality to her and did commit suicide upon her absence.
167. And, um, sometimes you might not know that you are suicidal; so we would go through the criteria, you know, things like that. That helped. I think me talking to X helped a bit.	Continuing her thoughts she would say to clients that they therefore might think that they are not suicidal but still could stand the chance so they would go through symptomatic criteria, this and the verbalising of her experiences had a positive impact on the subject.
168. Sometimes they would say: "Okay, this is how I feel sometimes, but I'm not that suicidal – I wouldn't kill myself". That is what X said. I didn't do anything about it, I just gave them the story.	At times the subject experienced similarities between clients and the deceased, in response to this she would simply verbalise her experience with the deceased, not taking further action as before.

Those clients that you told about him; were they your closer clients, more closer clients that you worked longer with?

169. Ja, they were. One of them was a	The clients that the subject recounted

teenager and she was very suicidal, and them I told her about X and after a while, she was fine.	her experience with therapeutically were clients with whom good rapport existed, the subject experienced good therapeutic results with this.
170. She asked me how I felt at one time, and then I told her how I felt. It was a relief in a way, to talk about it. I hope didn't overburden her and stuff, but I just told her how it felt: me not being there and how responsible I felt.	The subject also at one time verbalised her own thoughts and emotions about the events with a long-term patient, this had a positive impact on the subject although she was still aware not to burden her client with her own material.
171. And then I would relate that to what is happening with us, and say: "If you do kill yourself now, I feel like I should see that, and I should be responsible for you not doing it. So it would be better for me to know now and then to refer you to a psychiatrist, than you killing yourself and me not knowing about it".	The subject would use this contact of a more personal nature with her patient, using it to voice her concern and wish to be let in as to her plans in order for her to provide some help.

Okay, your feeling of grief?

172. I had been seeing X for, I think, four months when he killed himself. And I saw him every week. I felt like I knew him; he was more than a client who came in every week and sat there. He was a person. I could talk to him, we could laugh together, I knew his family, I knew details about them, I knew of their lives, I knew of his vulnerabilities.	The subject would verbalise her relationship with the deceased, it being of a long term and close kind. With a lot of personal information known about emotions and family.

173. So I felt very close to him. I think as an older man and me as a young woman in therapy with him; I think for him it was different having a woman, and a black woman, as a therapist. It was something very different, and we were very close in that respect.	The closeness of the therapeutic relationship is also for the subject based on the novelty of the particulars of said relationship, it being an older male with a younger female of a different ethnicity.
174. Because he said the first time he saw me, he didn't think I was gonna help him, because he felt I was too young and I was black. Even though he is not racist, he said he felt like I wasn't gonna understand what he was going through. And because I am not married, I don't have grown-up kids and I haven't been working long; I wouldn't relate to what he was going through.	The deceased at first contact with the subject felt that she would be unable to offer therapeutic help on the basis of her age, gender and ethnicity. Although the subject did not regard the deceased as biased in this respect.
175. So, that brought us even closer, because he was very open about how he felt about me, and I was very open about how I felt about him – as an older Afrikaans man who came in for therapy. And we talked about things like that. So he felt like a client and a person that I knew very well.	The willingness of the deceased to verbalise these thoughts set the stage for honesty within the therapeutic relationship that the subject regards as the catalyst for the close nature of the relationship.

It sounds almost as if the nature of the relationship could almost have been, later on, father-daughter. Do you relate to that?

176. I do, in a way. You know when they say: when you get older, your	The subject felt the type of relationship as one of parent child but

roles get reversed? You take care of your parents. That how I felt towards him. I felt like he was older and he was retired, and I had to take care of him; as an older man and me as a younger woman.	in particular as an older child caring for a parent who could not.

So, given that background, the grief must have been very bad?

177. It was enormous. I think for three months after that, I never booked anybody for the time that I saw him. I saw him Mondays at 11, and I never booked a person after that, for three months. Monday at 11 I was free all the time, I was open. I felt like, if I brought in somebody, it was in a way I felt like I was replacing him. And I didn't want that, so I just kept the space open. From 11 to 12.	The grief that the subject felt was tremendous for her, manifesting in her keeping the physical time that they would regularly spent open as not to feel that she is replacing him in some way.

And personally? Other than those things?

178. Um, I think, the grief was more relating to him dying in the way that he did. I felt like he didn't deserve to die like that. He was very peaceful and when I hear people tell me about how he die; I mean, the brains falling out and things like that and the distance that he fell, I can just imagine how he died. And that is, I don't think it's the way I would want him to	The subject regards her grief as relating more to the way in which her patient died as to the fact that he died, the violent manner of the suicide did not relate with her image of the deceased, she regarded him as a tranquil person and she would not prefer the means with which he died.

die.	
179. I would want him to die in a very peaceful way, I don't know, with a very peaceful look on his face. Something like that. I grieved for the way he died. I felt like he didn't deserve that.	The subject felt that the deceased's manner of death should have been more peaceful, not feeling that he was deserving of such an end.
180. If I was to say that I was angry at him, it would be for the way he killed himself. But not for the fact that he died. But the way that he did it.	The subject's anger was also directed at the manner of suicide and not the person itself.

And now this has happened? How many months now that you've been … where do you find yourself now, as a therapist?

181. I think I have grown a lot from that. I know that I have limitations as a therapist and as a person. I know there's only so much I can do for a person, and other than that, there's nothing more I can do.	The subject regards the events as having a learning effect on her, making her realise her limitations as a professional and as an individual. Realising that her extent of possible help is limited.
182. And I think that helps me as well with my clients. I know I can push my clients up to some level, but I can't push them over their limit.	This the subject also applies in therapy, realising the emotional limitations of her clients.
183. I have limits as well. So, it has helped me a lot. When it happened, I felt like it was the worst thing that could have ever happened to me, especially because it was very early in the year and he was my very first client, and that happened. But now I feel like it has taught me a lot.	Realising that she has limitations as a therapist as well the subject also regards the impact of the suicide as particularly strong since this was her first client, at the time nothing could be worse for the subject, in retrospect she sees however that the experience was of a particular educational value

	to her.

Okay, that is as a therapist.

184. And as a person.	The subject sees the learning value in her life both as a professional and as an individual.

So what would you do differently, given say, you get a client that is very similar to that one?

185. I don't know. I don't know if I would do something different. With X, I felt like I did absolutely everything that I could have done. And I don't know what else I would've done differently.	The subject regards that what she had done therapeutically for and with the patient as sufficient and does not wish to have done more.
186. Sometimes I ask myself if I pushed him too hard. I wrote, even in my process notes, that I felt like, after he died, that maybe I shouldn't have pushed him. Maybe I, I don't know.	The subject is asking herself whether the pressure that she placed in the therapeutic relationship on her patient was not perhaps too great.
187. But when I went through my process notes again, I didn't push him as hard as I thought I had. Most of the things that he came up with, he came up with by himself. I didn't prompt him to come up with those things.	However as she went through the notes she kept on the therapy it became clear that most difficult subjects dealt with was introduced by the patient without prompting from her.
189. And I think those were very difficult issues that he came up with about his mother and the way he grew up and the situation that he was in at that moment. And how he couldn't	The subject names those issues that the patient came up with, it being related to his childhood and the relationship he had with his mother. Here the patient felt that he couldn't

escape how he felt about his mother and how he can't escape how he still felt about his wife; things like that – those that he came up with.	escape his emotions about his mother and wife.
190. I think they were very difficult issues for a person like him, because he was very intellectual. And I think those were the issues that I would say contributed to what happened with him. But I wouldn't say I pushed him too hard on those issues.	The issues were difficult for the patient according to the subject on account of the fact that he was a very intellectual person; still her feeling is not that she put too much pressure on her patient.

You mention a lot that you - your process notes and everything. It seems that you went over them many times; dissecting it, having a very deep autopsy of the therapy.

191. I did. I think with X, for me, it was very important that I kept process notes. I wrote them every week after I saw him, because I felt like he was a very difficult case and if I didn't put down something, that I was gonna forget what happened in the session.	The process notes was an important tool for the subject as she regarded this as a difficult case in which she did not want to overlook any aspect
192. And then after he killed himself, I just went through the notes again to see if I didn't miss anything; if he didn't say something that would have led me to believe that he was gonna kill himself. You know, something I…	After the suicide the process notes again served as an important tool in the emotional autopsy carried out in regards to the therapy.

So did those notes help you to integrate the whole thing?

193. They did. I think especially the notes just before I left. The three weeks just before I left. They helped me integrate what was happening with him.	The notes also helped in her own emotional work dealing with the events, with special reference to the last three weeks' notes.

Anything else?

194. No.	The subject signals the end of the interview.

4.5 STEP THREE

The raw data has now been delineated into separate meaning units. Those meaning units have been translated into more psychological language with specific regard to the topic under study. The next step within this process, consistent with the descriptive dialogical case study conducted here, is the identification of themes within this information. Since this is a study of limited scope, the themes that are identified here only focus on those that correlate with the literature reviewed. There are, however, many more possible themes within the data, such as the subject's view of death, and particularly suicide. Other possible topics may range from the aspect of control to the image that the subject creates of herself as a therapist. These aspects are discussed within the scope of other themes, such as the guilt and grief that the subject experienced. However, they are significant enough to be regarded as separate themes within the scope of a broader, more exhaustive study. Therefore further study on this work is possible. Following are the themes and their specific numbered meaning units, as identified from the data. These themes correlate directly with those aspects that have been identified within the literature study.

1.) The subject initially felt confusion upon receipt of the news of her patient's suicide. Such an act did not fit with the image that the subject had of her patient, given that the patient, in the eyes of the subject,

seemed to have religious beliefs that forbid the taking of one's own life. Also, it seems that the subject viewed her patient as a tranquil person, not prone to violent acts, especially in light of the method chosen for the suicide (35, 37).

2.) The subject experienced feelings of guilt pertaining to many aspects of her therapeutic relationship with her client. These include her feeling guilty about being away when he committed suicide and guilt for not doing more to stop the events from taking place. The guilt the subject felt for being away centred on the fact that she felt that her patient was in an emotionally vulnerable stage at that point. He had begun to verbalise many emotions and thoughts that he had previously not mentioned at all. The subject felt that her patient, not being contained in this phase, was especially vulnerable and alone. The other aspect of the subject's guilt revolved around the fact that she felt that she should have been able to foresee the events, and so take measures to prevent the suicide (41, 42, 43, 56, 62, 63, 68, 78, 120, 121, 143, 145, 148).

3.) The grief that the subject felt was centred on aspects such as the fondness that she had for her patient. She likened their relationship to taking care of an older parent. The patient was the first that the subject had treated in her internship and thus also held a particular significance to her. The fondness that the subject had toward her patient was further emphasised in the strong therapeutic relationship, despite early misgivings on the patient's side. He thought that, as a young black woman, she would not have insight into his world as a middle-aged white male. The relationship seemed strong in spite of this, or, according to the subject, perhaps because of this. She also grieved for, as she put it, the way in which he died. Again, as with the theme of guilt, the subject did not see her patient as a person who would take his life in a violent way. She saw her patient as a tranquil person who should not have died 'alone', as she put it (40, 55, 173, 177, 178, 179).

4.) One particularly strong theme within the information was the question of 'did I do enough?'. The subject struggled the most with this question, and the answer to this seemed to be at the centre of her emotional recovery. This question also falls within the spectrum of guilt and grief that the subject experienced, although it appears to a significant extent within the material to warrant individual mention as a separate theme. Through the process of answering this question, the subject dealt with her emotions and struggles around such diverse aspects as guilt, grief and the setting of boundaries between her and her patients (127, 128, 130, 133, 185, 186).

5.) The subject also felt very strong self-doubt throughout her recovery. This doubt pertained to her capacity as an effective therapist and unlocked many other themes such as that of control. The subject questioned her insight as a therapist through not foreseeing her patient's suicidality. She doubted whether she would ever be able to be an effective therapist, especially regarding suicidal patients and patients with depression. The image that the subject created for herself professionally also came into doubt, as up until the event she had not seemed to allow herself to be fallible as a professional. She seemed to be touched particularly strongly by the realisation that she could not control every aspect of the therapeutic process (44, 53, 85, 90, 114, 135, 138, 143, 156, 157, 162).

6.) A final theme is that of support. The subject experienced support both positively and negatively within her working environment. The meaning units showing both sides are stated here. The subject experienced support from her peers, the psychiatry department and her supervisor as positive in that those individuals approached her and seemed to share the emotions that she was experiencing. On the negative side, it seemed that the subject did not experience the same support from other departments and superiors as she felt them to be reluctant to approach her with advice and support (95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 115, 116, 117).

4.6 SUMMARY

This chapter was devoted to the phenomenological process, specifically steps two and three, in which the raw data as gathered through the interviews were translated into psychological language. This language was specifically geared to the phenomenon studied. Following this, specific themes were identified which correlate with those found in the literature. Many more themes could be extracted from the data and some suggestions for this were presented. However, as this is a study of limited scope which focuses specifically on the phenomenon of patient suicide within the realm of psychotherapy, those themes will be disregarded.

The following chapter focuses on the next step within the phenomenological process, namely, the exploration and analysis of the identified themes. This precludes the final step of interpretation and therefore is purely explorative and descriptive in nature. Chapter five further contains recommendations for future research and concludes the study.

CHAPTER 5

THEMATIC ANALYSIS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter devotes itself to the next step within the phenomenological process, namely, the integration of the material gathered according to themes, to form an idea of the whole and all the different parts. The research material is therefore discussed according to the subjects or themes that were recognised in the previous step. The process follows the thoughts of the subject, called 'A' from this point on, as she makes sense of her own thoughts and emotions through the interviews. For example, the first part of the analysis is formed by the use of the interviews with A regarding the exploration of the therapeutic relationship that she had developed with her patient. The exploration of material then concentrates on the contact that A had with the patient's wife, and A's thoughts and emotions regarding the responsibility she felt towards her patient's family. Following the exploration of these aspects, A's emotions, including guilt, grief and confusion, are discussed. This takes the analysis to the questions that A asked herself. These questions in some way sum up the emotions that A had experienced, and forms to a great extent part of the conclusion and integration that A had formulated for herself, both as a therapist and a person, during the process of working through her emotions.

The final section of the chapter contains the integration of the discussed themes with the literature study. The aim of this is to reach some conclusions and provide recommendations for further possible study in this field.

5.2 THEMATIC ANALYSIS

5.2.1 Some thoughts on the therapeutic relationship

Although very little of the material is devoted to the therapeutic relationship that existed between the therapist and her patient, some thoughts on this are

included here in order to establish some background to the set of events as a whole. From the interviews, it seems quite clear that A's therapeutic approach was one of direct and clear honesty from the first moment. Any possible distractions and impediments, in this case the question of racism, were addressed as soon as possible.

The background given by A indicates that the patient was dismissed from his work on account of accusations of racism. This the patient denied. It was almost immediately addressed in the therapy, however. In the third interview, with many months having elapsed since the events occurred, A noted that their relationship was of a deep and emotionally intimate nature because of this honesty and openness of communication that had existed from the very start: "Even though he is not racist, he said he felt like I wasn't going to understand what he was going through. And because I am not married, I don't have grown-up kids and I haven't been working long, I wouldn't relate to what he was going through. So, that brought us even closer, because he was very open about how he felt about me, and I was very open about how I felt about him – as an older Afrikaans man who came in for therapy".

Indeed it seemed that the closeness of the relationship manifested within the dynamics of the patient's marriage. The patient's wife also asked to enter therapy, seemingly not to seek help for her husband but to address her own emotional difficulties. The only hypothesis that A could draw from this was that she felt jealous of the relationship and wanted her own part of it. That she did not speak about A's relationship with her husband may have indicated that she did not harbour any maliciousness towards the therapeutic relationship between A and her husband, but simply also wanted to be in such a relationship, rather than destroy her husband's. In A's own words: "… we talked about his wife and he said that his wife wanted to talk to me. And I thought that she doesn't want to talk about him really. I thought that she felt excluded from what she saw as X's relationship with me, and that he's excluding her and that X and I have something that he and she doesn't". This is, however, purely speculation within A's mind and one would never truly have certainty as to the truth of such speculation.

The therapeutic relationship that A had with the patient seemed, at most, to be collaborative, with no verbalised or otherwise manifested suicidal tendencies. In retrospect, one might have identified some symptomatic indications for suicide but none that, in the authors' view, could be conclusive enough to warrant any action at that time. One incident that the subject described was when the patient came into the session very anxious and could not sit down. Apparently there had been an argument at home, but what seemed most prominent from this was the type of questions that the patient asked. They were laced with fear of abandonment, and with thoughts of not being remembered when the sessions ended. The rest of the relationship seemed to have been, again, of a supportive and collaborative kind, with times of good progress and times of anxiety. At several stages, the patient described good progress, feeling that the medication was working and that all was going well. This was underscored by the fact that the patient had been admitted before, without the knowledge of the therapist. Also, it seemed that the patient desperately wanted things to improve at that time as he felt that a weekend spent at home had been positive. A disagreed with this. She thought that the dynamics at home were distracting, because, at that particular time, the patient's children were visiting, and the patient spent no time alone with his wife. She felt that this was a problem area. The patient, however, insisted that things were improving.

At no point, except the one session referred to above, did A experience the therapeutic relationship as taxing or that she felt that the patient placed great demands on her as a therapist. In retrospect, A hypothesised that death was becoming the only option within the mind of her patient. She states: "Rationally, I could understand why he did it. He didn't like his life and there was no way out for him. That was the only way out for him. Either to stay anxious and depressed, or to kill himself" She mentioned that, due to childhood events, he had great difficulty in verbalising a cry for help. A adds: "But I think I should have known that he wasn't the kind of person who would have called me if he needed me".

5.2.2 Contact with patient's wife, taking responsibility

The first contact with the wife of the deceased was quite surprising for A, as very little of the blaming she expected took place. A described panicking before the call was made, but in response, the wife simply wanted to know why she had not called earlier. Here A reports that the wife also strongly wished for containment of her feelings through answers: "But she was, I don't know, she sounded very, sad, and we talked about X for a while and she asked me how did that happen…".

The suddenness of events had the same shocking effect on the deceased's wife as it did on A: "So she said, ja, her family was taking it very badly, but they knew that he was depressed and that there was a possibility that he might kill himself, but they felt he was getting better, because he was acting much better. They thought he was recovering and then it happened, and it was like a shock to them". Although both A and the wife experienced shock, they dealt with it in different ways. At one time, A said that the death of her patient was at some level a therapeutic move for him; it would take him out of his situation. She did not think, however, that this view would be shared by the wife. "… X came to me for help and then, in a way I see his dying as help for him. But I wasn't sure if she's gonna see it like that".

It seems that A's dread of the deceased's wife was compounded by A's image of her as someone who was strong and hard emotionally: "She is, I don't know, in a way a very hard kind of person. And I thought the first thing she was going to do was to blame me". In terms of taking responsibility, A went as far as inviting the wife for a therapeutic session. She did not come, however, and A simply had to make peace with that.

5.2.3 Feelings of guilt and confusion

Continuing with A and moving to the emotions that she experienced during her process of recovery, feelings of guilt, confusion and grief were identified.

Another prominent feeling was that of responsibility and grappling with the question of "did I do enough?".

Among other emotions, these were seemingly strong enough to form a trend that could be followed through the three interviews. The types of confusion A experienced included, for example, professional self-doubt. She lost her confidence in her therapeutic abilities. This is illustrated strongly through the feeling she had when coming back to work, thinking that it was too early. A shared this loss of professional confidence with the psychiatrist working with her on the multidisciplinary team. Both wondered whether the feelings would ever end, if they would ever regain their confidence to work and identify potentially destructive trends in their patients. To hypothesise, it seems that since the profession of psychology is at some level based strongly on intuition, in which therapists use themselves as an instrument, a loss of confidence could be devastating. A states: "But then I, after seeing two or three patients, thought maybe I feel anxious because I think I'm not good enough. I'm not competent enough to be seeing clients".

Paradoxically, it was this feeling of self-doubt that provided an avenue for A to deal with the events, since the other member of the team working directly with the patient also felt the same doubt. This sharing of emotions and identification with the other team member seemed to be the strongest single factor that assisted in A's recovery: "And it was like …hmm… a very huge sigh of relief, like I know what you're going through, and it's okay that you're feeling like this". Through an article that A read on therapists going through patient suicide, given to her by her supervisor, she also felt less alone, more connected by the knowledge that she was not the only one that this had happened to, that she would certainly not be the last and that the emotions that she was experiencing were natural and shared by many others who had had a similar encounter.

A's feeling of confusion was related to almost all aspects of the suicide. She felt confused about the method chosen for the suicide because she did not regard this as consistent with the person she had come to know through her

therapy, seeing her patient as a gentle man who would not resort to such violent means. This also did not fit with what A knew about her patient's religious beliefs.

Regarding the emotion of guilt that A experienced, it seems that its core lies in the specific guilt she felt about leaving the patient in a vulnerable state. It was clear from the analysis that what was later hypothesised about the patient's mental state was not known at that time: "I think the way I thought about it was that X was a very intellectual person and I had taken him to a place where he wasn't comfortable enough, and he hadn't been there before. And in a way, I did that and then I left".

Revision of the therapy through process notes and memory revealed that both A and her supervisor felt that the patient had been "opened up" or put into an emotionally vulnerable state before A left on leave. Although it is also quite clear from the process notes and interviews that A's absence had been discussed and handled, A nonetheless felt extremely guilty for what she then perceived as leaving or letting her patient down. At one stage, A actively blamed herself and felt guilty that she had not had the foresight to see the intensity with which her patient was experiencing these emotions. A subsequently worked through these feelings of guilt by arguing that the patient would not have truly verbalised the intensity of his emotions. This made A realise that if the patient wanted to end his life there was nothing that she could have done to stop him: "…there's nothing more that I could have done for this client". These factors indicate quite powerfully the extent to which A conducted a critical self-analysis on herself as a therapist with the patient, and how her own dynamics might have played some part in this process.

5.2.4 The emotion of grief

Another emotion that perhaps lies on the same continuum as guilt or self-blame is grief. Feeling guilty would put A in a position of seeing the deceased in another light. She left him at a critical time, when he was emotionally vulnerable. As A was very close to and concerned about her patient, and

regarded him highly, she felt sorrow and grief. On more than one occasion during the interviews, A verbalised that she had liked him, that their rapport was honest and of a deep emotional type. She had also, very importantly, verbalised that she felt she had lost more than just a client through the suicide, but a person, as she was fond of him. A had described her identification with the patient on the level of a father–daughter relationship. She felt that she was taking care of a parent who could not take care of himself anymore. This again shows the level of emotional attachment that A felt toward the patient. A's feeling of grief towards her patient manifested in a poignant and powerful way in that she kept his usual therapy time slot open. For months afterwards she did not schedule any other patient in this space because she felt that she would then be replacing him. This could also be seen as a way for A to honour or respect her patient in her process of grieving.

Many people resort to different rituals or behaviours within their process of grieving. The process of leaving open her patient's time slot could be considered a ritual for A. Another very prominent aspect of A's grief relates to the method of the suicide. The patient had met with a very violent end, by jumping from a staircase on a floor high up in the building. When she heard this, A was traumatised to the extent that she initially did not want to incorporate this information as it did not fit with her understanding of the personality of her patient. A attributed a more tranquil quality to her patient and verbalised that her grief was very much for the manner in which he died.

A also devoted some time and comments to expressing, in more than one manner, that she would rather have had him meet his end in another way. It is interesting though, to note that A at no time verbalised that she would rather not have had her patient die. This ties in with her earlier feeling that the suicide was in some way therapeutic for her patient. She said that "…in a way, maybe it was help for the client, but that's not the help I had in mind". A seemed to strongly respect the wishes of her patient, even in the gravest of decisions. This view, of course, would not be shared with the family or other significant others. A therefore withheld her views from those who might have disagreed: "So, we

talked a bit about that and I think I gave her the impression, I don't know if it was wrong or right, that I don't know anything either".

5.2.5 The question of: "Did I do enough?"

As A's feelings of confusion and especially guilt moved to grieving for the patient, this grief elicited questions regarding the therapy. A found herself grappling with the difficult question of 'did I do enough?' during the process of recovery. Although this process may be important later for possible future reference to similar cases, this was very much a part of the recovery process, and linked strongly to the grief and guilt emotions discussed earlier. The reason for this question, according to A, was that subsequent to the suicide she saw a patient who presented with somewhat similar dynamics to those of the deceased. A discovered that she was overly wary of the dynamics that were occurring in therapy especially since she would again be geographically removed from this new patient during what A then perceived as a time of need for her patient. In discussion with her supervisor, A agreed that the dynamics linked to her deceased patient may have been replaying in the therapy with her new patient. A experienced such strong emotions in this therapy that she started consulting with her current patient three times a week, which exceeded the norm accepted by the particular institution for outpatient therapy. At the time of the interview, A was emotionally at a point where she could refer this patient for admission and recognise that her responsibility and ability to help could stretch no further than that. A realised that her fears and caution had its origins in the events that had taken place earlier that year: "…and this is about me again feeling that if I'm going to leave he is going to kill himself or something".

The event of the suicide and its subsequent playing out in other therapeutic relationships seemed to have had the effect of placing A in the position of re-evaluating aspects of her therapy, such as the extent of responsibility toward patients (in other words, what is enough and what can be too much). Doing too much relates particularly to the therapist's overinvolvement. Where must the therapist draw the line before becoming too involved with a patient, and

therefore not objective? Even in the final interview, conducted after A's internship had ended and she was removed from that particular system and set of parameters, she still could relate powerfully to the fact that her guilt and grief were closely linked to her sense of not fulfilling her duty as a therapist. This does seem to stand in paradox to A's rationalisations regarding death as a therapeutic move in her patient's case, or to her opinion that the voluntary ending of one's own life is a choice that no one else can make, and should therefore be respected. It shows possibly that A still needs to fully integrate these aspects, or it could simply be part of a long and ongoing debate between the choice of life and death that stretches across the academic realm to include religion and ethics. The conclusions about the suicide that A arrived at seem to reflect an inclusive view: although she had feelings of neglect of duty, feelings of sorrow and anger at the manner in which her patient died, she also saw his death as a form of help. The alternative that A saw in her patient's life was, to her, equal to emotional death: "…rationally, I could understand why he did it. He didn't like his life and there was no way out for him. That was the only way out for him. Either to stay anxious and depressed, or to kill himself. And I think he wouldn't have survived being anxious and depressed". A could understand her patient's reasons for doing what he did and respected these, although she wanted the manner in which he died to have happened differently, either through choosing another way to die (one that was more in line with the A's view of the patient) or another outcome entirely. Interestingly, A mentioned at more than one stage that she would have wanted to see her patient die in another, more peaceful way. At only one stage did she voice the wish for an alternative outcome. This was almost an offhand remark while talking about the contact that she had had with the patient's family. She said that while she saw his death as therapeutic for him, it was not the manner of "help" she had had in mind.

5.2.6 Support from peers and superiors

In the process of emotionally "working through" the events that occurred and integrating them into A's image of herself, both as an individual and as a professional therapist, she experienced the help or absence of help from other

individuals. A was an inexperienced therapist, still working under supervision. She would have had to consult superiors for guidance and support. A also worked in the context of a hospital with a large psychology department that caters for many other interns in an educational environment. A also had access to many peers for support. In reviewing the data collected with the interviews, it is clear how A experienced this contact with peers and superiors as positive and supportive or not.

A turns firstly to her peers for support. She verbalised clearly that she had the opportunity to spend time with peers, analysing her thoughts and emotions on the events. This group consisted of other interns in the same department as well as the psychiatrist from the psychiatry department who was the same age and also new to such an event. A lingered here, describing more in detail how the contact she had with the psychiatrist was of great supportive value. A and the psychiatrist remained in contact telephonically and upon her return to work, he contacted her first. He expressed an identification with her emotional state and made himself available to talk about their emotional experiences: "…the psychiatrist was involved with X as well, he was seeing him as well. So he called me constantly and I called him constantly as well when we were on leave, he took leave as well so we kept contact. And when I got back he was the first person at psychiatry to say welcome back, I know what you're going through and I'm going through the same thing as well. And it was like hhhm, a very huge sigh of relief, like I know what you're going through and it's okay that you're feeling like this."

However it became clear from A's verbalisations that, although this type of support was positive and welcomed, it lacked the aspect of advice and guidance that only contact with more experienced therapists would provide. This led to the experienced support that A received from her superiors. Firstly, A made it clear that she received support through regular contact with her supervisor, even during times when she was reluctant to deal with the emotions that she was experiencing. Her supervisor made several phone calls to her for contact and support. Although this support was both needed and welcomed by A, she did not experience the same support from her other superiors. A's supervisor

was, at that time, not working at the same offices as her and was posted in another department. A felt that the experienced therapists who worked with her completely a different attitude towards her. A felt "left to her own devices" as she verbalised it, by her superiors in the psychology department. A felt that her superiors carried the knowledge of what she was experiencing but chose not to make contact verbally, for example, allowing A to speak about her experiences with them. Although eager for contact with her superiors in this regard, A felt reluctant to approach them herself, as she felt disconcerted by their discomfort as she experienced it: "Because I felt like, whenever I walked in, they would be there and they would see me and, I think, I imagine that's how it is when somebody goes through something and you see it. You either choose to be there for that person or not to be, and they chose not to be there".

It seems that A perceived a kind of awkwardness between herself and her superiors. Whether A's superiors in the department experienced discomfort, cannot be commented upon, as interviews with other members of the department were not conducted. However, no contact was made from either side. A did not initiate contact because she expected her superiors to approach her. This, incidentally, did happen in the psychiatric department: "And then the senior psychiatrist asked me how I was doing, and it wasn't what me and the psychiatrist was doing it was other factors, and we should feel bad about it and the senior psychiatrist said that if I needed anything, if I needed to talk or anything he was there and I could go to him". This experience was not the case at the psychology department, where A spent most of her working hours.

A's desire for support from her superiors was expressed at a number of points in the interview. At one stage, she verbalised in an almost polite tone, the wish that she wanted support from her superiors: "It would have been nice, nicer for me if my superiors were there as well, because they were more experienced and they've had exposure to this more that us interns had". This points to A's inexperience as a therapist, and her need for guidance in such a traumatic matter this early in her career. A experienced such support from the psychiatric department so this may have informed her expectations of support from her

own department also. Confronted with this discrepancy, A may have longed for consistency.

5.2.7 Further questions struggled with

As discussed in the section on A's emotions of grief and guilt, A worked with the question of "did I do enough?". This was among many questions that occupied A's thoughts as she went through the events in her mind. This question is at the core of the emotion of doubt that A experienced, and all other questions can be traced back to this. On other levels, A found herself questioning and re-evaluating aspects of her contact and involvement with patients: "…and I feel like that has a lot to do with what happened with X, again. Should I just leave him and go, should I cancel what I'm supposed to do and stay for him? I think, for me, maybe it has a lot to do with boundaries. Where or how far am I supposed to go with a client? Should it be, like, okay, I have done so much and is that much enough?".

A seemed to be in a process of redrawing her pre-existing lines of involvement. The aspect of involvement with a patient is salient here, specifically, how much pressure can be put on a patient within the therapeutic relationship: "Sometimes I ask myself if I pushed him too hard. I wrote, even in my process notes, that I felt like, after he died, that maybe I shouldn't have pushed him. Maybe I, I don't know". After her patient's suicide, A examined closely the aspects she felt may have contributed to his death. On a more conscious level, A was redefining who and what she is within therapy and how she would work with future patients, and asked herself more often than before: "What will be enough or too much?". This indicates the strength of reshaping that takes place with an event as powerful as the death of a patient. It is likely that this event will forever shape A in her professional capacity as a therapist.

5.2.8 Own hypothesis, answering own questions

The next step is to examine the answers or conclusions that A has drawn from her process of self-evaluation and questioning. A has drawn her own

conclusions and has integrated the events into her life as both a therapist and an individual. This integration is necessarily unique to A, although her experiences will later be compared to relevant findings in the literature. The central question that A asked herself, and which is seemingly the core of her emotional experience in terms of feelings such as guilt, fear of reprisal from the family or other professionals and A's grief for the patient, is: "did I do enough?".

It is through answering this question, it seems, that the form or precise manner with which A dealt with or integrated the events into her life may be found. As has been suggested previously, A re-evaluated her involvement with patients in terms of what constitutes too much pressure within the therapeutic relationship, or what pressure the patient can take: "how hard can I push?". The answers that A found for herself at this time could be seen in her relationship with another patient whom she was seeing at the time of interview. A experienced this patient as similar to the deceased in many ways. This new therapy gave A the opportunity not only to play out the answers and decisions that she had formulated, but also to check the level of emotional attachment she still held to her patient who had committed suicide.

It seems clear from the interview, that A approached this with knowledge and caution of her own dynamics. She was especially careful to remain aware of her own transference and countertransference. Fortunately, A was still working under supervision, so there was a ready and usable source of guidance for her. From this supervision, A was able to reach the conclusion that the dynamics and emotions that she experienced in her new therapy centred around her issues with the deceased: "This week it just came out, or that's how my supervisor saw it, that what is happening now with this client is linking me back to what happened with X".

A felt very anxious about leaving her new patient as she had with the deceased: "And I feel guilty again about leaving him. And not being there for him especially when he needs me, when I feel like he needs me". However her conclusion was that despite the source of this anxiety coming from within her,

she would nonetheless refer the patient to the psychiatry department for evaluation. A found some comfort in this and was satisfied that her action was sufficient, regardless of the outcome.

5.2.9 Being back in therapy

How will the reintegration of answered questions and new conclusions play out in A's return to the role of therapist? This concern forms the focus of the next segment. A's ideas about her new patient, and the specific comments she made about how she felt emotionally in returning the role of therapist, will be reviewed. It is important to note that although the interviews spanned a period of several months, and the last interview was conducted only shortly after A had finished her internship, this time frame is too short to allow for a proper evaluation of the type of therapist A had become after her experience. Therefore this segment concerns only A's immediate reintegration into the role of therapist, as well as her opinions and stance regarding aspects within her therapies that pertaining to the events that occurred.

At first, A was afraid of using her own judgement within therapy, choosing to ignore as much as possible the aspect of any suicidality within her patients: "When going back to my other patients, I felt very anxious, I didn't want to deal with issues of depression and suicide anymore. I didn't want to see depressed patients". Her avoidance of this aspect can be seen as natural, given the short time that had elapsed since the events occurred (Shnur & Levin, 1985).

These feelings link with A's earlier verbalisations on the method she used to deal with the events emotionally. At first, she tried not to think about them, avoiding the issue until she felt ready to do so. Following this, A moved to the other extreme and was overly aware of possible suicidality within her patients. A reported that, at this stage, she would more than once dwell on the aspect of suicide within therapy even though her patients would repeatedly reject her concerns: "Secondly, after then, I would, um, continuously ask them if they were suicidal. They would say 'no', and then I would feel like they were lying

to me. And then I would continuously ask them – this week, the following week, and the week after that. That: 'I feel like, you ask me, I might be wrong but I feel like you are suicidal'. Then they would say: 'no' and then I would do the same thing again next week. And then I would see that in my process notes, that I did the same thing three consecutive weeks. Which I think was bad".

Her explanation for her excessive concern was that the patient who committed suicide had not verbalised any suicidality either, and thus the same could be happening in her current therapies. This tendency within therapy was disconcerting to A when she realised it during supervision. The realisation mobilised her into the next stage, that of integration: taking those traumatic thoughts and emotions that had proved to be problematic and distressing up to that point, and making them a part of her being as a therapist to enable her to work in a new way. This integration was reached as A started to use her experiences within therapy. She recounts that her experience later served her well in certain therapies as she told the story of her patient to other patients: "One of them was a teenager and she was very suicidal, and then I told her about X and, after a while, she was fine". A found this a useful strategy in this therapy where she had established good rapport with the patient, and could keep track of the dynamics within the therapeutic space.

A told some of her patients about her patient who committed suicide and mentioned that he also, like some of them, had denied that he was suicidal: "Sometimes they would say: 'Okay, this is how I feel sometimes, but I'm not that suicidal – I wouldn't kill myself'. That is what X said. I didn't do anything about it, I just gave them the story".

A imparted her belief on the subject of suicide that it is the patient, as an individual, whose choice it is to decide what to do with his or her own life and that she could not stand in their way; however, she would like to be informed about such a decision, to be kept within the circle of information. At one time A verbalised her emotions on the events with another patient with whom she had a good therapeutic relationship over a long period of time. The patient

questioned A on this. A responded and experienced the retelling as positive, although she took care not to burden her patient with unnecessary emotional content.

5.2.10 Seeing death as help

The last point of this analysis regards some of the thoughts that A now has on the issue of suicide. It is important to note that A had, after the suicide, regarded this move as therapeutic in some way for her patient. This thought seemed to have been further shaped and refined as she progressed in her emotional recovery and reintegration of the events. At the stage when the final interview was conducted to explore in what way A had reached integration, A expressed her belief that she can only offer guidance within the choices that her patients make. She cannot make decisions for them. Therefore, if suicide becomes one of those choices, then it must also be treated within the same paradigm, namely, that only guidance can be given.

Ultimately, if a patient wishes himself dead and is determined to make that wish come true, he cannot be stopped. It seems that A realised this: "Um, I don't know if I would say death is a goal in therapy, but I would say, if as a therapist, you can help a client decide what best to do with their lives, that is a goal for me in therapy. If they think killing themselves is okay, and you help them realise that killing themselves is okay, then that is your job. That is what you do". This correlates with the attitudes of some therapists regarding death as a right in a free society (Litman in Shneideman et al., 1976). In asking herself whether what she did therapeutically was enough, A could have realised that, no matter what she did, the patient would still have killed himself. A saw suicide as a subject to be reviewed on a single case basis, and felt that she could not make any hard and fast rules to apply to every case. She felt that if death is the only alternative, then this choice should be respected by her: "I think it's, um I think it's a judgement call. But for me, I would say, if it's the only way out, you then, you do it. I wouldn't say it's wrong. I can't say it's wrong". A regards the ending of one's life to be a decision that rests within one person only, that being the person whose life is the concern: "I feel like, if you

want to kill yourself, it's your right to kill yourself. Nobody else can say don't kill yourself, because nobody can know exactly what you are going through".

5.2.11 Summary of section

This section followed A's thoughts on themes that correlated with those found in the literature. Her experience compares favourably to others in her position. What is unique to the subject in this case are the answers that she came to while working through her emotions. This unique set of answers are at the core of this study, since its aim is to explore and document the specific experiences of one therapist. These answers constitute what was referred to in the methodology chapter as her "Lebenswelt" or "life world". Themes that emerged included the guilt that the subject felt, her question of whether her actions were sufficient and her experience of support. The next section integrates these aspects with the literature that served as the guideline for the delineation of the specific themes.

5.3 INTEGRATION

This section contains the final integration of the data gathered in this study and the literature review. This is done by comparing the data and conclusions within the thematic analysis with the information contained in the literature study to identify points of similarity. In this way the existing literature is verified or augmented. The argument firstly concentrates on the emotional experience of A, that is, how she dealt with the emotions that she encountered through the events. Following this, these experiences are linked to postulations on the dynamics and other aspects of the therapeutic relationship that A had with her patient.

5.3.1 Emotional experience

The first aspect of comparison regards the emotional states experienced by A. Since this forms the basis of the study at one level, this comparison is both

crucial and inevitable. Therefore it is important to explore whether A identifies with emotional states recorded during research done on other therapists. This question was also directly asked within the interview process. To begin with, A felt a clear and strong identification with the emotions of guilt and confusion. A's confusion seems to correlate with what has been described in the literature as disbelief. Shock, described in the literature by Litman (in Shneideman et al., 1976) also relates to this emotional state. A described her confusion in terms that would correlate with disbelief, such as the fact that she could not integrate the fact of her patient's suicide with the image that she had of her patient. The violent manner in which the patient committed suicide (by jumping down a stairwell) did not correlate A's view of her patient as a tranquil, peace-loving man. Another correlation with the initial reaction of shock can be found in the way A avoided thinking about her patient before returning to work from leave. The literature draws a comparison between the reactions of a therapist and the posttraumatic stress that soldiers in combat situations sometimes feel (Hendin, et al., 2000). A's attempted avoidance and the inevitable failure of this mimics the stress that soldiers feel, being aware of possible death at all times, but still not emotionally prepared for it and therefore shocked when it occurs to someone close to them. In the same way, A may have been aware of the possibility of her patient's suicide, but was still shocked when it happened to the extent that an attempt was made to keep this out of thought.

It seems that the core of the reason that the suicide was such as shock to everyone involved, was the patient's lack of disclosure. He seemed to be coping well and even improving to his family and his progress presented itself as no more different than any other patient with his symptoms to the medical team that was involved in his treatment. And to his therapist, there existed a good rapport and a deep sense of understanding and honesty, nestled in sharing information on a basis of good will and trust.

The literature suggests that even experienced therapists are traumatised by the suicide of a patient. Since A did not at all expect this event, the lack of preparation could be expected to intensify the initial shock. When considering what preparation could be made by the therapist in therapy to deal with a

patient's suicidality, a problem arises. To engage in therapy with patients who present themselves as non-suicidal with the constant notion of possible suicide would be impedimental to the therapeutic process. Preparation, in this case, would require treating the patient as suicidal and therefore therapy takes the form of clinical suicidology, which is a different process altogether (Karasu & Bellak, 1980).

The treatment of a suicidal patient differs from normal therapy in that the lethality of the patient must be constantly assessed. Transference and countertransference must also be continually reviewed (Karasu & Bellak, 1980). The focus is thus removed from the latent meaning of communication. Transference can no longer be reflected on in therapy (Karasu & Bellak, 1980). Rather, the case must be managed and supervised. As has been proposed in the literature review, the power is now fully held by the patient. Applied to therapy with a non-suicidal patient, this approach is clearly not beneficial to the therapeutic process. The therapist will constantly fear what the patient will do. This is clearly demonstrated by A's report of her return to therapy and the description of her initial few weeks after her return. A was hypersensitive towards the possibility of suicide within her patients and, on more that one occasion, reflected on it in consecutive sessions. Through reviewing her process notes, A realised the potential negative impact of this on the therapeutic process. The conclusion that is drawn from this is that therapists have no choice but to continue with the process of therapy, regardless of the concerns they may have of patients' possible suicidal tendencies, and should turn to a management approach or clinical suicidology only when patients become clearly and overtly suicidal. Therefore therapists must accept the possibility of death as part of what they do in their profession; they cannot continually try to avoid this, because no therapeutic work can then be done.

The analogy of the soldier is again relevant here, as therapists must continue attempting to guide patients in therapy, in spite of lurking danger. With A, there was no warning strong enough to warrant the classification of her patient as suicidal. She had no choice but to simply do the work she was trained to do with her patient in therapy.

5.3.2 Postulations on the therapeutic relationship

Although it is not the direct aim of the study, it nonetheless seems relevant to hypothesise to some extent about the thoughts of both the patient and A as the therapeutic relationship played out. This creates a perspective on previous arguments on the lack of forewarning knowledge that A, and the rest of the team, had of the suicide. It could also provide a frame for some of the thoughts and emotions that A felt with regard to her patient and his family, the conclusions that she drew regarding death, suicide and her opinions on the subject. These are discussed later on.

A study of the interviews reveals that A's patient felt deeply dependant on her emotionally. A good example of this is the appointment that the patient made as an emergency, where he was very anxious and "all over the place" as A described it. As he calmed down during this session, the verbalisations alluded strongly to the patient's need for containment. The patient feared that his therapist "forgets" him when he walks out of the room.

It seemed that the patient felt contained within A and if she did not keep him in thought then he as if he did not exist. This hypothesis is possibly underscored by his comment at the end of that particular session that he felt as if he could stay in that space forever. However, any hypothesis in this regard remains purely speculative since the true thoughts of the patient can now never be known. There was only session of that kind as the patient seemed very restricted, and A believed that he would not easily verbalise a cry for help to any great degree. It is this proclivity of the patient to keep emotions to himself that may have been the largest factor in the total shock and surprise that his suicide caused the therapeutic team. On the surface, he looked as if he was responding to the medication and therapy and that his progress was satisfactory.

The theme of responsibility seems to be a prominent aspect in A's emotional recovery. A stated, at one stage, that she wanted to be informed that her patient was admitted to hospital, in spite of the fact that she was on leave and therefore

would not need to be brought in. A would have cancelled her leave and come in to see the patient. This proves strongly the sense of responsibility that A felt towards the patient. The literature reports that the reaction of therapists to the suicide of patients with whom they were deeply involved is much stronger than that of therapists whose contact with a patient has been brief (Litman in Shneideman et al., 1976). A's involvement with her patient was of a long term nature, therefore her feeling of responsibility could be understood in the context of the literature.

5.3.3 The emotion of grief

A also felt grief as time progressed and as she worked on integrating the events into her life. A shares this emotion with nearly 50% of all therapists who suffer the event of a patient suicide (Hendin et al., 2000). As was noted in the literature, the emotions of guilt and grief are closely related, possiblyas points on a continuum. Guilt may be felt on one side of the spectrum if the therapist's involvement was of a brief or impersonal kind, for example, short-term therapeutic relationships that did not develop beyond a superficial exchange. A had a much more intimate therapeutic relationship with her patient, placing her on the other end of this spectrum, with grief rather than guilt being the primary reaction.

A identified with her patient as a kind of parental figure, this being a parent whom she cared for as he became older. The literature states that therapists (especially younger ones) typically show a strong emotional reaction to the death of a patient who reminds them of a parent (Litman in Shneideman et al., 1976). The combination of these two factors, namely, the parental identification and intimate nature of the therapeutic relationship, intensified the feeling of grief or mourning that A experienced. This is underscored by the rituals that A adhered to within her period of mourning. The most significant of these rituals was keeping her patient's regular time slot open. Her emotional state, and the preparation needed to make contact with the patient's family, are other examples of this.

The intense emotional reaction described in the literature (Litman in Shneideman et al., 1976) was experienced deeply by A. Here the correlation with the literature is clear and direct. The only point of slight deviation is the particular type of parental identification that A experienced. It is unclear whether the identification referred to in the literature refers to a similar experience of parental identification to that felt by A, namely, that she felt as if she was taking care of an older parent. A experienced something akin to the role reversal between parents and children that sometimes takes place when parents become sickly. Perhaps on an emotional level, A identified this "sickliness" within her patient in that he did not have the emotional strength to cope with the life changing events that he was experiencing. Perhaps the patient did not bargain at all on being dismissed from work at an age which precluded the possibility of finding a new post.

A's identification with her patient would have intensified her caring for him. Another point worth mentioning is the fact that this patient was the first case that A handled at this particular institution. These factors combine to show how significant the patient was for A. A expressed this notion by stating that she felt that her patient was more than simply a patient; she felt for him as a person with whom a deeper connection was forged. This feeling is illustrated by A's description of how the therapeutic relationship was forged through overcoming the patient's preconceived ideas about gender and age (and possible race, although the patient never admitted to this).

These factors may have contributed to the preciousness of the relationship for A as it may have shown her that some barriers can be overcome and deep relationships formed as a result. These factors strongly suggest how the therapeutic relationship moved to a deep level and explain the intensity and appropriateness of the grief experienced by A.

5.3.4 Unfulfilled expectations and self-doubt

In addition to the deep therapeutic relationship felt by A with her patient, several additional factors could have contributed to emotions of self-doubt and

feelings of inadequacy. These emotions centre around A's image of herself as a professional therapist. A shares this emotional state of self-doubt with other, less experienced therapists who have gone through similar experiences (Hendin et al., 2000).

It is therefore to be expected that A would be confronted with harsh questions from herself. These questions include statements such as "how did I miss it?", as well as more direct doubt in her own therapeutic abilities and a fear of returning to therapy. A experienced apprehension before going back to her role as a therapist and felt she was not ready yet. One source of support, through all these self-questioning thoughts, was A's identification with the psychiatrist who had also worked with the patient. Both shared similar emotions of self-doubt and wondered how long these feelings would last. The therapeutic effect of this sharing of emotions is discussed later.

A's doubt centred on the question of "did I do enough?". This correlates strongly with the expectations that A seemingly had of herself as a therapist. She wanted to be there, she wanted to be able to do something. She also questioned the policy of the hospital on notifying therapists on leave of patient admissions. She hypothesised that, had she been notified, she probably would have cancelled her leave and come to work. It seems that A created an image of what she should be able to accomplish as a therapist, and when this expectation was so violently shattered it created a very personal struggle within her. She was suddenly faced with her fallibility as a person and not being the "perfect, faultless" therapist she aspired to be. This seemed to be the essence of the feeling of self-doubt and inadequacy that A felt, an emotion she shares with many other therapists going through similar experiences (Litman in Shneideman et al., 1976).

In this case, A's intuition failed her. She did not see this tragic event coming and therefore doubted herself. Her feeling was: "I cannot see into my patient, I cannot predict what is going to happen" and therefore she did not feel capable of conducting therapy. What seems to have had the most impact in this particular suicide was the suddenness of the event. No one, least of all A, felt

in any way prepared for the events as the patient was not regarded as at all suicidal by any of the staff.

5.3.5 The subjective experience of support

The aspect of support given to A, and how she experienced this, is a difficult but imperative subject to explore. It is difficult in the sense that A's subjective experience is unique to her, and thus not easily comparable with other cases. The support that A felt she obtained is a subjective experience, and may not correlate at all with the support that others perceived that they gave her. A did not subjectively experience much support from her supervisors. Although this type of support would be rated as the most effective (Litman in Shneideman et al., 1976). A described that she felt discomfort from her supervisors' side, a reluctance to approach her and give support. She felt that her supervisors in the psychology department chose not to "be there" for her.

The reason for the perceived lack of support from the A's superiors is not known. Apart from genuinely feeling uncomfortable to approach her, one may hypothesise that A's superiors expected A to approach them first. This may be attributed to the culture and style of work existing in that department, which might differ from other departments (such as the psychiatry department who was perceived as more supportive). As an intern, A had at the time only been working in the organisation for a few months. Her relative newness with this vast system and her a lack of familiarity with the ways in which work is conducted there may have resulted in an inability to obtain support. In support of A's experience and hypothesis, it is possible that the therapists in the psychology department were equally inexperienced with the event of a patient suicide, and were therefore reluctant to approach her out of fear of not knowing what type of guidance to provide. Another hypothesis in this regard is explained by the difference in support given by the psychiatry and psychology departments. The literature suggests that the impact of a patient suicide is experienced as less traumatic if it occurs in a psychiatric hospital setting (Litman in Shneideman et al., 1976). The psychiatric staff were more directly affected by the event because the patient was treated by this department. The

suicide occurred directly after a psychiatric ward round where the patient was seen, and the sound of the patient falling was heard by the staff. All these factors brought the event much closer to home and its impact was much stronger and traumatic for the psychiatric staff than for the psychology department, which is located in another building in the hospital complex. The directness of the events may have mobilised the psychiatric department in a much more powerful way than the psychology staff.

5.3.6 The re-evaluation of boundaries

All these emotions forced A to address the issue of boundaries between therapist and patient. At first, it seemed that A did not formally create a set of guidelines by which she would be able to judge acceptable levels of personal involvement and emotional attachment. Formalising boundaries only became truly relevant to A after she was forced to deal emotionally with an event where the emotional impact was directly proportionate to her emotional attachment to her patient. In short, to protect herself in future from trauma similar to this, A had to learn to create distance between herself and patients, without becoming so distant that she could not longer function effectively as a therapist. The literature provides many warnings about keeping work with suicidal patients down to a minimum and not spreading oneself too thin with many such patients (Karasu & Bellak, 1980).

The current case was complicated by the fact that the patient was not sufficiently suicidal in presentation to be labelled as such. This makes the issue of boundary setting not only more personal for A, but also broader, as it applies to all patients, no matter what their presented condition might be. A's patient fell overtly within the more neurotic range of mental problems. He had symptoms of anxiety and stress related to life changes considered normal for his age. A had little warning of his intention and therefore had no choice but to continue to act within her normal role as a therapist.

Following her patient's suicide, A was therefore faced with the re-evaluation of boundaries in all facets of her therapeutic relationships. A's treatment of

another patient after the suicide is indicative of how she set about dealing with the issue of boundaries. A was eventually able to accept the limitations of what she can and cannot do, and then implement this acceptance through believing that what she does is enough. For A, in this case, it was enough to refer her patient for evaluation by the psychiatrist and then accept whatever decision was made. Although A's judgement was to admit the patient to hospital, she needed to accept that this would not necessarily be the psychiatrist's conclusion.

We could hypothesise that if the events just described had taken place earlier during A's recovery from the suicide, she might have gone to great lengths to ensure that her patient was admitted. A's acceptance of the psychiatrist's evaluation suggests not only a good recovery but a realisation and acceptance of her own limitations as a therapist.

It seems that A reached a point where she could integrate her feelings about her role as a therapist, especially regarding the extent of her involvement with patients. She reached a point where she could be satisfied that what she does will be enough, accepting her personal limitations as well as those of the therapeutic relationship. This can be seen as an important step within the recovery process for A, and an important milestone in her integration of the events into the "new therapist" that will eventually emerge out of this process. Unfortunately the literature does not seem to provide an account of a therapist's recovery and emotional attitudes after a patient suicide. This would be a noteworthy area for further study. The literature suggests that A's recovery is the result of her dealing with her emotions of guilt, grief and inadequacy (Kleepsies et al., 1993; Litman in Sheideman, 1976).

5.3.7 Emotional working through and questions answered

Through working with the events and their emotional impact, A integrated these aspects into herself as a person and a therapist. Such a process naturally leads to new viewpoints and realisations. These "answers" and emotional realisations are important to this study in terms of understanding the unique reality of someone who has worked through a patient suicide.

A's emotional journey started with the sudden and severe shock of receiving the news that her patient had committed suicide. This set off a process of questioning herself and a fear of returning to therapy. At first, A did not wish to deal with the event, and attempted to put the thoughts out of her mind. Upon realising that this was becoming impossible, she then started thinking hard about what had happened. By this time A was also back at work, so discussions with peers and supervisors took place.

This sequence seemed to have been present in her later therapies as well, with events progressing roughly along the same path. As with working through her own emotional issues, A found it difficult here to persist in her avoidance of the issue of suicide. The next step for her was to move to the other side of the spectrum in playing attention to possible suicidal tendencies in her patients. A preferred to err on the side of caution to the effect that she found herself too sensitive to signs of suicidality.

As time progressed, A seemed to integrate her patient's suicide as both a person and therapist. The integration of the event into A as a person was subjectively easier for her than integrating it as a professional and a therapist. A indirectly suggests that this was due to the expectations that A had set for herself as a therapist. It seems that A had an image for herself as an infallible therapist, and permitted herself no room for error. As a therapist, A felt that she should be able to help, to illicit change for the positive and not make 'mistakes'. When the greatest imaginable "mistake" happened for A, she was forced to re-evaluate this expectation. On the other hand, A allowed fallibility in her personal role or capacity. She allowed herself to make mistakes as a person and felt free to discuss them without the fear of being regarded as unprofessional or negligent. As a professional, however, the fear of blame from the patient's family and the professional community preyed strongly on A's mind. The resolution of this crisis started taking place as A became increasingly able to use and share the events that took place within therapy. When patients presented with what she regarded as suicidal tendencies, A would recount the events with her patient strategically to either aid the

patient's thoughts on the matter or to build trust. It is important to note that A was at this stage ready to recount her experiences. This can be regarded as an important milestone for A, as she could speak about her emotions without the fears she had earlier expressed. To hypothesise, it seems that A reached a point where she felt in control, unlike previously when the events and her emotions controlled her.

From this position, A developed a new set of opinions and beliefs regarding suicide. These events shaped her as a different therapist from what she had previously been. An example of this is A's re-evaluation of boundaries. Before the suicide, A did not consciously consider what her level of emotional involvement with a patient should be, nor the extent of her own mental involvement and how this affected her. After the suicide, considering these factors became a conscious effort, born from the questions of "did I do enough?" and "what is enough?".

In this light of change, A adopted a new stance on the ending of one's life. It is notable that A reached a point where she accepted that if a person chooses death and truly intends to go through with this decision, then there is very little that anyone can do to stop this. Also, it seems that A regarded the reasons for taking such steps with a completely new set of thoughts. She no longer felt that any person, other than the individuals themselves, could fully know the circumstances of their lives. Because of this, A felt that no one can judge whether the choice of ending one's life is right or wrong. As a therapist, A regarded her duty to be the guidance of individuals in life decisions. If suicide is one of those decisions, then this possibility also needs to be explored.

Therefore it seems that A could see that the ending of one's life can be understood and regarded as a real choice (Litman in Shneideman et al., 1976), although A did not consider it to be the most desirable outcome. This is underscored by A's assertion that she could understand and see that death would be the only viable alternative in the thoughts of her patient, but that it would not have been the alternative that she would have wanted him to choose.

To take this stance toward death and suicide seems to be the final integration that A achieved at the time of interview. This was the core of the "new" therapist, shaped out of the traumatic events so early in her career. Some individuals may claim that such a conviction is devoid of any true concern for the patient, or for any significant others left behind after a suicide. However, A has gone through an experience of patient suicide and is therefore in some way uniquely qualified to voice such a view. On another level, this stance reflects a deep respect for the patient in therapy. Such respect for her patients could contribute strongly to A's strength and competence as a therapist.

5.4 CONCLUDING THOUGHTS

To conclude this study, the author reviews some thoughts and realisations that he experienced through conducting the research. A captivating thought is the aspect of a therapist's preparation for such a contingency as patient suicide. Although it seems highly desirable that therapists prepare themselves for the worst, this is almost impossible from a therapeutic viewpoint. With any patient, there is a degree of risk in terms of suicide; one can never rule this out. Many suicides, such as the case under study here, happen to the complete surprise of those involved. With cases that are clearly presenting a danger of suicide the treatment enters the realm of clinical suicidology, which is quite different from normal therapy. The result is that preparation for suicide on the therapist's side within the therapeutic relationship can impede to the therapeutic process. This puts the therapist in a difficult position. As argued earlier, therapists have no choice but to continue to work as before, attempting to guide their clients toward insight and to offer guidance in the choices that the client is considering. The only hope that therapists have is that the therapeutic relationship is of such a strong and trusting nature that the client will inform them of any suicidal intentions. As has been proven by this case under study, this is not always the case.

This leaves therapists with only the option of preparing themselves mentally to handle a patient suicide. They must find the balance between professional detachment and solipsism, and avoid being so removed that the therapeutic

relationship suffers. In terms of preparation for suicide, the literature reports that experience also offers no tangible preparation for the emotional impact of such an event. This has been cited as a possible reason that the staff of the psychology department did not provide the necessary support to A. This again puts one in the position where the only realisation is that, no matter what steps are taken in preparation for such an event, the impact is likely to always be traumatic and possibly life changing.

The life changing aspects for A, in this case, were far-reaching and perhaps controversial, specifically with respect to the view of death and suicide that she has adopted. Working through her emotions, A reached the point where she could not state that she would regard suicide to be undesirable in every respect. She would have to consider every case individually, and would be loathe to interfere with individuals' decision to take their own life. To her, it is a decision that only individuals themselves can make, as they are the only one with that particular insight. However, one can also argue that if a patient is diagnosed with a psychiatric disorder, as 90% of all suicide victims are (Deisenhamer, DeCol, Honeder, Hinterhuber, & Fleischhacker 2000), then the patient's judgement may be impaired. Thus the patient may lack the perspective with which to make a decision.

The aspect of suicide is indeed a feared occurrence within the therapeutic community. Its prevalence is higher than any therapist would care or like to admit. Preparation for this event is difficult and prevention perhaps even more so. The aim of this study was to explore the perspective of someone who has gone through this dreaded event. The purpose of the research was not to provide definitive answers but to present material for thought as seen in terms of the life world of the subject. Readers are therefore invited to draw their own conclusions.

5.5 RECOMMENDATIONS FOR FURTHER STUDY

There is a great need for future research which is directed at researching the long term effects of patient suicide on a therapist. The literature concentrates

heavily on the immediate effects of such an event, but there is a dearth of studies which investigate therapists' adjustment over an extended period of time. Another noteworthy area of investigation is the possible discrepancy found within the literature between the vulnerability of older and younger therapists to patient suicide. Hendin et al. (2000) found that older and younger therapists experience the trauma as equally severe, while McAdams and Foster (1999) state that younger therapists experience the events as especially traumatic if their patient reminded them of a parental figure. Further research could resolve this discrepancy and contribute further to the literature in this area.

A final recommendation for research concerns training contexts such as a psychology intern facility. Mechanisms in such settings could create an opportunity for intern therapists to verbalise their emotions on a formal level following traumas relating to their experience as trainee therapists. It is argued that since adequate preparation for the eventuality of a patient suicide is not possible, post-event support systems should be investigated and implemented.

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